STATE OF HEALTH OF MIGRANTS 2005

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CARAM Asia

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ACCESS TO HEALTH

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It's simply impossible to mention all those who have been involved in this monumental effort; the production of the first ever state of health report on migrants.

Numerous persons have been involved in training workshops, researching and compiling data and information. They have in turn worked with many others in their own organisations to get the job done.

Indeed, this publication reflects a truly collective effort, a proud moment for CARAM Asia. We certainly could not have reached the completion of this long collaborative process without the support and involvement of the migrants' communities in all the countries covered in this report.

Particular appreciation must go to the State of Health taskforce members, who were at the core of the entire project. Devoted and resilient, the taskforce managed to wade through difficult and challenging times in seeing through various stages of the project; from trainings, capacity building, technical support, analysis, validation of the findings, and finally writing of the report.

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FOREWORD

I am honoured to have been asked to write a foreword to CARAM Asia's first Annual Report on the State of Health of Migrants. This is indeed a timely initiative. The topic of migration has been steadily rising up the global agenda. This is not just because more people are migrating but also because of increasing recognition of the complexity of the topic and the importance of managing migration effectively. The movements of today are no longer uni-directional and permanent, but are increasingly temporary, circular and multi-directional.

But while migration in general is now an important focus of attention, the issue of health and migration is only now beginning to receive the attention it deserves. Many have ignored the impact of health and of population mobility on development. Similarly, as the report points out: "those working on international health concerns often fail to look beyond a strictly medical paradigm to consider the larger social, cultural, political and economic context in which health issues are embedded."

This study helps to fill that gap. Its focus is on Asia, but it makes a significant contribution even beyond the Asian continent because both the method and the results are valuable.

The report reviews laws and policies pertaining to international migration and health in several origin and destination countries, but then, importantly, goes beyond this in carrying out primary research with migrant workers and relevant stakeholders. It lets the reader hear the voices both of the policy makers and of the migrant workers. It highlights the disconnect that may take place between policy and practice, reminding us that vigilance is needed to ensure that even the best policies will be correctly implemented in practice, right down to where they affect the individual.

NGOs play a crucial role in documenting and exposing poor practices, abuses and injustices. In many cases, such reports demonstrate the importance of access by migrants to information. When migrants do not know they have health insurance, for example, they do not claim reimbursements for medical care to which they are entitled.

This first Annual Report on the State of Health of Migrants reminds us forcefully that respect for human rights, including of migrants, is an essential element of managing migration for the benefit of all. All actors – migrants, governments, international organizations and civil society – have an important role to play. Safeguarding of public health entails the safeguarding of the health of all, including of migrants.

IOM salutes this valuable contribution to our knowledge and understanding of the issues.

Brunson McKinley
Director General
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INTRODUCTION

The movement of people from one place to another is as old as human history, but presently the scope and intensity of international migration are increasing as a function of globalisation processes. People, often from developing countries, are on the move in search of a better life – their dreams nurtured by the potential rewards of participating in the global market economy.[1] Migrant workers[2] make up a significant part of this landscape of human movement. According to United Nations (UN) and International Labour Organization (ILO) estimates, out of the 175 million people who live outside their countries of origin, 120 million are migrant workers and their families.[3]

People who relocate to another country for work comprise a diverse group of individuals – from wealthy oil executives stationed overseas to domestic workers[4] eking out an existence far from their families – though a distinction is often made between skilled and unskilled migrant workers. The former group is composed of highly paid professionals and technicians, whereas the latter group is concentrated in what is commonly referred to as 3D jobs, work that is generally regarded as dirty, dangerous and degrading.[5] This Report is concerned with migrant workers in the latter category and their right and access to appropriate health information and adequate, affordable health services.

CARAM Asia's 2005 State of Health of Migrants Report aims to:

1) assess the accessibility of quality health information and services for migrant workers in Asia;
2) determine whether national laws and policies in Asia promote, protect and ensure migrant workers' access to health; and
3) establish a set of recommendations on how to improve access to adequate health information and services for migrant workers in both origin countries and destination countries

Unique to this Report is the inclusion of the migrant worker's 'voice', meaning migrant workers' personal experiences and perspectives are represented to strengthen the analysis and more fully illuminate migrant workers' realities.

Since November 2004, 11 CARAM Asia partner NGOs and two independent participants have been working simultaneously in 13 countries (Bangladesh, Cambodia, the Hong Kong, SAR of China Special Administrative Region, India, Indonesia, Japan, Malaysia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand, and Vietnam) to review the laws and policies pertaining to international labour migration and health and to conduct primary research with migrant workers and relevant stakeholders in the effort to gather firsthand information on migrant workers' access to health in the Asian region.

Foundational to this Report are the understandings that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,"[6] and the belief that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family."[7] These statements, as articulated in the Constitution of the World Health Organization (1946) and the United Nations Declaration of Human Rights (1948), respectively, inform the direction of this Report, which argues for a rights-based approach to health.

This Report argues that all humans have the right to enjoy the highest attainable standard of health, irrespective of sex, race, colour, language, religion or conviction, political or other opinion, national, ethnic or social origin, nationality, age, economic position, property, marital status, birth or other status. Where specific groups, such as migrant workers, encounter obstacles in achieving the basic right to health – whether as a function of discrimination, marginalisation, isolation, and/or stigmatisation – national governments and key stakeholders are obligated to respond proactively with laws, policies, programmes, and monitoring mechanisms to ensure that health rights are promoted and protected.

* * *

The first chapter in the 2005 State of Health of Migrants Report presents evidence to support the idea that health status is an important indicator of migrant workers' well-being during international labour migration. An overview

of the vulnerabilities and challenges migrant workers experience at every stage of the migratory process is provided. Women's particular vulnerabilities during migration are touched upon, because research has shown that women are extremely vulnerable during this process. This chapter also demonstrates that governments generally fail to erect laws and policies that protect migrant workers' health and rights, even though international instruments and declarations set out clear guidelines on the provision of health for all, which can be used for such purposes.

Chapter two highlights governments' hesitations in addressing migrant workers' vulnerabilities and health rights, explains the possible reasons for this and demonstrates how this hesitation results in limited policy and programme work being undertaken. Regardless of the described setbacks, the chapter goes on to outline a number of established programmes around the world which focus on migrant workers and HIV/AIDS prevention, treatment and care. The last half of this chapter details challenges in designing and implementing such programmes, taking up the issues of culture, gender, diversity amongst migrant workers, and top-down versus bottom-up strategies.

The third chapter begins by describing the research strategies and processes utilised by the 13 research participants in this Report. This is followed by the country reports which offer significant insight into the context of international labour migration in each country represented, including whether or not relevant national laws and policies are in place. The origin countries are presented first. This set of reports principally focuses on migrant workers' experiences in accessing health information and services prior to departure from their home country and upon return. The destination countries, which appear next, concentrate more on migrant workers' experiences once they are working abroad.

Chapter four presents a critical overview of all the countries in the Report from an origin and destination country perspective. This chapter draws attention to the fact that failures in providing legal and policy protection for migrant workers are not unique to a particular country, but reflect gross negligence on the part of governments and other key stakeholders throughout the Asian region. Parallels between countries on the issue of inadequate implementation of policies and programmes are also shown to exist. These failures are illuminated by the stories of migrant workers, which are remarkably and distressingly similar across Asia.

The fifth chapter provides recommendations for action which bring together recommendations from every country represented, with a number coming directly from migrant workers themselves. They detail a range of actions that need to occur at regional, national and local levels by governments, policymakers, recruitment agents, employers, and other key stakeholders to ensure that migrant workers' health and rights are safeguarded during every stage of the migratory process. The recommendations provide a comprehensive and practical way forward.

The 2005 State of Health of Migrants Report is the first in what is to be an annual series undertaken by CARAM Asia aimed at monitoring and reporting on the status of migrant workers' health and rights in the Asian region and beyond. It is our hope that this Report will inspire the protection and promotion of migrant workers' rights and access to health and that future Reports will be able to monitor positive progress in this area.

References

[1] Zaman, Habiba. 2004. "Transnational Migration and the Commodification of the Im/migrant Female Labourers in Canada." International Journal of Canadian Studies. 29:40–61.

[2] For the purposes of this report, we use the term 'migrant worker' as set out by the Convention on the Protection of All Migrant Workers and their Families (1990), which reads: "a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national." Part of the significance of this definition is that it does not regard that loss of employment results in the loss of migrant worker status. For example, a migrant worker who fails to comply with the conditions to which his or her entry, stay or employment is subject may still be regarded as a migrant worker. 'Irregular' or 'undocumented' migrant workers are party to the definition used here. The term 'illegal' migrant worker should not be used, as the negative connotations of the term 'illegal' disregard the contributions made by migrant workers to the economy, the complex circumstances that can result in undocumented status and the fact that a human being cannot inherently be illegal.

The most common category of documented migrant workers are temporary contract workers who remain in a country for a limited and set duration; though it is sometimes possible for migrant workers to remain in destination countries for longer periods of time, where they may receive permanent resident or citizenship status. In addition, we recognize that the terms and conditions under which a person moves from one place to another can shift markedly, but the term 'migrant worker', as it is used in this report, is not directly inclusive of foreign students, internally displaced persons, refugees, development displacees, tourists, asylum seekers, smuggled migrants, and victims of trafficking. At the same time, it must be acknowledged that individuals in these categories may refer to themselves as migrant workers. In this respect, a degree of flexibility is called for in attempting to define the term 'migrant worker'.

[3] International Labour Organization. ILO Meeting, Call for Change in Migration Policies in Southern Africa. Press Release.

[4] The term 'domestic worker' is used in this report, as the term 'domestic helper' does not adequately acknowledge the labour involved.

[5] There is little doubt that the tasks performed by unskilled migrant workers are arduous and dangerous, but there is nothing intrinsically 'dirty' about the essential tasks undertaken by migrant workers. It should be noted that this description fails to reflect the dignity of the labour involved.

[6] The Constitution of the World Health Organization was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States, and entered into force on 7 April 1948.

[7] Universal Declaration of Human Rights. Adopted and proclaimed by General Assembly resolution 217A (III) of 10 December 1948.

CHAPTER ONE

MIGRANT WORKERS, HEALTH AND HUMAN RIGHTS

Placards prepared by migrant worker spouses for the AIDS day rally in Nepal.

CHAPTER ONE:

MIGRANT WORKERS, HEALTH AND HUMAN RIGHTS

Reviewing international labour migration through the lens of health serves as an excellent tool by which to explore the myriad of factors that impact upon migrant workers' experiences abroad. The health of migrant workers is at the centre of a number of intersecting issues, including the increasing international movement of people, the vulnerabilities associated with such mobility and the international and national mechanisms in place (or not in place) to protect those participating in international labour migration. Health status ultimately serves as one of the most tangible indicators of migrant workers' well-being.

Given the value of using a health perspective to explore the impact of international labour migration, it is regrettable to report that a discussion of health has been largely absent from the globalisation discourse, which continues to concentrate on the political and economic contexts in which goods, ideas, people, and capital circle the globe.[1] At the same time, those who are working on international health concerns often fail to look beyond a strictly medical paradigm to consider the larger social, cultural, political, and economic contexts in which health issues are embedded.

To use the work being done on HIV/AIDS as an example, Dennis Altman, a member of the Programme Committee for the XI International AIDS conference in Vancouver (1996), recalled that only a single abstract among the six to seven thousand submitted dealt explicitly with either the political economy or globalisation processes.[2] Again, with HIV/AIDS, there has been improvement in recent years, as researchers have begun focusing on the relationship between migration, patterns of high-risk sexual behaviour and vulnerability to HIV and STIs; but data on certain vulnerable groups (e.g. displaced groups and migrant workers) remains limited and studies continue to focus on single countries, ignoring international transmission patterns of the disease.[3]

The health of migrant workers needs to be on the agenda of both national law and policy makers and health professionals around the world. If this is not done, a sizable number of the world's population will suffer. Consider that the Saudi Ministry of Labour estimated there were approximately seven million foreigners in the kingdom in 2003, making up nearly 33 per cent of the total population, with expatriate labour constituting around 67 per cent of the total workforce and 95 per cent of labour in the private sector.[4]

It is true that migrant workers are often healthier than the local population of the destination country due to the 'healthy volunteer' bias and pre-migration health screening that selects for the healthiest individuals, but studies show that the 'healthy migrant' effect is lost over time.[5] Migrant workers frequently experience a deterioration of their former stability. Friends, partners, spouses, doctors, and other individuals who play a supportive role are no longer available to meet their needs. They are therefore susceptible to health problems in their new environment, while their needs remain intact.

For example, sexual needs do not evaporate upon arrival in the destination country, and, as such, new intimate relationships may be formed or visits to sex workers may take place. If access to health information and protective measures, (e.g. condoms) are limited or if such measures are not available, health problems can ensue. It is common to discover that diseases such HIV/AIDS have spread quickly throughout populations who are displaced or temporarily employed away from home.[6] Given the elevated incidence of health problems after migration, decisive action is needed.

Rather than monitoring migrant workers as they cross national borders through strict mandatory health testing and deportation procedures, the focus should be on improving the conditions of international labour migration. It is through improving the circumstances of migration that migrant workers' health vulnerabilities can be decreased over the long-term. This approach requires that human rights be respected. Human rights are legally guaranteed protections for individuals and groups against actions that interfere with fundamental freedoms and human dignity. These rights encompass a full range of civil, cultural, economic, political, and social rights. International human rights instruments explicitly recognise that human rights, including specific health rights, apply to all persons.[7]

The move here is away from a surveillance paradigm, which only serves to blame the migrant worker for his or her health status, to a protective, rights-based approach that recognises the context of migration is difficult and risky and that one must be supported through this process. A comprehensive, multi-sector response focusing on migrant workers' right to health is called for. Action of this type would involve a move towards accessible, affordable and quality health care, counselling and legal services; confidentially of one's HIV status (including a challenge to mandatory HIV testing); protection against discrimination (including access to legal redress); the application of local labour laws to foreign workers; access to basic social security during transit; and the ratification of various international instruments that directly or indirectly address the protection of migrant workers.[8] As this Report will demonstrate, Governments and key stakeholders currently fail to act on these rights.

State governments have historically been more interested in civil and political rights, and the international conventions and declarations that pertain to them, than the health rights of those who reside within their borders and of citizens overseas. This does not mean that health has been left off the international human rights agenda and that States cannot draw from what has been laid out in international conventions, declarations and constitutions. The international human rights framework provides an ideological construct, as well as a clearly laid out and widely accepted legal foundation, for practical and legislative responses in the realm of health and international migration, as shown in the text box below.

INTERNATIONAL HUMAN RIGHTS INSTRUMENTS AND HEALTH

United Nations

United Nations human rights instruments raise the issue of health and wellness for all. The Universal Declaration of Human Rights[9] outlines in Article 3 that "Everyone has the right to life, liberty and security of person" and in Article 5 that "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." In Article 25, it states:

1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2) Motherhood and childhood are entitled to special care and assistance.All children, whether born in or out of wedlock, shall enjoy the same social protection.

The International Covenant on Economic, Social and Cultural Rights[10] covers the issue of health explicitly in Article 12:

1) The States Parties to the present Covenant recognize the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2) The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:

   a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

   b. The improvement of all aspects of environmental and industrial hygiene;

   c. The prevention, treatment and control of epidemic,

endemic, occupational and other diseases;

d. The creation of conditions which would assure medical service attention to all, in the event of sickness.

The United Nations International Convention on the Elimination of All Forms of Racial Discrimination[11] directly refers to health in Article 5:

> In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:
>
> b) The right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution;
>
> d) Other civil rights, in particular:
>
> iv) The right to public health, medical care, social security and social services

The United Nations Convention on the Elimination of All Forms of Discrimination against Women[12] mentions health in Article 12:

> 2) States Parties shall take appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
>
> 3) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy.

The most obvious recognition of migrant workers' human rights is the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.[13] It establishes a

broad base of application and recognises the entire migratory process as a basis for consideration and puts forward health as an area to be addressed.

Article 1

1) The present Convention is applicable, except as otherwise provided hereafter, to all migrant workers and member of their families without distinction of any kind such as sex, race, colour, language, religion or conviction, political or other opinion, national, ethnic or social origin, nationality, age, economic position, property, marital status, birth or other status.

2) The present Convention shall apply during the entire migration process of migrant workers and members of their families, which comprises preparation for migration, departure, transit and the entire period of stay and remunerated activity in the State of employment as well as return to the State of origin or the State of habitual residence.

Article 45

1) Members of the families of migrant workers shall, in the State of employment, enjoy equality of treatment with national of that State in relation to:

   c) Access to social and health services, provided that the requirement for participation in the respective schemes are met.

International Labour Organization

The International Labour Organization (ILO) takes health into consideration when it establishes conventions that outline work practices that will better ensure workers health and well-being. Examples of such conventions include the C1 Hours of Work Convention[14]; the C14 Weekly Rest (Industry) Convention[15]; the C33 Minimum Age (Non-Industrial Employment) Convention[16]; the C89 Night Work (Women) Convention (Revised)[17]; the

C105 Abolition of Forced Labour Convention[18]; and the C148 Working Environment (Air pollution, Noise and Vibration) Convention.[19]

ILO Conventions that directly mention a concern for health include the following:

C97 Migration for Employment Convention (Revised)[20]

Article 5

Each member for which this Convention is in force undertakes to maintain, within its jurisdiction, appropriate medical services responsible for:

a) ascertaining, where necessary, both at the time of departure and on arrival, that migrant for employment and the member of their families authorised to accompany them are in reasonable health;

b) ensuring that migrants for employment and member of their families enjoy adequate medical attention and good hygienic conditions at the time of departure, during the journey and on arrival in the territory of destination.

C102 Social Security (Minimum Standards) Convention[21]

PART II. Medical Care

Article 7

Each Member for which this Part of this Convention is in force shall secure to the persons protected the provision of benefit in respect of a condition requiring medical care of a preventative or curative nature in accordance with the following Articles of the Part.

Article 8

The contingencies covered shall include any morbid condition,

whatever its cause, and pregnancy and confinement and their consequences.

C118 Equality of Treatment (Social Security) Convention[22]

Article 2

1. Each Member may accept the obligations of this Convention in respect of any one or more of the following branches of social security for which it has in effective operation legislation covering its own nationals within its own territory:

   a) medical care;
   b) sickness benefit;
   c) maternity benefit;
   d) invalidity benefit;
   e) old-age benefit;
   f) survivors' benefit;
   g) employment injury benefit;
   h) unemployment benefit; and
   i) family benefit

Article 3

1) Each Member for which this Convention is in force shall grant within its territory to the nationals of any other Member for which the Convention is in force equality of treatment under its legislation with its own nationals, both as regards coverage and as regards the right to benefits, in respect of every branch of social security for which it has accepted the obligations of the Convention.

C161 Occupational Health Services Convention[23]

Article 5

Without prejudice to the responsibility of each employer for the health and safety of the workers in his employment, and with due regard to the necessity for the workers to participate

in matters of occupational health and safety, occupational health services shall have such of the following function as are adequate and appropriate to the occupational risks of the undertaking:

(a) identification and assessment of the risks from health hazards in the workplace;

(b) surveillance of the factors in the working environment and working practices which may affect workers' health, including sanitary installations, canteens and housing where these facilities are provided by the employer;

(c) advice on planning and organisation of work, including the design of workplaces, on the choice, maintenance and condition of machinery and other equipment and on substances used in work;

(d) participation in the development of programmes for the improvement of working practices as well as testing and evaluation of health aspects of new equipment;

(e) advice on occupational health, safety and hygiene and on ergonomics and individual and collective protective equipment;

(f) surveillance of workers' health in relation to work;

(g) promoting the adaptation of work to the worker;

(h) contribution to measures of vocational rehabilitation;

(i) collaboration in providing information, training and education in the fields of occupational health and hygiene and ergonomics;

(j) organising of first aid and emergency treatment;

(k) participation in analysis of occupational accidents and occupational diseases.

C167 Safety and Health in Construction Convention[24]

Article 4

Each member who ratifies this Convention undertakes that it will,on the basis of an assessment of the safety and health hazards involved, adopt and maintain in force laws or regulations which ensure the application of the provisions of the Convention.

Article 6

Measures shall be taken to ensure that there is co-operation between employers and workers, in accordance with arrangements to be defined by national laws or regulations, in order to promote safety and health at construction sites.

Article 7

National laws or regulations shall require that employers and self-employed persons have a duty to comply with the prescribed safety and health measures at the workplace.

World Health Organization

The Constitution of the World Health Organization[25], in conformity with the Charter of the United Nations, declares that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Selection of Declarations that Refer to Health

United Nations Millennium Declaration: This United Nations Millennium Declaration (8 September 2000) was drafted to reaffirm faith in the Organization and its Charter as indispensable foundations of a more peaceful, prosperous and just world. Included among its contents are a commitment to halt and reverse the spread of HIV, malaria and other major diseases; the promotion of gender equality and the empowerment of women as effective ways to combat poverty, hunger and disease, and to stimulate development that is truly sustainable; and the encouragement of the pharmaceutical industry to make essential drugs more widely available and affordable to all who need them in developing countries.

UNGASS Declaration: This document is a resolution adopted by the United Nations General Assembly on HIV/AIDS held in June 2001 in New York City. It outlines the actions to be taken to slow the HIV/AIDS epidemic. The declaration highlights areas where efforts are to be focused, including information dissemination, capacity building, gender equality, and fighting poverty. It puts in place guidelines for UN agencies and UNAIDS co-sponsors to effectively respond to the problems arising from HIV/AIDS and to work together to fight the spread of the disease.

Beijing Declaration: This declaration of the Fourth World Conference on Women in Beijing (1995) is determined to advance the goals of equality, development and peace for all women everywhere in the interest of all

humanity. Point 17 states: "The explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment."

The Cairo Declaration on Population and Development: The Cairo Declaration on Population and Development (September 1994) in Point 5 urges all national governments to do their utmost to remove all remaining barriers that inhibit access to family planning services, information and education, as well as to help support the provision of reproductive health and family planning services as widely as possible. Point 9 clearly articulates the right for all to primary health care: "We therefore support the right of all people to have access to primary health care by the end of the current decade and pledge to work to reduce the disparities in health condition and mortality risks between and within countries as detailed in the goals contained in the Programme of Action."

Alma Ata: This declaration, stemming from the International Conference on Primary Health Care (1978), expresses the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people of the world.

IMPEDING THE RIGHT TO HEALTH

Given that international human rights instruments put forth the idea that all humans are born free and equal in dignity and rights and state the right for all to a standard of living adequate for health and well-being, it is unfortunate that many national governments have not applied these principles to their own laws, policies and initiatives, in a way that protects and promotes the health rights of vulnerable groups such as migrant workers.

Rather than establishing mechanisms to aid and protect migrant workers when they transition into their new living and work environments, countries have principally focused their energies on erecting immigration policies that are characterised by controls that serve narrowly defined national goals.[26] Governments presently engage in mandatory medical testing, which generally includes an HIV test, to block migrant workers' entry into the country or as a mechanism to deport them should they fail their medical test.[27] According to the US Department of State, approximately 60 countries require foreigners to be tested for HIV prior to entry for long-term visitors, including migrant workers.[28] The United Arab Emirates went so far as to screen their entire population for HIV and then repatriate foreigners who tested positive.[29]

This method of attempting to halt the spread of HIV has yet to be proven effective. Available epidemiological data on HIV transmission demonstrates that allowing HIV-positive foreigners into a country does not create an additional risk to the population of the host country. According to UNAIDS and the International Organization for Migration, the ineffectiveness and counter-productiveness of movement restrictions are due to the fact that: 1) HIV/AIDS is already present in every country in the world; 2) it is impossible to close borders effectively and permanently; and 3) to the extent that people are afraid of the application of restrictions, they may enter or remain in a country without the necessary documents, and existing in such clandestine fashion, fail to access preventative interventions.[30] In addition, mandatory testing perpetuates the notion that HIV/AIDS is a 'hostile outsider' brought into the country by foreign 'carriers' of the disease, a belief that further marginalises a group already discriminated against.[31] Mandatory testing also nurtures a false sense of security in the host population who believe they have screened for and deported the virus, which is an understanding that could lead to greater risk-taking behaviours.

In sum, mandatory HIV testing does little to address the spread of HIV as an issue of global concern and responsibility; instead it reinforces the stigmatisation and segregation of infected individuals. The resulting perceptions reinforce the development and implementation of discriminatory laws and policies that target certain groups such as migrant workers. At the same time, resources are then not adequately devoted to advancing innovative initiatives focused on education, treatment and care.

Beyond the issue of whether mandatory HIV testing should or should not occur, the circumstances around which such testing takes place are also contentious. To use practices in Malaysia as an example, FOMEMA (Foreign Workers Medical Examination Monitoring Agency) is a privatised consortium, though linked to Malaysia's Ministry of Health and Department of Immigration, that has been given the contract to conduct the mandatory medical examination required of foreign workers prior to the renewal of their work permits. Before the mandatory medical test, which includes a test for HIV, migrant workers have to sign a consent form. They are rarely informed about what they are being tested for. They are not provided with pre- or post-test counselling, and they are generally not aware of why they are being deported, if they fail. Furthermore, there are no referrals to health and counselling services made available, either in Malaysia or in their country of origin.[32]

These practices are in violation of the international standards set out by UNAIDS and WHO regarding consent, counselling and confidentiality during health testing. They also violate the right to information and education. Additionally, should a migrant worker fail the medical test and be barred or deported, this is a violation of the right to freedom of movement and the right to livelihood. Not only is mandatory medical testing a violation of various human rights, it is a counterproductive strategy. In 1998, more than half of the migrant workers in Malaysia did not show up for medical checks. Part of the reason for this was because HIV, STIs, hepatitis, and other conditions were being used as the basis for deportation, and they feared testing positive.[33] Migrant workers in desperate need of medical assistance do not come forward to seek help because they feel threatened by the very real possibility that they will lose their jobs and be sent home.

Migrant workers' health rights are further compromised when they are unable to access health care in the same manner as the local population. For example,

the Malaysian Double Fee policy presumes that migrant workers place a burden on the public health system. Foreigners in Malaysia are required to pay twice as much as locals for the same treatment. For a group that already makes significantly less money than the local population, the high cost of health care results in their increased reluctance to seek help.

This leads migrant workers to self medicate and delay visits to the doctor until the situation becomes dangerously acute. Even when migrant workers make the trip to the doctor's office, they sometimes do not receive satisfactory care. Coming from a foreign country, where the culture and language may be different and combined with the fact that many negative perceptions of migrant workers exist, it is not surprising that migrant workers are dissatisfied with the quality of care they receive from health professionals. They speak about the poor quality of care, the weak listening skills of doctors, the lack of explanations given, and the limited time they are granted.[34]

THE FEMINISATION OF MIGRATION

The migration of female workers has been steadily increasing in both absolute numbers and in terms of the proportion of the migrant population. Women now comprise nearly half of all migrant workers worldwide[35], and in some countries the number of female workers leaving for overseas employment is much higher. In the Philippines and Sri Lanka, for example, women made up 69 per cent and 68.2 per cent, respectively, of the migrant worker population going abroad in 2000.[36] This trend towards the feminisation of migration is a function of the demand for female employment in the service sector, the health and entertainment industries and, in particular, the domestic sector. To look at domestic work more closely, developed countries require a constant infusion of migrant domestic workers, as women in developed countries increasingly need to or desire to participate in the formal waged economy. In this context, and supported by neo-liberal policies, foreign workers are employed to take on the tasks associated with social reproduction, including childcare, elder care and household maintenance.[37]

Given the feminisation of migration, it is imperative to review migration from a gender perspective, as women who migrate are doubly marginalised. Gender inequality and female marginalisation have been much discussed in

recent decades, but it is now important to consider such issues in the context of migration. Women who go abroad to work may readily find themselves in isolated and demanding living and working conditions, where they are vulnerable to physical and sexual violence, psychological abuse, under nourishment, and extreme exhaustion.[38] Female migrant workers are also more likely to be exposed to forced labour and sexual exploitation than men and are more likely to accept precarious working conditions and less pay in gender segregated and unregulated sectors of the economy. It should be noted that the Convention on the Political Rights of Women (1952) and the Convention for the Elimination of All Forms of Discrimination against Women (1979) both articulate the belief that women, as a group, are in need of international human rights protection.

It is all too common that women arrive in destination countries with the promise of a certain job, only to find they are expected to engage in sex work. Several cases have been reported where male sponsors bring women into a country, whether to work as seamstresses in factories or as domestic workers, only to lock them in apartments and force them into sex work. Even when women are employed in the sector they anticipated, unbearable conditions prompt women to leave, where they then turn to the sex industry as a means of survival and subsequently lose rights that might have been afforded to them as a documented worker. It is extremely difficult for women to take action in these circumstances because their passports are often held by their employers, their status may be undocumented, they may still owe labour agents large sums of money, their social status and self-esteem are compromised, labour and health laws fail to address the precarious conditions of their work, and they receive minimal information on the resources in place to assist them.[39]

Migration related anxieties, including concerns about being sent home by employers or being caught without the proper documents, increases psychological distress and the physical risk of being harmed, as women are afraid to come forward. Living in continuous fear produces a sense of helplessness in many women, a feeling they cannot control their lives sufficiently to escape.[40] In this context, migration laws and policies, or lack thereof, are party to inflecting both physical and emotional strain on female migrant workers, to the extent that they do not recognise the particular vulnerabilities of female migrant workers and protect them accordingly.

National governments cannot be held solely responsible for employer abuse, since agency resides with the abuser, but governments can be held accountable for the manner in which laws and policies buttress the power of employers and simultaneously diminish that of employees. In some cases, female migrant workers have virtually no protection under the law. In Bahrain, for example, Article 2 of the Bahrain Labour Law for the Private Sector (1976) exempted "domestic servants and persons as such" from the purview of the law, on the basis of the private nature of domestic work. In the case of a dispute, domestic workers can appeal to the police or to the court, but official action taken against employers is negligible. It is also illegal in Bahrain for domestic workers to run away from their employers, and if found, they are deported. Both Laws support an environment in which sexual, physical and psychological violence against female migrant workers can readily occur.[41] Female migrant workers' sexual and reproductive health, in particular, are often rendered vulnerable by their living and working conditions. Isolated, and perhaps even confined, female migrant workers are often at the mercy of their male employers who may expect and force them to have sexual relations with them. Even when intimate relations are consensual, whether between a female migrant worker and her employer or with another individual, they remain vulnerable to HIV and STIs, as they tend to have minimal access to information on sexual and reproductive health. Moreover, given the power differential, women have little opportunity to demand that protection be used.

Some countries, like Saudi Arabia, make it practically impossible for victims of sexual assault to report abuse and seek assistance. Under Saudi Law it is illegal to have sexual relations outside of marriage. Human Rights Watch conducted interviews with four domestic workers from the Philippines who were victims of forced confinement and sexual abuse in Saudi Arabia and found that in all four cases the perpetrators – three of whom were alleged rapists – were not held legally accountable for their actions and did not face criminal investigation and prosecution.[42] Furthermore, the Saudi Ministry of Health issued a directive in 2003 that prohibited hospitals from admitting pregnant women who were not accompanied by men willing to acknowledge paternity. This is particularly damaging for female migrant workers in Saudi Arabia who become pregnant. If a pregnant single woman was in need of emergency care, the new rules stated that she must be detained in a special room to prevent her escape.[43] The health ministry's directive violates Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979), which Saudi Arabia has

ratified. For those countries that have ratified the Convention, Article 12 (1) requires they "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning." If Saudi Law outlines for single women be arrested for 'illegal' pregnancies, this practice represents blatant gender discrimination and an outright denial of women's right to health.

Women's health needs to be protected and ensured by both origin and destination countries. Many women find strength and pride in their ability to carve out new lives for themselves and earn a living, which often helps their families back home. For example, there are approximately 7.6 million Filipinos working abroad, the majority being women, and their remittances from January to October in 2003 reportedly totalled US 6.9 billion, according to statistics from the Philippines Central Bank.[44] Despite the fact that many perceive women earning a living overseas as destructive to the ideals of domesticity and 'home', international migration has the potential to improve the status and autonomy of women. Beyond the economic independence that can be gained, female migrant workers frequently view the life skills and knowledge acquired during the migratory process as a source of personal change, development, heightened self-esteem, and empowerment.[45] Ensuring women experience the full range of human rights during migration is crucial, particularly if Goal 3 of the United Nations Millennium Development Goals, on promoting gender equality and empowering women, is to be achieved.

CHALLENGES TO HEALTH DURING THE MIGRATORY PROCESS

Put simply, migrant workers cannot afford to be ill or injured. Their time abroad is contingent upon the fact that they are working to earn more money than they would have in their country of origin. Thus it is essential they remain well and able to work. This makes it all the more distressing when their health begins to deteriorate while working abroad. Unfortunately, there are a myriad of external and internal factors that jeopardise the health and well-being of migrant workers, which will be discussed in greater detail below.

Living Conditions

Migrant workers, even though they are making more money than they would have at home, still make less than the average citizen in destination countries. As a consequence, their existence is one of relative poverty, where they often live in crowded, poorly ventilated and unsanitary accommodations that promote the spread of disease. In the United Arab Emirates, for example, migrant workers in the garment and construction sectors often live in private labour camps. They live in quarters that measure only 10 square metres, but still six or more people live and sleep within these dimensions; and, given the limited space, storage, cooking and socialising are all done outside, where the sun, dust and wind are constant. A Pakistani labourer in the UAE, describing how he lived, said: "We live in such terrible conditions…We have to jump over each other's beds to get around the room; there's no window to let in fresh air and even the doors open out into dark, airless corridors."[46]

Female migrant domestic workers, who tend to live in the homes of their employers, also suffer as a result of their living arrangements. In many cases, these women do not have a room of their own – a refuge where they can relax and rest. Instead, they are forced to sleep with their employer's children, with other female workers or even on the floor in the kitchen or elsewhere in the house. In extreme cases, employers build a room for the domestic worker on top of the house, to monitor her movements and control whom she is able to visit.[47]

In addition, given that wages are generally low, and money is often saved and sent home, migrant workers are generally not able to purchase nutritious foods. Migrant workers may be compelled to purchase meals supplied by the companies they work for, which are relatively expensive.

Initially we brought packed food from the house. But we were told that we cannot bring food from home and that we must buy our food from the company's canteen. There plain rice cost about RM 0.70 and a vegetable dish cost about RM 1. We have to pay about RM 2 per meal, so at times we eat in the canteen and when we do not have enough money, we do not eat at workplace. (Male migrant worker from India in Malaysia)

In the event that workers receive their meals directly from their employers, there is often a deficit in the amount and quality of the food, because employers desire to save as much as possible. Low caloric intake, combined with challenging physical labour, can result in fatigue and increased susceptibility to illness and injury.

Working Conditions

Migrant workers are typically placed in high risk, low paying jobs with unsatisfactory supervision. They accept positions that local workers refuse, which are frequently in the domestic, mining, construction, manufacturing, agriculture, and service sectors. In these positions, they can be exposed to a range of occupational health risks. The risk of injury and illness are increased by linguistic obstacles, poor communication, lack of familiarity with modern machinery, and varying attitudes towards safety; and are further exacerbated by their short-term contract status, as employers often consider these workers too temporary to invest adequate training in.[48] Support for this can be found in the fact that in Europe, occupational health accident rates are about twice as high for migrant workers, compared to local workers[49] In addition, the uncertainties posed by being a migrant worker – the various fears of losing one's job, financial insecurities, becoming sick, being deported, and being abused by one's employer – layer to become a source of extreme anxiety.

For many migrant workers, long hours and heavy workloads are a source of intense strain and fatigue. The trials of domestic work serve as an example of this. Domestic workers frequently toil upwards of 12 hours per day, with many domestic workers being required to work through the night caring for infants, small children, the elderly, or the infirm. Employers also expect them to perform a variety of household tasks, including cleaning, cooking, driving, laundry, childcare, shopping, sewing, washing cars, and gardening. There are even cases of different families, though oftentimes related, who share a domestic worker, where the worker is shuttled back and forth between two different homes to do twice the work.

Domestic workers do not have fixed schedules and work duties; they are on call all the time to take on almost any domestic task. It has been found that many domestic workers are unable to have regular days off and paid annual leave, and even if they are ill or injured, they often have to continue working.

My employer finally noticed, though I was still working. I was crawling in order to make milk for the baby. They took me to the doctor, and I was limping. They paid for it, but I was not allowed sick leave. I still had to work. (Female domestic worker from the Philippines)

Since the Labour Laws in many countries do not cover domestic workers, if it difficult for them to demand their basic rights. As a result of this, their health and well-being suffers greatly.

Transitioning to a New Environment

Migrating from one country to another can be physically, mentally and emotionally exhausting. Migrant workers must cope with and adapt to a different sociocultural context. Differences in food, traditions, religion, law, language, politics, climate, transportation, interpersonal interactions, dress, and relations between the sexes can be disorienting, especially when migrant workers receive minimal knowledge about the destination country they are travelling to. Studies have shown that acculturative pressures can lead to significant psychological disorders, such as clinical depression and anxiety disorders, when changes in the sociocultural context exceed individuals' capacity and resources to cope with the speed and magnitude of the change in context.[50]

Furthermore, upon arrival, cultural competence is usually low. Misunderstandings and misconceptions occur on a daily basis. Often it is the case that migrant workers are travelling from a rural area to an urban environment. In this situation, migrant workers quickly observe and possibly absorb new patterns of behaviour and belief systems – a process that can occur rapidly given that previous community controls no longer exist in their new environment. Away from home, migrant workers are able to 'try on' new cultural and sexual identities.[51] While exciting, this too can be overwhelming and can potentially comprise migrant workers health if they are unable to access preventative health information on HIV/AIDS and STIs and health care services in the event they become ill.

Loneliness and Sexual Needs

Loneliness is another common facet of the migratory experience. It is natural to want to be cared for and understood. It is also normal to desire to have one's

sexual needs met. Individuals who previously met these human needs are no longer available. As a consequence, migrant workers seek out and establish new social relationships with others, which sometimes become sexually intimate.

Health initiatives that maintain a platform of abstinence are unrealistic. The majority of migrant workers are between the ages of 25 and 45 and in the prime of their reproductive health. Many are single and encountering an environment where they are relatively free from the normative social constraints in place at home. National governments unfortunately tend to ignore the fact that migrant workers are humans with needs for intimacy; instead they strictly regard them from an economic vantage point, as a cheap source of labour to be sent back home once their contracts are finished. Stakeholders involved in developing and implementing national laws, policies and programmes on migration rarely tackle issues of gender equality and empowerment, lack of access to reproductive and sexual information and services, limited access to condoms, and the motivations behind risk taking behaviours.[52]

Social Support and Status

Migrant workers' vulnerability is increased by the fact that social networks that were once in place in one's country of origin are no longer there. In the destination country, there is rarely anyone for migrant workers to turn to for advice, information or support, or even to take them to the clinic or hospital. Among spouses, friends and family there is often a sharing of experiences and knowledge, including information on health, along with how to access health services.[53] Alone in a destination country, migrant workers no longer have others to watch over their well-being in the same way.

Migrant workers also face the additional trials that come from being among the lowest rungs of society in destination countries. The image of migrant workers is routinely linked to notions of poverty, disease, criminal activity, social instability, and low morality. National laws and policies and the media reinforce these beliefs, rather than challenge them. If migrant workers internalise these understandings about themselves, this can result in reduced self-worth and self-awareness. In turn, these negative feelings can cultivate a sense of helplessness and dependency, which lowers their capacity and confidence. This can diminish their agency to seek out the necessary information and services to maintain their health.

In sum, migrant workers' struggles in transitioning to a new environment, their limited social support and their elevated susceptibility to disease and injury, coupled with legislative and policy environments that fail to acknowledge and protect their health rights, combine to diminish their health status considerably. It is essential to grasp migrant workers' realities in all their complexity for appropriate and effective initiatives to be undertaken. Regrettably, governments and key stakeholders have failed to adequately take notice of migrant workers' dire circumstances. This limits forward movement in establishing a holistic, rights-based approach from which to address migrant workers' health in both public and private sectors, as the following chapters will explore in greater detail.

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CHAPTER TWO

HEALTH INITIATIVES TARGETING MIGRANT WORKERS

In solidarity against mandatory testing and high cost of ARV treatment for migrant workers - a rally at the 6th International Congress on AIDS in Asia and the Pacific in Melbourne.

CHAPTER TWO:

HEALTH INITIATIVES TARGETING MIGRANT WORKERS

For migrant workers to attain a sufficient level of health, the vulnerabilities they endure must be recognised by international agencies, law and policy makers in origin and destination countries, NGOs, health professionals, researchers, and migrant workers themselves. In turn, these unfortunate circumstances must inform the development of protective policies and targeted programmes that aim to ensure migrant workers achieve access to health information and services. Moreover, it is necessary for individuals and groups from different levels and sectors to work towards these goals in a collaborative manner. [1] At the present time, such recognition and action are not adequately taking place. This chapter helps to explain governments' hesitancy in this area, gives a number of best practice examples, from which much can be learned, and describes the challenges frequently faced in policy and programme design and implementation.

As discussed in the first chapter, national governments take minimal action to ensure migrant workers' health and rights and concentrate instead on exclusionary efforts focused on screening migrant workers and either barring or deporting those determined to be 'unfit'. This system reinforces the belief that only migrant workers in perfect health enter and remain in destination countries. In turn, those in destination countries are led to believe they need to do minimal work on the side of policy and interventions to ensure and maintain migrant workers' health.[2] Furthermore, negative public perceptions of migrant workers in destination countries reinforce policies based on control and restriction, rather than facilitation and accommodation. In destination countries, migrant workers are often implicated in a plethora of social problems: crime, the spread of disease, taking jobs away from locals, and driving down local wages. The media reinforces this negative image by focusing on migrant workers' violation of migration regulations and their failure to integrate, while never crediting their role in various economic upturns.

Given these negative perceptions, national policy and intervention responses to the health needs of migrant workers have not been a priority and have been slow to develop overall.[3] Governments are generally reluctant to touch these issues – particularly HIV prevention and care for migrant workers – because they do not wish to be associated with such issues, and the way to proceed from abstract discussion to practical response appears time consuming, expensive and overwhelmingly complex. Governments also wish to steer clear of many of the issues connected to sexual and reproductive health for fear of alienating their supporters and inciting debate.[4] Many governments endorse that citizens and non-citizens alike engage in a 'moral' way of life – meaning abstinence before marriage and no sex outside of the marriage relationship – which is a stance that ultimately releases the government from assuming responsibility for the health status of many.

Even when policies and programmes are developed to protect and ensure the well-being of migrants, there is often inadequate funding and supplies, poor or minimal leadership and coordination, and a deficit in the number of trained human resources. These circumstances hinder the path to the actual implementation of progressive policies and programmes. Consider that it is estimated that 30 to 50 per cent of the developing world's population of persons trained in science and technology, including health care, live in the developed world. In poorer countries, the number of local individuals who could potentially be involved in a professional and leadership capacity continues to dwindle, which further limits efforts aimed at improving migrant workers' health rights.[5]

The reality is that most countries have not committed to developing and implementing programmes focused on achieving real equity in health between non-citizens and nationals. Instead, obligations towards foreigners rarely extend beyond essential care or care in emergency situations.[6] Governments need to grasp that early investments in addressing and integrating the health needs of migrant workers will improve the public health situation in their own country by decreasing the long-term strain on local health and social resources.

One of the fundamental public health principles is that major gains in public health require the development of preventive and early intervention initiatives, targeted at the most vulnerable populations. These insights have led in the last twenty years to the development of a 'new' model of public health; one that relies less on exclusion and screening and shifts more towards inclusion and

cooperation with the relevant sub-population.[7] As articulated by Haour-Knipe: "This model, one of social learning, of inclusion and cooperation, involves harm reduction, persuasion in modifying lifestyles linked to disease, education, voluntary testing and counselling, protecting privacy and social interests".[8]

A paradigm shift is needed to see health in the context of society, for health is more than the presence or absence of disease or injury. According to the Western biomedical paradigm, the individual is seen to exist as an isolated entity, where illness is the straightforward result of a biophysical pathology, suggesting infection to be the consequence of one's behaviour. This implies that the individual can and should be held personally responsible for his or her health condition.[9] This biomedical stance fails to address the complexity of disease transmission and the social determinants of health as well as the diversity of experiences that can occur amongst those who have the same disease.

Those designing and implementing policy and interventions need to acknowledge the complicated reality in which health and disease are produced and understood in society, particularly when working with a population so heterogeneous, mobile and complex as migrant workers. This approach, which has been called the development paradigm in the health sciences, incorporates not only the individual and elements of risk, but takes into consideration society, community and the nature of vulnerability.[10] The move here is away from a singular focus on individual risk, psychological motivation and behaviour modification, towards a greater recognition of the importance of solidarity, empowerment and attempting to improve the conditions in which people live and work.[11]

The development paradigm recognises that the environment creates situations that can result in certain populations being more vulnerable than others and further identifies those in power as frequent accomplices in the maintenance of these vulnerabilities. This suggests that governments have a responsibility to change accordingly and implement laws, policies and programmes aimed at protecting migrant workers' health. For real equity in health to be achieved, stakeholders must identify migrant workers as a special group made vulnerable by their environment and circumstances and, in turn, work towards creating an environment in which migrant workers' access to appropriate health information and adequate and affordable health care is not limited in any way.

INITIATIVES FOCUSED ON MIGRANT WORKERS AND HIV/AIDS

Geographic mobility has come to be recognised as one of the main facilitating conditions of HIV transmission. Studies have determined a clear link between elevated HIV seroprevalence and short duration of residence, travel along major transportation routes, citizenship status, and international travel.[12] Whether one is a victim of trafficking, a refugee, a migrant worker, or posted on military duty, all encounter contexts that increase their vulnerability to infection. One study found that migrant construction workers sampled in rural Lesotho had an HIV prevalence rate of 5.3 per cent compared to 0.8 per cent among age and sex-matched local villagers.[13] Another study discovered that male migrant worker returnees sampled from the Doti district in western Nepal (95 per cent having returned from work in Mumbai, India) had a 4.5 times higher HIV prevalence rate than non-migrants, with a longer stay in India being associated with a greater likelihood of infection.[14]

In this section, interventions addressing HIV prevention and care among migrant workers will be used to demonstrate how national governments, international agencies, NGOs, and other interested parties have become increasingly aware of vulnerabilities faced by migrant workers. It will outline examples of specific initiatives that have been implemented. Yet overall there is still a great deal of work to be done in this area, as this report repeatedly demonstrates. Consider that fewer than one in five persons have access to basic HIV prevention programmes, with access being even less for migrant workers.[15]

From the outset, it should be noted that successful programmes can rarely be transferred intact from one environment to another, as the social, cultural, economic, and political contexts, along with the migrant worker populations themselves, are always different. Many private and non-profit organisations market educational programmes that guarantee universality or adaptability to a wide range of cultural conditions, but their guarantee of universality is dubious.[16] Migration is a unique situation, fusing loss and transition with cross-cultural encounters. Programmes targeting the local population may not be appropriate, as patterns and modes of transmission, as well as risk factors, may differ between locals and migrant workers. Hence the need to develop programmes that address the specific health vulnerabilities faced by migrant workers and the surrounding local community with which they interact. The following paragraphs outline a number of initiatives around the world aimed at HIV prevention and care for migrant populations.

In Africa, the distressingly high incidence and prevalence of HIV/AIDS and the knowledge that the disease readily travels along development corridors, led to some of the earliest efforts to prevent the spread of HIV and also care for those infected and affected by HIV/AIDS amongst mobile populations. In East Africa, the 'Great Lakes Initiative on HIV/AIDS' involving Burundi, Democratic Republic of Congo, Kenya, Rwanda, Uganda, and the United Republic of Tanzania focuses on HIV/AIDS and mobile populations. The Initiative undertakes a wide range of activities, including information exchange, HIV/AIDS care and support, integrating the response to HIV/AIDS into socioeconomic and development agendas, the promotion of operational research, the development of mechanisms of coordination and collaboration between countries, and resource mobilisation.[17]

In South Africa, a number of projects have been implemented. For example, one smaller project focused on creating and increasing awareness of HIV/AIDS among African migrants residing in the Gauteng province in South Africa by combining HIV/AIDS information campaigns with soccer tournaments for migrant workers from different areas. During four soccer tournaments, a locally contracted NGO distributed basic HIV/AIDS information to participants and spectators, as well as distributing condoms and femidoms. There were also information stands where interested individuals could obtain more information, including information on voluntary counselling and testing and the location of such services. South Africa is currently witnessing an unprecedented influx of both documented and undocumented migrant workers, thus projects of this kind are vitally important. Undocumented migrants usually desire to remain hidden from the authorities in South Africa, making them difficult to reach with standard programmes. For this reason, it is necessary to find creative ways to reach specific migrant populations, like the use of soccer tournaments. Other groups have also developed innovative intervention strategies to reach migrant workers, including radio messages; radio call-in shows; informative audiocassettes; pamphlets (made small enough, so they can be put in a pocket); visuals (particularly about the correct use of condoms); videos; theatre productions; musical shows; and mobile health services.

Another initiative in South Africa, the Mothusimpilo Project, has been running since the beginning of 1998 in Carletonville, which is home to the largest gold mining complex in the world. Up to 70, 000 male migrant workers from South Africa and the surrounding countries are employed at the mine; and, at the same time, many women are drawn to Carletonville from countries in the region

to make a living selling sex and alcohol. Drawing on experiences from other projects, organisers of the Mothusimpilo Project implemented a community-based intervention focusing on ensuring good treatment of STIs, peer education and condom distribution. The importance of STI diagnosis and treatment should be highlighted, given the strong link between STIs and the sexual transmission of HIV infection. The presence of an untreated STI can enhance both the acquisition and transmission of HIV by a factor of up to 10. Consequently, STI treatment is an important HIV prevention strategy in any population, and given that STI treatment is relatively inexpensive, it is an important way to decrease overall public health expenditures through the lowering of HIV incidence and prevalence. From the outset, the Mothusimpilo Project tried to fully integrate the Project into the local health services provided by the mines, the State, private practitioners, and traditional healers. In addition, the Project was integrated into a local home-based care programme supported by the Provincial Department of Health. The success of the Project is thought to be a result of the way in which all stakeholders – trade unions, mines, scientific organisations, different levels of governments, and an array of CBOs – collaborated to ensure effective implementation and deal with any problems that arose.[18]

In Europe, the European Project on AIDS and Mobility was initiated in 1991. Originally, it was predominantly focused on HIV prevention, targeting travellers and migrants in Europe but in recent years it has expanded to include and integrate care and support issues. This linking of prevention, treatment, care, and support cannot be underestimated, as each forms a key component of the response continuum. This challenge of integrating prevention into treatment and care is essential to meet, as the effectiveness of programmes will improve when they are sutured together. There are many benefits to be gained: the sharing of information, learning and experience; the reduction of costs and the more efficient use of limited human resources as well as decreased levels of discrimination and stigmatisation towards migrants, especially those with HIV/AIDS.[19] Groups in Western Europe have built on this understanding and one of the most important developments in the last ten years has been the establishment of support groups for HIV-infected migrants. These groups assist migrants in gaining access to health care services and act as a bridge between HIV infected individuals from their communities and health service providers. Importantly, some of these organisations have started HIV prevention activities, along with campaigns to fight the stigmatisation of and discrimination of HIV infected migrants.[20]

In 1999, the European Project on AIDS and Mobility also organised national seminars, with each one based on priorities set at the country level with respect to HIV/AIDS and migrant and ethnic minority communities and other mobile groups. Other activities of the Project have included regional training programmes aimed at NGOs and CBOs, addressing the need for peer education among migrant populations and migrants living with HIV/AIDS, and culturally and linguistically appropriate services. The Project also set up an information and documentation centre, including databases connected to the Internet. Overall, the Project has focused on the need to make health services more accessible for migrants through strengthening the services that already work with migrants, improving the collaboration between the different services, increasing involvement by migrant workers, and sensitising health and social service professionals to cultural and linguistic issues and needs of migrants.

In the United States, the Whitman Walker Clinic in Washington, DC is one of the largest HIV/AIDS service organisations in the United States, providing services for people living with HIV/AIDS regardless of their documentation status. The Clinic has a wide range of services available: anonymous testing and counselling, medical and dental care, legal services, case management services, mental health and addiction treatment services, and day treatment services. All the Clinic's services are available regardless of a client's income or insurance status, and language barriers are addressed by providing access to staff that speak the appropriate language. Similarly, in Australia undocumented migrants with HIV/AIDS have been treated through the Sexual Health Centre Network. This organisation provides confidential services and does not ask for identification, meaning migrant workers with HIV/AIDS without legal residence in Australia can obtain outpatient care and treatment at relatively little or no cost, including antiretrovirals, other drugs and health monitoring.

In Asia, like Africa, there is an imminent need for HIV/AIDS programmes and initiatives, particularly for mobile populations such as migrant workers. Although HIV/AIDS came later to Asia, its spread has been swift. Some of the most populous countries in the world, such as China, India and Indonesia, are seeing signs of rapid increases, so unless serious measures are taken to stem the epidemic, the consequences could be ravaging.[21]

In response to the growing HIV/AIDS crisis in Asia, CARAM Asia, a regional network of NGOs from South and Southeast Asia, initiated an action research

programme focused on mobility and HIV/AIDS. Between the CARAM Asia NGO partners, programme objectives include the production of information on the health status of migrant workers and their particular vulnerabilities; advocacy work to improve the living conditions of migrants; the development of grassroots interventions focused on the health of migrants, especially HIV/AIDS education and improved access to health facilities; and the overall protection and advancement of the health and labour rights of migrants. CARAM Asia has also played an important role in drawing attention to specific issues and challenges in working with migrant workers, focusing on issues like the feminisation of migration and migrant workers' level of mobility, specific fears, constraints on time and availability, and documentation status.

For example, the Malaysian NGO Tenaganita, a CARAM Asia partner, has worked with male Bangladeshi migrant workers. Tenaganita staff were initially able to gain migrant workers' trust through assisting them with their immigration documents. Based on this relationship, workers from Tenaganita were invited into the compounds where the migrant workers lived, and it was here that they were able to hold meetings to discuss sexual and reproductive health and needs and how to prevent and seek treatment for HIV/AIDS and STIs. These sessions were held at night, after the workers returned from late shifts, and were conducted secretly because employers frequently objected to such interventions. In addition, this led to the men taking Tenaganita staff to nearby brothels, so they could also educate sex workers about sexual and reproductive health care.

Impressive health initiatives have also been undertaken in Thailand. Thailand, as one of the most developed nations in the Greater Mekong Region, attracts thousands of undocumented migrant workers from neighbouring countries. Unfortunately, as a consequence of Thai migration policies, undocumented status is the grounds for migrant workers to be detained and deported. If apprehended by the Thai immigration police, undocumented migrant workers are usually brought to the detention centre at San Plu in Bangkok, where approximately 1,200 migrants are held at any given time. International Organization for Migration (Bangkok), understanding migrant workers' health vulnerabilities and the risks posed by detention, intervened at the detention centre, providing health education on TB and HIV/AIDS to both detainees and staff. The training included role playing, health education, culturally appropriate HIV/AIDS and TB brochures, as well the provision of personal hygiene items and condoms.[22]

To end this section, it should be pointed out that for positive, lasting changes to occur, migrant worker interventions need to be initiated alongside and in conjunction with general programmes and policies that promote human rights; the eradication of hunger and poverty; the achievement of universal primary education; and the promotion of gender equality, the empowerment of women and improved maternal health. Such overarching objectives are exemplified by the United Nations Millennium Development Goals (MDGs). Unfortunately, nowhere in the final MDGs document is there mention of migration, even though the link between development and migration is increasingly recognised. Given the role that international migration plays in development and public health care, it needs to be on the international development agenda and addressed in broad international frameworks such as the Poverty Reduction Strategy Papers, Common Country Assessments and United Nations Development Frameworks.

POLICIES AND PROGRAMMES: CHALLENGES FACED

In looking at policy and intervention strategies related to migrant workers and health that have been undertaken, it is evident that certain issues and challenges surface repeatedly. Stakeholders have made various efforts to identify and work with such obstacles and variables throughout design, implementation and evaluation stages. This section covers some of the issues that must be considered if policies and programmes are to be successfully implemented.

Context

Many project reports and studies addressing migrant workers and HIV/AIDS commented on the need to take into consideration cultural beliefs, norms and practices. Policymakers and programme developers attempting to institute regular safe sex practices have their work cut out for them in working within the frames of entrenched cultural, religious and moral belief and value systems. This process becomes even more complicated when such understandings are transported to the new environment of the destination country.

In a study focusing on truck drivers in India, difficulties and fear in accessing official health institutions were reported. Truck drivers articulated that they felt more comfortable attempting to treat themselves, particularly for STIs, with traditional medicinal herbs or pills with which they were familiar. They

also mentioned the difficulties they had in accessing professional services as a result being so mobile, with clinic appointment and follow-up visits being almost impossible to meet.[23]

At the very least, if groups are educated on the need to consistently use condoms, condoms must be readily available and affordable. This is a baseline initiative. Beyond this, creative approaches to encourage people to use condoms and seek health care assistance must be instituted. For example, in India, condoms were made available at any hour of the day at condom banks located in gas refuelling stations along Highway 8. There were also health centres stationed at transit points, often positioned in close proximity to other places that truckers might stop, such as restaurants and tea shops.

It is equally important that frontline professional health care and social workers receive cultural sensitivity training. They should have knowledge of the circumstances which render migrant workers particularly vulnerable: employer abuse, poverty, malnutrition, sexual abuse, discrimination, and so on. It is also important that all health information be disseminated to migrant workers in their own language, and it may be necessary for information to be delivered orally, rather than textually, as some migrant workers may not be able to read, particularly if they come from rural areas, and even more so if they are women from rural areas.[24]

Gender

There is a pointed need to address gender as an issue to consider in migrant health initiatives. Power relations and social inequalities, which are often gender-based, have been found to create and perpetuate vulnerability to HIV infection and other health problems amongst female migrant workers. Women are more often exposed to forced labour and sexual exploitation. They are also more likely to accept precarious working conditions and poorly paid work in gender segregated and unregulated sectors of the economy.

This being the case, policies and interventions must specifically address and target this unfortunate reality to ensure equal access to health for female migrant workers. The creation of an enabling and empowering environment is essential, and part of this process is the presence of appropriate policy instruments with the legal backing for enforcement.[25] To establish an environment where migrant women are healthy, safe and informed is very important given that migration

can potentially increase women's self-esteem, status and autonomy.[26] When women migrate for work, they often become the primary income earners for their families. Even when their husbands migrate, the responsibility and decision-making authority of women increases. Besides economic empowerment, the survival and coping skills learned by women during the migration process becomes a potential source of change and advancement.[27]

To address the issue of gender in the context of HIV prevention efforts, specifically, women do not constitute a 'risk group' in the usual sense because women do not tend to infect one another. Instead, they generally acquire the infection through their intimate relationships with men. As a result of women's diminished status, even when they express a desire for sex with a condom, men are often obstructive to this goal. Existing sexual and reproductive health programmes tend to target women, to the sole exclusion of men, because women more often suffer the consequences of poor sexual and reproductive health, and they have generally been found to be more responsive to interventions. But interventions often fail to take adequate account of the social vulnerability of women and the unequal power relations that make it difficult for women to influence decision-making in their sexual relationships[28], particularly for migrant women dealing with their male employers.

The key elements of many HIV prevention programmes – partner reduction, condom use and STI treatment – are not necessarily appropriate for women who tend not to have multiple partners, cannot always influence the decision to use condoms and may be asymptomatic for STIs.[29] Because men have more sexual partners than women, because men tend to control the frequency and form of intercourse and because women are economically more dependent on men, men's behaviour frequently determines how quickly and to whom HIV is transmitted. Therefore, educating men on how to protect themselves from HIV is an important step in protecting women.

Diversity

Migrant workers constitute a large and heterogeneous group – there is not one 'type' of migrant worker. There are great differences in personal characteristics, experiences and background. Given this diversity, it is important for policy makers and programme developers to assess and understand the perceptions, experiences and behaviours of men versus women, those coming from rural versus urban environments, along with factors such as origin and destination

country, type of employment, age, education, documentation status, and health status. Considering such variables helps in assessing whether certain groups of migrant workers are more vulnerable than others and how vulnerabilities differ between groups, which helps in developing the most effective interventions.

It has been found that migrant workers' access to health information and services can diminish as a consequence of undocumented status, gender, location, age, sexual orientation, poverty, health status, pregnancy, and the type of work engaged in. Ideally, for anyone to visit a health care provider and return again services should be user friendly, safe and confidential; but for migrant workers, in particular, services need to be comprehensive, inexpensive and 'youth friendly', and offer flexible hours, female health care providers, translators, referral services, and have a well-trained staff sensitive to and knowledgeable of issues related to culture and international labour migration.

Top-down versus Bottom-up Strategies

A top-down approach to policy development, combined with inadequate representation and participation of relevant stakeholders at the municipal government and community level, often leads to delays and opposition to policy and programme implementation. Policies and programmes are often developed at the highest levels with the expectation that their intended effects will magically trickle down to the grassroots level. There is the expectation that policy, once it is approved and ratified at the federal level, will then be successfully implemented at the community level. But this rarely happens because the basis of the policy position is often poorly understood at the community level. In the absence of careful planning, solid leadership, human and financial resources, and monitoring and evaluation systems, policy and programme measures fail to be made operational. In addition, programmes and projects are frequently driven by donors' resources and log frames, which results in the measure of success being the sign off on a document by an upper-level executive.[30] Donor pressure also puts significant stress on the whole process to balance the challenges of a lengthy design and consultative process, even though thoughtful and informed planning is essential for eventual success.

Lack of consultation and involvement at the community level can limit the impact of a programme or project: it may not reach the intended target group, the message might not be understood appropriately and there may be limited commitment when those involved have no sense of project ownership. There

is also the pressure from donors to cease the project once it is believed that a saturation point has been reached within the target population. Unfortunately, this might diminish the long-term success of the project. There are always new migrant workers arriving that need to be reached and those previously exposed to the intervention should have their knowledge reinforced. In a review of HIV/AIDS interventions in sub-Saharan Africa and Asia, Wolffers and Painter found that most interventions were relatively recent and short-lived: nearly half dated from 1994 and operated for an average of three years. Additionally, they found that multi-sector and multi-level responses were lacking overall; the tendency was to target only certain mobile groups (e.g. sex workers and long-distance truck drivers); almost half listed no target group and did not monitor who was reached by the intervention; and community-based forms of social support and education were not utilised effectively or at all.[31]

On the continuum between design and evaluation, there needs to be greater input from migrant workers themselves. Policy and programme developers need to directly consider the thoughts, feelings, needs, and experiences of migrant workers, with a reciprocal and equal flow of information happening between the 'bottom' and the 'top'. Participatory Action Research (PAR) can provide a space for migrant workers to voice their opinions and engage in the dialogue regarding their own health and welfare. PAR is not a specific research method, it is rather an orientation towards gathering and working with information that is extremely useful in undertaking work with marginalised groups, as it increases their agency, promotes awareness and is geared towards immediate action.[32]

When stakeholders at regional and national levels develop and implement strategies, it is imperative that they are not imposed on migrant workers, but proceed with migrant workers' involvement and support, as migrant workers need to have a sense of ownership over processes that impact their lives. Ideally, migrant workers, leaders in the community and community-based groups must be involved in policy and programme decision-making.[33] Activist and interest groups within migrant populations should prepare their agendas and recommendations from their own unique perspective, because this helps to identify special concerns and issues that higher level stakeholders may not think about. Migrant workers direct involvement is also critical in the monitoring and evaluation stages, as their input is essential to the critical assessment of programme relevance, efficiency, impact, sustainability, and ethical soundness.

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CHAPTER THREE

COUNTRY REPORTS

An outreach program: Checking health of migrants and their children at a construction site in Thailand.

CHAPTER THREE:

COUNTRY REPORTS

THE RESEARCH PROCESS

This preface to the country reports details the research methods and processes undertaken by the 13 CARAM Asia partners involved in the State of Health of Migrants (SoH) Report.

CARAM Asia organised three regional workshops for SoH Report participants. This was done in order to ensure clarity and uniformity in the research framework and strategies when partners embarked on their research at the country level. The first workshop was held in Chennai, India in November 2004. The purpose of this workshop was for partners to have a deeper understanding of migrant workers' 'right to health', as enshrined in international instruments. Working from this rights-based approach to health, a specific topic, 'Access to Health of Migrant Workers', was selected by partners to be the area of study for the 2005 SoH Report. It was determined the report would assess migrant workers' access health information and services.

To undertake this assessment, the research was divided into three categories or indicators: structural indicators, impact indicators and process indicators. For the structural indicators, partners reviewed international instruments to determine whether provisions were in place to protect, promote and ensure migrant workers' access to heath and health rights. Partners then checked to see if relevant international instruments were ratified by their respective national governments.

Partners also reviewed national laws, policies and programmes to ascertain whether they reflected the letter and the spirit of relevant ratified international

instruments, and generally assess whether governments recognised migrant workers' difficulties in accessing health information and services. They looked at whether governments made efforts in law, policy, programmes, and budget allocation to counter these barriers and improve migrant workers' rights and access to health.

For the impact indicators, partners examined the current demographic, labour migration and related health indices in each partner country. This section has not been fully developed in this 2005 SoH Report, but will become a larger segment in the future. To repeat what was stated in the main text, this report will be published annually to allow for information and progress on the status of migrant workers' health and access to health to be assessed regularly over time.

The process indicators, of primary importance to the SoH report, link the structural and impact indicators by focusing on how national laws, policies and programmes are actually implemented and utilised. This information was checked against the experiences and insights of migrant workers' accessing, or attempting to access, health information and services in each country reviewed. In addition to collecting information on migrant workers' realities, the insights of relevant stakeholders on how health and migration laws and policies are implemented were gathered.

A workshop was conducted in Jakarta, Indonesia in May of 2005 to bring together the researchers from each of the 11 partner NGOs and the two who were independent. The main objective of this workshop was to refine the guidelines for the process indicators, as well as to enhance the skills of the researchers in conducting focus group discussions. Two more workshops were held in Kuala Lumpur, Malaysia in December 2005 and March 2006. These workshops were devoted to enhancing partners' skills in data collection techniques, qualitative data analysis and report writing. In December 2005, a 5-member taskforce was set up to coordinate and guide the progress of the research between the different partners and to provide technical support to partners. Two members of the taskforce also visited partners in their countries to further oversee and support partners' field research and data analysis.

DATA COLLECTION

The data gathering phase was guided by frameworks and guidelines developed by the partners during the regional workshops and were refined over the course of the research process.

For the impact and structural indicators, most of the information was collected from official documents produced by national governments and much of this information was available on government websites. In certain cases, information on national policies, laws and health statistics was located in reports produced by international agencies, including UNAIDS, WHO, IOM, and ILO. This material was later verified through interviews with key officials in relevant government agencies. Impact and structural indicator information was gathered and updated during the 2005 year, but it was determined that changes would not be made after December 2005.

In their field research, SoH Report participants employed a combination of different data gathering methods, in order to collect a broad spectrum of information on migrant workers' health status, health knowledge and experiences in accessing health information and services.

Because CARAM Asia utilises participatory action research strategies, partners made sure that participating migrant workers and stakeholders could question and comment on the research process and that they were active collaborators in modifying the research process. Information gathered was also used in an ongoing, active manner in 2005 to modify and improve existing programmes for migrant workers, and useful information on health and labour was also frequently delivered to the migrant workers during interviews and focus groups discussions (FGDs). In addition, most research partners made the effort to revisit participants to share and confirm their findings, and the final Report will be made available to all migrant workers and stakeholders who participated, so they can use the information as they see fit.

Overall, the process of gathering information from migrant workers proved to be a considerable task, requiring flexibility, creativity and patience. FGDs were the most widely employed method used by research partners and were mainly conducted with groups of migrant workers, generally ranging in size from 3 to 12 participants. A number of in-depth interviews were conducted

with migrant workers as well, though in-depth interviews were principally done with key stakeholders. To increase accuracy and understanding, partners also employed triangulation techniques, comparing what was said in FGDs and in-depth interviews between different migrant groups and stakeholders.

In some countries, balloon mapping exercises were used with the migrant workers to elicit information. In balloon mapping, migrant workers, through drawings, expressed their thoughts and experiences in relation to questions on access to health information and services. This technique worked particularly well with those migrant workers who had difficulty verbally articulating their feelings and realities. Certain partners, such as ACHIEVE in the Philippines, also gathered information on migrant workers' access to health from ongoing research activities, stakeholders' forums and roundtable discussions on programmes for migrant workers.

DATA ANALYSIS

To streamline the analysis of the massive amount of information gathered, guidelines for the analysis were established. All in-depth interviews and FGDs were recorded on tape and transcribed verbatim. Transcripts were then translated into English and sent to the taskforce for review and feedback. Research partners were then asked to hold additional FGDs and in-depth interviews to increase the amount of information in areas where there appeared to be insufficient data.

All transcripts were coded and clustered into specific categories developed and agreed upon by all the research partners. After thematic clustering, the data was analysed. Partners were able to determine relationships between sets of data, which shed light on migrant workers' access to health information and care services. For instance, provisions in national laws, and the manner in which such provisions were implemented, were compared to migrant workers' perceptions and experiences. In addition, what government stakeholders said was analysed against what migrant workers experienced. This strategy allowed partners to identify gaps between national law and policy and actual implementation.

After partners completed the first draft of their country analysis reports, they gathered for the March 2006 workshop to refine their country analysis reports and discuss how country level information would be elevated to a regional

analysis. At this workshop, partners developed a framework for the regional analysis.

Before the country analysis reports were finalised, validation activities were conducted at the country level to confirm that the partners' analyses reflected the reality of the migrant workers. Some partners gathered groups of migrant workers together and presented the analysis of the research to them, while other partners sent copies of their report to migrant workers and stakeholders for their feedback. Based on feedback, the country analysis reports were modified accordingly. A number of partners also had to edit their country analysis reports to ensure they did not exceed the five to seven page limit. Many partners have a short version of their country analysis report – the version that appears in the SoH Report – and a longer, more detailed version that will be published by the respective organisation.

Using the regional analysis framework, the information from all the country analysis reports was organised. The first section of the regional analysis provides a brief overview of the international instruments relevant to international labour migration and health, detailing those countries that have ratified these instruments and their obligations. Two separate sections, one for origin countries and one for destination countries, then provide an overview of the laws, policies and issues in the countries presented in the Report. As much as possible, direct quotes from migrant workers have been used strengthen points and capture their everyday health experiences.

Based on recommendations stemming from both the country analysis reports and the regional analysis, with many recommendations coming directly from migrant workers themselves, an extensive set of recommendations was developed aimed at improving migrant workers' health and labour rights and their access to health information and services.

ORIGIN COUNTRIES

Bangladesh

In Bangladesh, working abroad is fast becoming a major employment and livelihood option for a good number of people. Between 1976 and 2004, 3,924,027 Bangladeshis left the country through official channels for foreign employment. It is currently estimated that 250,000 Bangladeshis leave the country every year to take-up employment elsewhere. The earnings of these individuals are a vital contribution to Bangladesh's economy. In 2004, total remittances sent home comprised 32 per cent of Bangladesh's GDP.

Unfortunately, international labour migration is often viewed in the context of labour demands and needs. Thus it is considered only as an economic phenomenon. This leads to migrant workers being perceived as 'commodities' or 'exports' and, as such, proper attention to their human dignity, rights, development, and well-being is ignored. Various intersecting factors impinge upon migrant workers' health during every stage of migration and their health status is thus compromised.

According to Bangladesh's Constitution, Articles 15 and 18 outline it is the fundamental responsibility of the State to make provisions for the basic necessities of life, including food, clothing, shelter, education, and medical care. The Constitution declares health to be a fundamental right. Additionally, Bangladesh has committed itself to both the UNGASS Declaration and the Millennium Development Goals (MDGs), sending a strong message towards eradicating such diseases as HIV/AIDS, TB and malaria and to developing strategies to improve all people's access to quality health services. A number of steps have been taken towards these goals, but the country is far from ensuring access to health information and services for all, especially for more marginalised and vulnerable groups such as migrant workers.

A national policy on labour migration has yet to be finalised and approved in Bangladesh. The entire migratory process is handled through the Emigration Rules (2002), which are a revised version of the Emigration Ordinance (1981). Moreover, in a review of existing health related laws and policies in Bangladesh, it was found that migrant workers were not specifically mentioned. In a positive

move, the national strategic plan for HIV/AIDS and STDs (2004-2009) recognise migrant workers as a priority group to target.

The Emigration Rules (2002) address the issue of a mandatory pre-departure orientation for migrant workers. Section 4 (clause r) reads, "to provide briefing to the outgoing overseas employees before issuance of emigration clearance." Meaning migrant workers must have some informative material disseminated to them before they are legally permitted to work abroad. Moreover, the Code of Conduct of Recruiting Agencies and License Rules (2002) have provisions by which recruiting agents must ensure that migrant workers attend pre-departure briefings before they leave. In the same Rules, it is outlined in section 7 (clause f) that recruitment agents must "arrange the medical examination properly." But for medical testing centres, there is no code of conduct.

The Emigration Rules (2002) also stipulate in Article 20 (2) that a fixed amount of money should be deposited in a Welfare Fund for migrant workers. In Bangladesh, there is also the Wage Earners Welfare Rules (2002), which, in Article 7 (clause e), states an obligation "to help the ailing or retarded wage earners." Both of these Rules suggest a 'safety net' for migrant workers should be put in place, but they do not go far enough, as they do not outline for the provision of comprehensive health insurance for migrant workers. Furthermore, Bangladesh's Bureau of Manpower, Employment and Training takes 1000 taka during the pre-departure process for basic insurance coverage in the event of a work accident, disability or death, but migrant workers are rarely informed about this. All those interviewed did not know about this insurance.

On the issue of mandatory medical testing prior to departure, there are inconsistencies in policy and practice. According to the national policy, there should not be any mandatory medical tests. Testing should only be done voluntarily. But migrant workers in Bangladesh go through mandatory medical testing, as per the requirements of destination countries, without ever receiving any counselling. Fortunately, NGOs are working to address this issue. For example, SHISUK, an NGO in Bangladesh, piloted a programme (with the support of the HIV/AIDS Alliance Bangladesh) at two diagnostic centres between 2000 and 2002 to provide HIV/AIDS information and pre- and post-test counselling to migrant workers.

PRE-DEPARTURE

Access to Health Information and Services

In Bangladesh, the pre-departure briefing is mandatory, but, in reality, many do not receive this training. The Bureau of Manpower, Employment and Training (BMET) is the only government agency conducting briefings. They do so from only one centre in the country, thus it is difficult for the BMET to reach all outgoing migrant workers. The Bangladesh Association of International Recruiting Agencies (BAIRA) has very recently taken steps towards organising pre-departure orientations, especially for female migrants, though in practice few recruiting agencies actually organise pre-departure briefing sessions. Moreover, these sessions mostly focus on the 'do's' and 'don'ts' in the destination country, along with some points on the weather, culture and the employment context.

Typically, neither the pre-departure sessions by the BMET or the recruitment agencies cover any health related information. There is no standard curriculum for these sessions. Observing a BMET briefing, researchers noticed the briefing was not participatory, the quality of the session was poor and the level of understanding of the participants was not considered. In the words of one prospective migrant worker: "We could not understand what the man read out over a screen. The people who can read can understand something by reading the booklet provided from the centre." Very recently, participants have been distributed a booklet on HIV/AIDS and STIs, which includes preventive health messages, but this is only accessible to those who are literate.

Positively, some major recruitment agencies and technical training centres have collaborated with NGOs in organising a pre-departure session with a significant health component, but the number of migrant workers reached with this programme is limited.

> All the migrant workers do not get opportunity to attend this training. There are about 800 recruiting agencies and many other sub-agency process the migration, whereas we provide the training in 10 to 12 recruiting agencies and technical training centres.

NGOs in Bangladesh are currently working on curriculum for migrant workers with a health component, which is to include a section on HIV/AIDS and STIs. To this end, manuals and IEC materials are being developed, but these efforts have

yet to be fully coordinated with pre-departure processes. At the community level, some solid work is being done by SHISUK and other NGOs. SHISUK has been working on a Peer Approach Programme (with the support of the National AIDS and STIs Programme, UNICEF, UNAIDS, ILO, IOM, and UNDP Bangladesh), as they attempt to disseminate information on the vulnerabilities of international migration and preventative health measures through having returnee migrant workers acting as educators at the community level.

ON SITE

Access to Health Services

The major barriers Bangladeshi migrant workers face in accessing health services in destination countries include a lack of information, documentation status, discriminatory treatment by locals and health professionals, high costs, language barriers, limited freedom of movement, and overly controlling employers. Of those spoken to, most shared bitter experiences of being abroad. For those who were undocumented, they shared their fear of being arrested and they dared not seek assistance at government hospitals. They resorted to self-medication and suffered accordingly.

> A person I know got water in his body [water retention].As he did not have passport, he could not be taken to the hospital. There is police guard in the hospital. So we could not take him to the hospital, due to the fear of police. After suffering almost one month that person died in front of our eyes without any treatment. (Bangladeshi migrant who had worked in Malaysia)

In Malaysia, Bangladeshi migrant workers, particularly in the manufacturing and construction sectors, are sent to panel clinics allocated by their employers. It was shared that some panel clinics provide treatment free of cost, while others had a ceiling cost of 10 to 20 ringgit, with any excess cost being borne by the workers. Many factories in Malaysia do not have contact with panel clinics, but make their own arrangements for first aid, but the treatment is not satisfactory. These conditions were much the same in the Gulf countries. In the Gulf, workers must have a work permit to seek treatment at government hospitals, but employers maintain possession of this document and would not release it to their employees, thus their access to health facilities was restricted. Workers in

the Gulf are sometimes given a 'health card', which can be used for one year to seek treatment at government hospitals at no cost. Yet in most instances migrant workers do not renew their card because of high fee: "Company gives medical card of one-year duration. After expiry of one-year term, one has to renew the card anew paying 300 to 400 dirham. We used to get salary of 370 dirham only, so many won't renew the card."

The health vulnerabilities faced by female migrant workers, most working in the domestic sector, are serious. Those returning from the Gulf shared they were treated like machines and that they did not have the right to be ill or injured. They were never permitted to go outside and could not seek medical assistance on their own. Those who fell ill were sent home almost immediately without proper diagnosis and treatment.

> They did not want to believe that we could also have illness in the body. We had to take medicine and continue working. They would not give any importance to our illness. Finally, Malik [employer] used to control everything.They would not allow us to go outside of home. So we had to depend on the Malik. If I fell very ill then the Malik used to say,"You will only work; I have brought you to work." Even then, when it was no more possible to suppress the fever or other general illness then I used to tell Ma, Malik's wife. But if it was any other disease, especially sexual disease, then I was not able to tell anyone, because if Ma or someone else from the Malik party comes to know of it then they will send me back home. (Bangladeshi migrant worker in the Gulf)

For Bangladeshi female migrants working in factories, their plight is no less than that of their domestic worker counterparts. Although they have more opportunities to visit the doctor due to medical clinics associated with the factories, they are limited in going due to time constraints, distance from the clinic, their tremendous workload, and security concerns associated with leaving the factory. Many choose to self-medicate rather than go to the clinic. One female Bangladeshi worker who had worked in a garment factory in Dubai shared about the difficulties of seeking treatment:

> The girls from the garments were not able to go to any hospital other than the company's dispensary because, first of all, the company used to give leave only for two - three hours once in a month. When they gave leave then may be there was not any necessity to go to the doctor. Secondly, the duty was from eight in the morning till eight at night.The company used to give gate pass after eight at night. While the doctor used to sit till nine at night. So, I used to feel afraid to go all alone, so

> late at night. The doctor's place was very far. Thirdly, they won't give leave time enough during illness. Fourthly, I used to get salary 370 dirham only, so I couldn't go to the clinic even if I wished to. Fifthly, if one gets big disease then the company used to take to the big hospital. But after that, won't take responsibility of treatment or make any sort of communication.They won't take any responsibility.

Migrant workers often have to pay more for their treatment than locals. In Malaysia, foreigners have to pay twice as much as locals for the same treatment at government hospitals, and this is the same in the Gulf countries. In going to private clinics, migrant workers have to shoulder the extra costs. Furthermore, employers and employment agents in destination countries rarely concern themselves with providing any insurance information to migrant workers. Many employers do not insure their foreign employees, while others collect their employees' insurance money, but still make their employees pay for their health costs out of their own pocket. Because migrant workers know little about the claims process and because they have limited opportunities to seek assistance on this issue, they rarely see the benefits of having insurance. Bangladeshi migrant workers shared that embassies offered almost no help on this point.

When Bangladeshi migrant workers were able to seek medical assistance, a number claimed they were treated as beggars, neglected and were not provided with the proper treatment: "The Arabic doctors do not give any importance; won't check-up properly…They would attend us negligently." Those who went to the Gulf shared that doctors would just give them medicine that would make them sleepy.

For a number of Bangladeshis, their only exposure to the medical system in destination countries was through the mandatory medical test, which was usually repeated every year to renew their work permit. In the event of this test, they are never informed of what they are being tested for and the conditions under which the tests are conducted are disrespectful. They are made to remove their clothes in front of one another, which they find humiliating. Moreover, migrant workers are rarely given detailed explanations as to their conditions if they fail their medical exams. They are simply deported; treatment and counselling are not provided. Sadly, returnees shared that employers tell them at the last minute about their being deported, so they can avoid paying migrant workers their salary. A restaurant worker in Malaysia has seen many of this fellow colleagues deported, and he shared about this:

> If something wrong is found in test then that person will be sent back home. If I am that unfit person, they won't tell me anything after the test. They will cut the ticket, will take me to the airport and then will say,"You have got a disease. Go see a doctor in Bangladesh." After the testing, they give maximum 15 days to one week, before sending back home. If it is very serious then he will be given only seven days. Before that, he will be given money to do shopping. I am telling this which is for food restaurants; don't know about others. As per my knowledge, many people are sent back like this. I know about 25 to 30 cases. Among these, I have sent back two persons in my own hand. I have sent back one friend. I felt great pain. His boss called and told me, "He has got a disease. Quickly, send him back home." He cried a lot. He asked, "What happened to me?" Boss said, "It is nothing. Go to Bangladesh and come back again after doing treatment." We sent him home. Later, one of my friends came and told me he died.

REINTEGRATION

Bangladeshi returnees are not addressed in any existing laws, policies and programmes, and no information database is kept on migrant workers returning to Bangladesh. Upon return, Bangladeshis shared they were treated poorly by medical staff, particularly if they had HIV/AIDS or STIs. One migrant returnee shared his difficulties with both a doctor and his own family as a consequence of his HIV status.

> I did not know anything about this disease [HIV].After being diagnosed with this disease, the doctor asked me to get out of the clinic right at that very moment. Even my closest relatives did not behave well with me. They did not come near me. Everybody moved far away. I can't express in words what loss was made to me by the doctor, by telling my condition to everyone.

Fortunately for some migrant workers returning with HIV, they are able to get in touch with a number of NGOs and CBOs that can assist financially and with medical referrals to the appropriate facilities. But there are no specialised services for migrant workers returning with serious injuries and health problems other than HIV, which is unfortunate because many informants shared they returned with serious health problems, including hepatitis B, TB, STIs, and major work related injuries.

India

India is a vibrant, cosmopolitan nation, but it is also a poor country. Over 44 per cent of India's population lives below the international poverty line – existing on less than one US dollar per day – and India ranks 127 out of 175 in the Human Development Index, the overall measure of a country's achievements in terms of life expectancy, educational attainment and adjusted real incomes.[1] Given these conditions, many Indians travel abroad in search of work and greater financial stability, and the opportunity for a better life for themselves and their dependents.

As early as 1993, the National Sample Survey in India reported that 24.7 per cent of the population had migrated, either within India, to neighbouring countries or overseas.[2] Unskilled migrant workers from India, more often than not, are concentrated in poorly paid jobs that are dirty, dangerous and degrading. These jobs tend to be concentrated in the agricultural, construction and domestic sectors. These are jobs where employers do not adequately train their employees; equipment can be old and malfunctioning, and therefore hazardous; employees become exhausted, as a consequence of excessively long workdays; on site medical assistance is rarely available or grossly inadequate; and governments fail to monitor what minimal protections are in place for migrant workers in these sectors.

Women domestic workers are among the most vulnerable to a host of abuses while working in destination countries. They are isolated, their movements are monitored and their passports are often taken from them. Life becomes even more difficult for domestic workers, when wages are not paid, debts are outstanding and physical and sexual abuse takes place. Many domestic workers enduring these circumstances run away and frequently turn to sex work as a means to survive. In certain cases, women from India are promised one job, but are trafficked into sex work.

> I was hit severely, when I refused to enter into the profession. I went there with a promise that I would get 20,000 rupees for a job as a housemaid in a rich Arab family. But I was put up in an apartment, and they held back my passport. (Female migrant worker from India)

As stories of the abuse and ill health Indian migrant workers experienced became increasingly more public, India's Central Government responded. On 20 November 2003, the Central Government of India drafted orders setting the minimum age for emigration clearance for women for employment as domestic workers in the Gulf countries at 30 years of age. Unfortunately, this order only encouraged the trafficking of underage Indian women. In a contradictory move, the Central Government in 20 February 2004 notified 54 countries that Indian nationals travelling to these countries do not require emigration clearance from the Indian Protector of Emigrants, including domestic workers. Conflicting positions in policy, such as this, results in confusion and leads to foreign workers' well-being and safety being neglected, as time is not invested in developing policies and programmes that ensure that India migrant workers are educated and informed before they go abroad.

PRE-DEPARTURE

Access to Health Information and Services

Given that the Central Government of India's recognition of the welfare of Indian nationals going abroad for labour purposes is in its relative infancy, potential migrant workers receive only minimal instruction on disease transmission, how to protect themselves from infection and where and how to access health services in destination countries. There is no law in India requiring migrant workers to receive pre-departure training. Official pre-departure training in India only takes place when required by a MoU with the destination country. For example, since November 2005, a MoU exists between India and Malaysia, outlining that all migrant workers coming to Malaysia must receive training in Bahasa Malay, English and background information on Malaysia's customs and laws.

Although the Central Government of India instituted an insurance scheme, the Pravasi Bharatiya Bima Yojana, on 25 December 2003, covering death, permanent disability, transportation, hospitalisation, disease, illness, maternity, and dependents, this Scheme is not popularised. Potential migrant workers, particularly those who are from rural areas, are not aware of its existence.

In addition, the culture of silence that surrounds sex and sexual and reproductive health also works as a barrier. Governments of India have historically been reluctant to touch such contentious topics, and this has been a barrier to the development of comprehensive health programmes aimed at educating migrant workers before they go abroad. NGOs in India have played a key role in raising HIV/AIDS related issues, but the media has not adopted the topic (though this has been changing of late), and senior policy makers, academics, politicians, and the medical community have been generally hesitant to engage in a proactive response to the disease.

Some information on HIV/AIDS, much of which is circulated by NGOs, has reached the public domain in India, though knowledge frequently remains incomplete or incorrect. For many Indian migrant workers, information is acquired through informal channels, such as friends and family.

Mandatory Medical Test

The governments of many destination countries Indians are travelling to for work require they undergo a mandatory medical test before they leave. Diseases such as TB, hepatitis, HIV/AIDS, and cancer are tested for to ensure they are medically fit. The conditions under which these tests take place are often less than ideal: no preventative health messages are delivered, no information on the test itself is shared and patients concerns are often ignored or minimised.

> Blood test, chest X-ray, urine test, HIV, ESR,TB.The doctor did not tell me anything about what the tests are for. But my agent told me about HIV and chest X-ray only. After the testing, my family doctor told me that you are medically fit. But the other hospital's doctor did not tell me even a single word, because at that time he has many other patients also. So, I seem to think he has no spare time for me to say anything. (Indian migrant worker)

ON SITE

Access to Health Information and Services

Indian migrant workers do not receive any health information upon their arrival in host countries. Even if information is available in public places and hospitals, it is not usually in a language accessible to the migrants. Their employers do not inform them about where and how to access appropriate health services. As such, the circumstances for Indian migrant workers living and working abroad can be dire. The news story of an Indian woman trying to seek treatment for her kidney condition in Bahrain attests to this unfortunate reality. In this woman's desperate attempt to gather enough money to cover the costs to treat her condition, she turned to sex work and was, in turn, jailed and fined: "I started doing this business to gather money to undergo medical treatment for my kidney."[3]

Similarly, a 33-year-old male migrant worker from India working in Malaysia, who came to the NGO Tenaganita to seek assistance on employment related problems, shared with the staff his various health concerns that had appeared since his arrival in Malaysia. Within three months of his arrival his weight had dropped from 68 kg to 50 kg; most of his hair had turned white; he was having headaches much of the time; he was having difficulties sleeping; his skin was irritated; and he was suffering from gastric distress. He slept on a carpet and drank the same water that was used for the toilets. Distressingly, his employer would not allow him to seek help from a medical professional. All the medicine he brought over from India had been used, and thus he currently had no treatment for his illnesses. In addition, he did not receive any pre-departure training before he left India.

Overall, Indian migrant workers abroad know very little about where to seek medical treatment and how to protect themselves from various infections. They are forced to self-medicate; they both help and rely on their fellow migrant workers; and they suffer.

> My agent did not tell me about health facility, but he mentioned that in the company this facility is available if you are ill, but now I found out there is no medical facility available. But my family doctor told me about health information like AIDS and liquor, and he asked me to take some medicine with me: AVI 250g, Colderene 250g, Limcy 500g, Becosule 250g, etc. So, I brought them. Now I have not even a single tab and cap, because I gave to my other friends. (Indian migrant worker)

REINTEGRATION

Foreign migrant workers, including those from India, as a consequence of being away from their spouse or regular sexual partner, in addition to being lonely in a foreign country, often form relationships with others and/or visit sex workers. This increases their vulnerability to STIs and HIV/AIDS, and, correspondingly, a number of Indian migrant workers have been deported based on their health status. There are no health programmes in place for Indian migrant returnees.

Returnee HIV positive migrant workers have a difficult time once they return to India, as their families, friends and even the medical establishment considers HIV/AIDS to be the disease of 'others' – of people living on the margins of society whose lifestyle is regarded as 'perverted' and 'sinful'. One study in India reported that 36 per cent of those sampled felt it would be better if infected people killed themselves, and the same percentage believed that infected people deserved their fate. In addition, 34 per cent said they would not associate with people with AIDS, and one fifth stated that AIDS was a punishment from God.[4] Studies also show that many Indian health service professionals hold equally damaging beliefs that would impact the quality of care HIV-positive migrant workers would receive.[5] Problematic also is the fact that there is not a culture of counselling in India, particularly in regard to issues that intersect with sexual and reproductive health.

As a result, many HIV-positive Indians keep their status secret, retreating and becoming closed off, fearing discriminatory treatment even from those in the medical establishment. Negative perceptions also hamper prevention efforts, as HIV/AIDS outreach workers and peer-educators have reported being harassed. While Indian governments do encourage NGOs to provide condoms and HIV/AIDS education, it continues to turn a blind eye to law enforcement agencies that have harassed staff providing these services.[6] Taken together, these conditions are dangerous because HIV-positive migrant workers could fail to be educated on how to prevent their current and future sexual partners from becoming infected.

The Central Government of India launched its second phase of the National AIDS Control Program in 1999, establishing 25 community HIV/AIDS care centres across the country. But the standard of care is limited to the provision of drugs for opportunistic infections and 25 institutions is inadequate to treat

and care for the number of individuals afflicted with this disease. Furthermore, even though India is a major producer of cheap generic copies of HIV/AIDS antiretroviral drugs being sold to many countries all over the world, they are only affordable to a tiny number Indians in need of them.[7] On top of this, the movement towards the privatisation of health care in India has caused the cost of health care to rise, with the increase being even more pronounced for the poorest Indians, such as migrant workers who have just returned from working abroad.

INDIAN MIGRANT WORKERS' RECOMMENDATIONS

Indian migrant workers shared that it would be helpful to receive pre-departure training containing a health component. They desired for this training to include information on the destination country – including information on the weather, the health care system, the social and cultural context, and the relevant laws and guidelines – and health information on HIV/AIDS and STIs. Indian migrant workers also wanted someone to educate them on the conditions of their work, meaning they would like to receive more information on: their salary, the type of work they would be doing, their employment contract, the company they would be working for, their employer, and their rights. They said it would be helpful if there was a website they could go to for this kind of information; and they also desired to have a resource centre where they could go to for information on issues related to health insurance.

Indian migrant workers shared that their rights needed to be protected and ensured through laws and policies and that these should be effectively implemented and monitored. They specifically spoke about their right to receive the correct salary, work the correct number of hours, have comprehensive health insurance, and have their employers/companies provide nutritious food and ensure a safe and comfortable place for them to sleep. They also mentioned that medical tests should be conducted in a respectful manner, so as not to cause discomfort and embarrassment.

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Indonesia

The number of Indonesians seeking to work overseas has grown rapidly in the last 15 years, from less than 90,000 in 1990 to 474,310 in 2005. At the same time, remittances sent by Indonesian migrant workers continue to increase, with US 1.31 billion being sent to Indonesia in 2000 compared to US 2.7 billion in 2005.

The financial possibilities of working overseas remain appealing, but the reality is that many Indonesian migrant workers suffer from abuse, serious health conditions and limited access to health information and services at every stage of the migratory process; and regrettably there are minimal provisions in Indonesian Law and Policy that offer migrant workers protection. In 2004, in a seemingly positive move, the Indonesian House of Representatives passed Bill no. 39 for the Placement and Protection of Indonesian Manpower in Foreign Counties (PPIMFC), in an effort to safeguard Indonesian migrant workers; but, as it has been argued by a number of NGOs, it does not offer significant protection. It only regulates recruitment and placement procedures, and fails to consider migrant workers' specific vulnerabilities.

PRE-DEPARTURE

Access to Health Information

In Article 34 of the PPIMFC Bill it states that before migrant workers are officially recruited they have to be informed about recruitment procedures, document requirements, their rights and responsibilities, conditions and risks in destination countries, and the system of protection for migrant workers. This information is delivered through two activities: the Pre-departure Orientation Seminar (PDOS), which is under the jurisdiction of the Director General of Placement and Training of Migrant Workers (DGPTMW), and the Pre-departure Training, which is held in private training and holding centres. The objectives of these activities are to prepare potential migrant workers psychologically and enable them to overcome any problems they might face abroad.

The Decree of the Ministry of Manpower and Transmigration Republic of Indonesia (no PER-04/MEN/II/2005) mandates the implementation of the PDOS. The PDOS is conducted in one day over an eight-hour period. According to an official, two hours of the training are dedicated to health issues, which include information on mental health and sexual and reproductive health (including HIV/AIDS). The PDOS also covers issues related to culture, law and the environment in destination countries; the role of the embassy; and work contracts and conditions. The content is prepared by Manpower Department, in cooperation with the Health Department, Ministry of Women Empowerment and the Foreign Affairs Department.

During one observed PDOS session in Jakarta, it was noted that approximately 80 potential migrant workers attended each class. Most of the information was delivered through lectures, and it was determined that some individuals did not find the class interesting, and some feel asleep. Only 45 minutes of the class was allocated for HIV/AIDS, drugs and trafficking issues. The instructor focused on the sexual transmission of HIV and how to prevent transmission in this context. Other modes of transmission were not discussed.

Interestingly, in the review of a training module for Indonesian domestic workers going to the Middle East, some incorrect information on HIV/AIDS was discovered. The module stated that people can be infected with HIV through saliva or if they wear the clothes a HIV-positive individual has worn or – neither of which is a mode of transmission. The module also stressed that HIV can be prevented if migrant workers increase their religious involvement, and avoid casual sex and the use of alcohol and drugs.

With regard to the Pre-departure Training held at private training and holding centres, it was discovered that at one training centre, the head of the Centre facilitated a meeting with the potential migrants to deliver health related information. Migrants also said they received information on how to prevent contracting diseases from posters displayed on walls around the centres. For the most part, though, information delivered related to functioning effectively in the work context. As a staff member of a recruitment company in Bogor stated:

> Yes.They have to be able to perform everything, from ironing, washing the dishes, doing the laundry. Some, mostly those who are from the villages, if asked to use the washing machine, well, they probably have

> never seen such a thing.There are cases like that. In here, we introduce them to washing machines, how to use it…They usually use coals; here we use electricity. So here, they fully learn.

According to a recruitment agency in Surabaya, they once tried to deliver HIV/AIDS information in their training sessions, but they encountered protests from the parents of the potential migrant workers. Parents felt the agency was condoning casual sex, because they were explaining how the infection was transmitted sexually and how to use condoms. In Jakarta, however, several recruitment agencies were able to successfully incorporate HIV/AIDS information, and other knowledge on sexual and reproductive health, into their training sessions, relying on AIDS NGOs in Jakarta to provide this training.

As a part of the recruitment process, potential migrant workers are legally required to undergo a medical test. The test is carried out at clinics appointed by Indonesian Manpower Department. It is clear that the tests are conducted for the benefit of the receiving country, not for the benefit of the potential migrant workers. The purpose of the medical test is to know the health status of the potential migrant worker, not to ensure he or she is healthy before going abroad. If they are found 'unfit', they are simply not permitted to go abroad.

> I know based on my own experience, the purpose is to know if we are in good condition or fit before leaving. When abroad, if we're being tested again and are found unhealthy, it's not their [recruitment agency's] responsibility. (Prospective Indonesian migrant worker)

In Indonesia, potential migrant workers' privacy and confidentiality are not respected. Health certificates are not given to potential migrant workers, but are sent directly to the recruitment agencies. Problematically, migrant workers who do not pass their medical test often do not find out why they failed, and thus their illnesses remain untreated. Potential migrant workers also have to undergo a HIV test. No pre- or post-test counselling or HIV prevention information is delivered. Not one of the potential migrants interviewed knew they were being tested for HIV, though some found out later on.

> At the clinic, they take our blood then check it. I know nothing.What I know, just I am fit. No counselling with the doctor. (Prospective Indonesian migrant worker)

If a migrant worker is found to be HIV-positive, one clinic owner said they would do a retest at another clinic. If confirmed to be HIV-positive, then they would be referred to Pokdisus-RSCM (Working Group on AIDS-RSCM). Although official data on HIV/AIDS cases among migrant workers are not available, data from HIPKTEK (Association of Medical Clinics for Migrant Workers) show that there were 131 cases of HIV/AIDS among 145,298 potential migrant workers (0.09 per cent), who underwent testing during their application to work in the Middle East from January to October 2005. This is an increase from the previous year, in which 203 potential migrant workers out of 233,626 bound for the Middle East tested positive (0.087 percent).

Fortunately, some Indonesian potential migrant workers also have the opportunity to acquire accurate and valuable health information from Indonesian NGOs. NGOs that conduct activities to increase migrant workers' health awareness are Solidaritas Perempuan (SP), Yayasan Kembang (YK), Yayasan Pelita Ilmu (YPI), and KOWANI. SP provides a community-based programme to increase migrant workers and their families' knowledge on health issues through discussions and disseminating textual material on health issues. YK also disseminates health information to migrant communities. YPI has conducted health and HIV/AIDS education programmes at training and recruitment centres; and has also established a HIV voluntary counselling and testing programme for migrant workers. KOWANI cooperated with the Indonesian Manpower Department on the Pre-departure Orientation Seminar (PDOS), helping to instruct sessions on sexual and reproductive health.

ON SITE

Access to Health Information

Through interviews and focus group discussions, it was determined that the majority of migrant workers did not receive any health information in the destination countries they travelled to. Even Indonesian migrant workers who worked in factories where they received training before their work commenced received minimal preventative health information; although some migrant workers were told at work about what they should do if they got sick, who they should contact and how the cost would be arranged.

> When we're there, the company didn't care about our health. Their only concern is when we got sick.We have to report to them, and they will pay for the cost. (Indonesia male returnee)

Some Indonesian migrant workers relied on health information they acquired in Indonesia, either from the Pre-departure Orientation Seminar or through training at the recruitment agency.

> There was information from recruitment agency to take care of our health, but when we were there, none. (Indonesian male returnee)

An Indonesian returnee migrant worker that had worked in Malaysia said they saw health posters at Malaysian hospitals, and they got educational brochures at Malaysian health institutions. This was not the case for undocumented migrant workers, because they did not access health institutions due to their fear of getting caught by the police and being deported. Furthermore, only male Indonesian migrant workers who participated in our discussions were able to access health information through posters and brochures. All the female migrant workers mentioned they had never seen any health related materials in the destination country. This is because of many of these women worked as domestic workers and did not have the freedom to leave their employer's home. This was particularly the case for Indonesian women who had worked in the Middle East.

Access to Health Services

Most of the Indonesian migrant workers who participated in this research said they had encountered health problems when working abroad. These illnesses ranged from mild conditions, such as having a cough, headache or flu, to more serious illnesses such as typhoid, digestive disease, stroke, and broken bones. When documented migrant workers got sick, those who worked in the formal sector said they would usually contact their supervisor or their team leader. Others contacted their employers first. They said that after telling their supervisor or employer, they were usually taken to hospital to be diagnosed and receive treatment. Unfortunately, not all Indonesian migrant workers received a concerned and proactive response from their employer.

> My employer served in the security forces. He was a policeman, but he was really ignorant about my illness. The sicker I was, the more reluctant he was in getting me some treatment. I had to figure things

> out myself. I decided to seek treatment on my own. (Indonesian male returnee)

For those who worked in the formal sector, some of them received treatment from health facilities provided by the companies they worked for. If the company did not have a facility, they went to the public or private hospital that was appointed by the company. Others sought health services on their own, but the cost was sometimes reimbursed by the company later. For migrant workers in the informal sector, it was hard to get treatment, and it depended more on their employers. For example, some domestic workers were taken to the hospital by their employers, whereas others revealed that if the illness was not serious they would not be taken. For seafarers, since they were mainly out in the ocean, they explained there was no access to health facilities. There is a clinic onboard, but no doctor. Seafarers shared how they relied on medicines, and only if the illness became serious would they be taken to the nearest hospital.

> We were at sea, so if anyone was sick, we only had the first aid kit, some storage of medicine. If the illness was serious, well, like I said, just call the office.You only need to do that, call them and they would take you to the nearest hospital. There was a clinic onboard the ship, but there was no doctor. Only first aid kit, some general medicine. (Indonesian male returnee)

From interviews and FGDs it was apparent that undocumented migrant workers were vulnerable because their access to health facilities was limited by distance (many worked in sawmills and plantations far from facilities); time (many worked long and irregular hours); and documentation status (many feared being caught by the police).

> That was the problem; going to the hospital was risky because there could be police there. If we were found without documents, we could be jailed for months. (Indonesian male returnee)

Undocumented Indonesian migrant workers, if they only experienced minor illnesses, tended to rely on the medicines they could purchase at kiosks. For serious ailments, they would go to private clinics. In this case, if possible, they might pretend to be a local, changing their name and speaking in a local dialect. If the undocumented migrant had a very serious illness and needed to go to the hospital, they would try to bring a letter from the company as a guarantee to the hospital. It seems that with this letter they could avoid being caught by

the police, since the company usually bribed the police, as the majority of their employees are illegal.

> No, unless it was serious…I had a friend from Bandung who was ill. He had a stroke; he could not walk for months. I eventually told the company.With other friends from the West Java, we asked the company to take him to the hospital. He was illegal, but in the case, he finally got a warrant from the company.This would not happen if his illness were not so severe. (Indonesian male returnee)

For many Indonesian migrant workers who worked in Malaysia and Brunei, language was not a problem when they went to health care facilities, because the languages are very similar. But for most of the migrants who worked in other countries, language was a barrier to receiving proper treatment, as they had difficulties articulating what they suffered from.

Insurance

Based on Ministerial Decrees No. 157/2003, Indonesian migrant workers overseas must be insured by their employers. The insurance is supposed to cover the migrant worker in case of: accidents inside and outside the workplace, including medicines and hospitalisation; death, including the cost of the funeral and sending the body to Indonesia; unpaid salary; and termination of the work contract. While the Decree states the provision of the insurance is the employer's responsibility, in reality the premium is added to the costs the migrants have to bear, and has to be paid before going abroad. Another problem is the fact that the procedures for obtaining insurance benefits while abroad are so complex and time consuming, it is nearly impossible to make and receive payment on a claim. Indonesian migrant workers are not educated on how the insurance process works. An experience shared by a returnee who worked in Brunei, shows this:

> Actually, I was insured by the employer. But when I was admitted to the hospital, there was no mention about the insurance. The medical expenses, the X-ray fee, the plane ticket home…these expenses were covered by my employer and my friends; they split the expenses 50:50, each covering 50 per cent of the total. My friends' money came from the pay they earned from work.The expenses included the admission fee and the medicine. From friends and the employer. I don't know whether the money from the employer was actually the insurance money.

Sometimes migrant workers have to bear all the costs by themselves, whereas in other cases migrant workers just shoulder part of the costs. A returnee from Brunei said there was a maximum allowance for health services provided by the company he worked for, which was only 20 Ringgit; and any costs exceeding this amount had to be covered by the migrant worker. In other cases, all health costs were deducted from the migrant worker's salary.

> I don't know; my employer should take responsibility for my condition. If we went to the doctor, I pay the cost. My employer borrowed my money, 2500 Riyals, but she never paid it back. From the hospital, I did not go to my employer's house. My employer sent me to the embassy to send me home. (Indonesian female returnee)

Quality of Health Services

The quality of treatment Indonesian migrant workers experience abroad seems to vary depending on the destination country, though no conclusions can be drawn given the limited number of migrant workers spoken to. In Saudi Arabia, one migrant said that the service was good. He did not find any difficulties in accessing adequate treatment, and said the health care staff treated them nicely and kindly. However, other migrant workers said that the quality of treatment depends on how much you pay for it.

Indonesian migrant workers in Korea commented that even if language was still a problem, it did not affect the quality of the treatment they received, and they felt they received the same quality of treatment as the Koreans. However, those who worked in Hong Kong, SAR of China felt language was a barrier that impacted the quality of treatment and care they received, as the following quote illustrates:

> Once, I saw an employee who worked for three months. She cannot speak in Cantonese fluently, so she doesn't understand. The doctor was angry and upset. Then the doctor talks not nice to her in the payment place.The nurse shouts at her. (Indonesian female returnee)

Generally, medical treatment for migrant workers in Malaysia is discriminatory, according to those spoken to. Migrant workers are charged a higher fee than Malaysians. An Indonesian returnee from Malaysia felt the treatment was inhuman because access to health services for migrants was different than locals. He said the doctor in Malaysia gave him medicine without doing a test or an examination on him first. Consequently, he did not take that medicine.

> The doctor is foreign graduation. The services to us are different, just like they don't treat us humanly. I have my doubt when taking in the medicines. So, finally, I buy Bodrex (a common drug for fever and influenza sold widely in Indonesia)

REINTEGRATION

Since 2004, Indonesian Act no. 39 on Job Placement and Protection for Indonesian Migrant Workers outlines that agencies are responsible for migrant workers' reintegration into Indonesia, including the provision of health services for migrant workers who are in poor health upon return. In reality, though, the NGO Solidaritas Perempuan found that several agencies did not adequately address the health problems of returnees. The agency sent former migrant workers home without ensuring they were professionally treated.

Raden Soekanto Central Police Hospital (RSCPH) is the only hospital where Indonesian returnee migrant workers are referred to get treatment. The cost of hospitalisation comes from the insurance company through the agencies. In certain cases, migrants were assisted by NGOs that pushed the agencies to make sure migrants' insurance claims were handled correctly. With the hospital being in Jakarta, it is only realistically accessible for migrant workers who come home via the Jakarta International Airport. There is no information on the availability of health care for returnee migrant workers flying directly to other regions of Indonesia.

It is possible for some Indonesian returnee workers to access more comprehensive services. For example, some female returnees who experience abuse in the destination country are treated at the Integrated Service Centre (ISC), a special unit for women and children who are victims of violence and abuse. Medical, legal and mental health services are provided through the ISC. In 2004, a Medical Recovery Centre was established as a part of the ISC to provide medical and psychological services to victims of trafficking. This was established based on a MoU with the International Organization for Migration (IOM). Some NGOs also provide access to health care for Indonesian returnees, such as the free health services provided by the Friends of Migrant Workers. While these initiatives are positive, the Indonesian government and other stakeholders must do more to ensure potential and returnee migrant workers have access to adequate and correct health information and comprehensive, affordable, high quality health care and treatment.

Nepal

Every year, many individuals from Nepal travel abroad to other countries, such as India, Malaysia and the Gulf countries, to take low paying jobs in the unskilled sector. Remittances sent home by these workers have helped to stabilise the Nepalese economy during the uncertain political climate of the last few years. According to an economic survey undertaken by Nepal's Ministry of Finance in 2004, remittances were determined to be 14.13 per cent of the Nepal's GDP for that year. Given Nepalese migrant workers' important contribution, it is unfortunate the government has not taken essential steps to promote and ensure migrant workers' health rights. No comprehensive laws, policies and programmes targeting migrant workers' health exist in Nepal. Migrant workers from Nepal are permitted to work in 108 countries, but no existing bilateral agreements between Nepal and other nations cover migrant workers' safety and well-being. Nepal's only bilateral agreement is with Qatar and this cannot be commented upon because it is not available to the public. Nepal did establish a Foreign Employment Act (1985), but this was less a measure to protect migrant workers and more a manoeuvre to control and manage Nepalese citizens working abroad, though this draft is in the process of being revised.

PRE-DEPARTURE

Access to Health Information

In Nepal, there are no programmes for migrant workers on health issues and health rights. Rule 27 of the Foreign Employment Regulation states that mandatory pre-departure training must occur, but no health component is mandated. Under this Regulation, 113 private companies have permission to conduct pre-departure orientations, but not all these companies are active. Many of them are linked to recruiting agencies in Kathmandu. The government of Nepal attempts to ensure the quality of pre-departure sessions by holding training sessions for the trainers of these sessions. These take place over nine days: seven days to learn how to give the pre-departure orientation and two days to learn how to teach the induction course. According to the curriculum

the trainers receive, they do cover a section on reproductive health issues for women. Research shows, though, that most migrant workers do not receive this information on reproductive health. Generally, pre-departure training is a simple overview of the 'dos' and 'don'ts' in the destination country.

It was found that only a small number of departing migrant workers attend the full pre-departure training session. Many are only present for part of the training, just enough to fulfil the requirement and receive their certificate.

> We thought no need to go, when we already have some knowledge. Four of us had gone there. They called us the second day, but we did not go. We got the certificates. (Nepalese migrant worker leaving for Malaysia)

Recruitment agents have been known to facilitate the process of migrant workers receiving their training certificates, a necessary requirement for labour abroad, without ever having attended the session. The lack of monitoring and supervision of the mandatory pre-departure training has caused the system to become weak and has been a contributing factor to the flourishing business of buying and selling pre-departure training certificates. A number of training institutions provide certificates to prospective migrant workers of their agents without their requiring the training to be undertaken. Officially, the stated fee for the pre-departure class is 700 Nepalese rupees but the price is negotiable depending on whether to sort of deal struck.

Also problematic is the fact that the pre-departure training centres are located in Kathmandu, which increases the financial burden upon prospective migrant workers. Coming from rural areas, and most being poor, some borrow money at a high interest rate to make the journey to Kathmandu. In the words of one migrant worker: "Orientation is very important, but you have to pay extra money and also other friends come from various places, for which you have to spend money on transportation. So that is the main problem." Also, once in Kathmandu, they have to pay for their food and lodging costs.

Interestingly, it was found that some trainers attempted to educate migrant workers about HIV/AIDS and STIs, which is positive, but receiving almost no training in this area themselves, the information delivered was of questionable quality.

> We say about HIV in a very indirect way, such as I tell them that Malaysia is a free country where you will be able to gamble and there are many places where you can enjoy. There you may find girls with whom you can have relationship and, in that case, you may be infected by HIV. So be careful when going to those places.You should enjoy, but you should have limitations. I never say about condom use. I may be comfortable but I myself do not know much about HIV, since I have not received any training on HIV, and I do not know much about it.

It was found that most prospective migrant workers in Nepal received health information from returnee migrant workers.

> Our friends who had returned from Qatar have said about the weather, they said it is hot outside, so we should not take bath immediately after coming back from work. First we need to take rest and then should bathe. They also said there are some liquids available which are used for cleaning the toilet. Other people drink it since it takes to quench your thirst for alcohol. Do not drink that, it is not good for heath, and after seven o'clock, do not eat outside. (Nepali migrant going to Qatar to work)

Mandatory Medical Testing

A mandatory medical test has been instituted for outgoing migrant workers based on requirements set by destination countries. Destination country governments also outline which tests migrant workers undergo, often requiring tests for HIV and STIs and, for women, pregnancy. In the case of Malaysia and the Gulf Countries, doctors appointed from the Malaysia Approved Medical Centre Association and the Gulf Approved Medical Centre Association, respectively, are in charge of determining medical testing centres to be approved to test prospective migrant workers. All medical testing centres are located in Kathmandu, which, again, makes it difficult for migrant workers travelling from other parts of the country.

Unlike the pre-departure orientation session, which migrant workers tend to give minimal consideration, the mandatory medical test is understood to be the 'iron gate' to get through to migrate: "Medical is the most important; we cannot go without the medical. There will again be a medical in Malaysia. If we fail there, we will be sent back. The test is done since we may be infected with fatal disease. If any disease is found we will be deported." No pre- or post-test counselling is given; tests are simply administered. Prospective migrant workers

are primarily interested in whether they passed or failed, not the details of their results: "We feel happy to find that we are fit. We do not ask about the test, and they do not explain. Nobody asks about the tests."

Although Nepal's national policy states that HIV test results should be kept confidential, this policy is not adhered to for migrant workers. Following the medical tests, reports are generally sent directly to the recruitment agency, which is a confidentiality breach. In the event a candidate is found to be 'unfit', testing centres call the prospective worker back to the testing centre. Here they are informed of their condition. In the case of less serious illnesses, candidates are given medicines. If they are cured in a few weeks time, they can be tested again and if they pass they are eligible to proceed. In the case of HIV and other more serious conditions, they are said to be referred to the appropriate medical facilities, but the doctor in the testing centre said that HIV-positive individuals feel shy and scared and do not come for any follow-up.

ON SITE

Access to Health Services

Once Nepalese migrant workers arrive in destination countries, they do not receive any comprehensive health information through government supported initiatives. NGOs and CBOs attempt to fill this gap, but resources to reach a large number of migrant workers remain limited.

On site, migrant workers may exist in crowded sleeping arrangements, have limited access to clean water and nutritious food, work long and irregular hours, and not have access to adequate bathroom facilities. Additionally, migrant workers also have to face differences in culture, which can be difficult. Many people in Nepal are Hindu and do not eat beef. When they are forced to eat beef in the destination country, when no other options are available, this can cause mental and physical distress: "I did not like the food there [Saudi Arabia]. I had to eat cow's meat, so I did not like the food. That was why I had gastric and later even had ulcer. So I had to come back."

Life abroad can be extremely tumultuous for undocumented migrant workers. They do not have the same power to come forward to seek medical, social and

legal assistance, and may keep changing jobs and locations, which increases their vulnerability: "I managed to work in Lead factory with the help of Nepali people in Korea. The working place was very dirty, though I worked for nine months. It was very hard to work being a woman. I slipped away to Seoul where I worked in iron company."

According to Rule 13 of Nepal's Foreign Employment Regulation (2004), foreign employment contracts should contain a stipulation covering the provision of medical treatment in the event that a migrant worker has a health problem. Even if this provision makes its way into a Nepalese migrant workers' labour contract (if one exists), it is rarely adhered to. Nepalese migrant workers have little knowledge of their health right and entitlements.

A major obstacle hindering Nepalese migrant workers' access to treatment is the cost. This is particularly the case for countries like the Hong Kong, SAR of China Special Administrative Region, Japan, Malaysia, and the Republic of Korea where the cost of living and services are much higher than in Nepal. Based on this fact, migrant workers even return to Nepal to receive treatment: "Doctor's fee expensive, so no doctor. Pain remained same; I paid myself for all my medicine. I came to Nepal." The story of another Nepalese migrant worker demonstrates that employers even send their workers home to avoid costs and the hassle.

> I took some medicine like Citamol, Aspro, Acilog with me. When ill, I did not go anywhere and took medicine myself. I was afraid to tell madam, as my job will be terminated. If we mention that we have some illness or diseases then there is high chance of termination, so we do not mention even if we have headache, stomach ache, etc. We go to the nearby Indian medical store to buy medicines and take those until we have chronic illness. Suddenly, I found myself sick and informed to madam, "I cannot work, what to do?" She said, "Go to Nepal, we do not take you to hospital."

Comprehensive health insurance would be one mechanism to lower costs for migrant workers, but most workers are not aware of existing insurance options and, even if they did know, such plans tend to only cover workers in the event of an accident causing injury or death at the workplace.

Language poses another barrier for Nepalese migrant workers in their attempt to access health services. One undocumented returnee from the Republic of Korea shared about his struggles with language at a health facility: "They

must have said something. I must have done something. Again, they tried to tell me something, and I might have understood something else. Yes, if I had understood the language, then maybe my kidneys would not have failed." In certain countries, namely Japan and the Republic of Korea, migrant workers expressed they received better treatment; although some Nepalese migrant workers did feel discriminated against by health service providers.

> They respect Pilipino, Chinese and Vietnamese. They do not treat us well.They would not take much care of the Nepalese patients, and they gave expired medicines.We are foreigners to them, and I do not know how they treat the VIPs, but they do not consider our life as life. The company also keeps a doctor. He gave me an injection once, which still hurts. (Male migrant worker deported from Malaysia)

REINTEGRATION

Nepal has yet to bring in a reintegration programme for returning migrant workers. Migrant workers simply access the health care system in Nepal as they did prior to their departure. There is no budget allocated to help ill and injured returning migrant workers and cost remains an issue for poorly paid migrant workers: "Private, if I go is quite expensive. It is cheaper in Bir Hospital [public hospital in Nepal], but I cannot go there. We have no good networking. In Nepal, people having low income will die."

This is gravely problematic in that migrant workers have had greater exposure to health risks while away and their health status may have diminished. They may need more specialised services upon return, but do not know how to or are unable to access them. Migrant workers' prior knowledge, friends and family and some NGOs supporting migrant workers are the sole source of support and information on health. It is even more difficult for HIV-positive returnees because they are stigmatised and discriminated against in Nepal. Returnees keep their positive status a secret and a number have died without receiving proper diagnosis, counselling and treatment. Positively, the government of Nepal has identified migrant workers as a group vulnerable to HIV/AIDS, but much still need to be done on the policy and programme front.

Pakistan

In Pakistan, the appeal to migrate to another country to work is considerable. In this developing country, with a population of almost 149 million, limited resources and consistent problems of poverty and unemployment, international labour migration is regarded as a road to greater prosperity. In the early 1980s, there were waves of migration to the oil rich Persian Gulf region. More recently, the direction of movement has been towards Europe, North American and East Asia as well. Between 1971 and 2002, over 3 million documented Pakistani migrant workers were involved in work abroad. Between 2001 and 2004 alone, 533,107 Pakistanis acquired employment through formal channels, making their way to over 40 different countries.

Demographic data shows the highest number of individuals went to Saudi Arabia, followed by the United Arab Emirates, Oman, and Kuwait. It has been reported that over 90 per cent of migrant workers come from rural areas and most are young males between 25 and 45 years of age. Most would be classified as unskilled or semiskilled labourers, and the majority of them take up work in the agricultural, construction and garment sectors. Approximately 80 per cent of unskilled Pakistani migrant workers are illiterate or semiliterate. Before going abroad, they have little or no knowledge of the destination country to which they are travelling.

The remittances sent back by Pakistanis working abroad constitute the largest single source of foreign exchange earnings. Migrant workers thus make a sizable contribution to Pakistan's economy. This being the case, it is regrettable to report the government has not allocated any part of its budget towards protecting and ensuring migrant workers' health. Pakistan's national health policy is based on a rhetoric of 'health for all', but there is no specific health policy addressing migrant workers as a group in need of special protections.

The Bureau of Emigration and Overseas Employment (BEOE) and its seven regional offices, known as the Protectorates of Emigration (POE), are the main government agencies responsible for overseeing international labour migration in Pakistan. Established in 1971, the BEOE is the centralised Agency of the

government set up to control and regulate emigration and to look after the interests and welfare of emigrants and seafarers. However, comprehensive laws, policies and programmes aimed at safeguarding migrant workers' health and well-being have yet to be conceived. Pakistan's Emigration Ordinance (1979) principally covers labour related issues and not health concerns. Although in Section 16 (c) the Ordinance outlines Pakistan's responsibility in "the establishment, supervision and regulation of any places of accommodation provided for emigrants and for their medical care while resident there." But there is no arrangement of accommodation for migrant workers in Pakistan, so the question of medical care does not arise. The Ordinance also outlines in Section 16 (k) for the "setting up of training centres and orientation and briefing centres to guide and advise intending emigrants and their dependents proceeding abroad." In the past, training centres were established, but they are not very active at the present time. Only three orientation and briefing centres in Pakistan are functioning.

PRE-DEPARTURE

Access to Health Information

The opportunity for prospective Pakistani migrant workers to encounter health information before leaving is very slim. From discussions with various stakeholders, their general opinion was that because migrant workers leaving Pakistan are medically fit, and because they come from a conservative society, there is not a great need to inform them about health issues, particularly HIV/AIDS and STIs.

At the Protectorates of Emigration (POE) Office, a briefing officer gives prospective migrant workers a 45 minute to one-hour talk on the culture, environment, and expected behaviours and attitudes one should display to one's employer and others in the host country. The terms and conditions of one's employment are also explained, with the emphasis being on how to be a 'good', problem-free employee. There is no set curriculum for this talk and no textual information is provided by the POE Office.

In a focus group discussion with prospective migrant workers who had just received their pre-departure orientation, they shared that no information on

health, HIV/AIDS and their health rights was discussed. These individuals demonstrated a keen interest in learning more about health and HIV/AIDS and gladly received the brochures provided by the research team. They remained longer at the POE Office to speak to the research team about health and HIV and one person shared: "We didn't know about HIV/AIDS. We know about this disease from here [discussion led by research team]. We need more information on HIV/AIDS." Another asked, "If we have any disease of this kind, like HIV or other, when we will come back in Pakistan, how and where can we take help?" Yet another individual shared his concerns about not knowing where to get information and health services: "Before this briefing [by the research team], we did not know of any organisation that gives us any kind of information about health. If we need help where we can go for help? And is there any this kind of organisation in Malaysia? We don't have these kind of information in our villages, therefore government need to establish committee to provide us information." The government of Pakistan does have a public campaign on HIV/AIDS, mostly conducted through TV and print media, but these messages do not reach many prospective migrant workers, because they live in rural areas and may not be able to read.

From those at the POE Office spoken to, health was not considered to be an overly important topic for discussion and no training is given to the briefing officers on health. According to a high official in the POE, "No, he is not trained in addressing health problems. No one is trained in this office and no organisation or government provides us training." The current HIV/AIDS situation in Pakistan and in other Asian countries has caused some officials to take note of the issue. A handful of briefing officers have attempted to bring up the issue in their own fashion. Problematically, there is a decisive focus on behaving morally, and minimal information is given on routes of transmission and protective measures.

> We tell them in hidden words how HIV spreads.We can't tell them that after going abroad don't do this and don't do that, I mean the things which are not allowed in our culture. We tell them that you could have access to so many things, which we can't have in our country easily, because abroad people are very broad minded and here we have conservative society, so you have to take care of all these things. We tell them it should not happen that you get infection and come back… They will be responsible for themselves because of the different and free environment in destination country, and they should not forget their own cultural values and should not adopt new habits abroad. (Pakistani briefing officer)

On the subject of providing information on health rights for migrant workers, he explained, "We don't know what are our own rights, what we can tell migrants." On the point of delivering health information, he shared that it is the duty of the medical testing centre staff to provide this information in detail.

Most potential migrant workers in Pakistan do not even know about the pre-departure briefing. Their primary concern is registering at the POE Office as per procedures obligated by the government. As such, only a small fraction of prospective migrant workers registered actually attend the pre-departure briefing. A briefing actually taking place appears to be contingent upon whether or not a briefing officer is available and how many migrant workers come to the Office at a given time. If only two or three prospective migrant workers arrive to register, the briefing will not take place.

One group of Overseas Employment Promoters, who are basically government licensed recruiting agents, were found to conduct their own training sessions, which are usually a week long. Upon their own initiative, they have included an hour long component on health, which is done by a doctor. Prospective migrant workers shared they received basic health information and some information on HIV/AIDS and how to prevent infection, but the information was not detailed or complete. No information was given on STIs, reproductive health and the correct use of condoms. When the doctor was questioned on the point of condoms, he said, "No-no-no, we don't tell them about it. We try to induce fear of infection."

It was found that medical testing centres provide no health information and no pre- and post-test counselling. No information is delivered to prospective migrant workers on the 19 tests performed on them, including the HIV test: "Doctor or other staff members said 'we will take your blood, urine and X-ray for examination'." In the event a person is found to be unfit, they are simply informed of this and given some basic information. As stated by a doctor at a testing facility: "We do inform them, obviously, when a person is found with infection. He asks why he is unfit while he doesn't have any symptoms or any health complaint. Our doctors inform them about hepatitis B and C and any other infection." However, there are no formal referral services in place to appropriate hospitals and clinics. Upon further questioning, the doctor claimed that he advised candidates to go to the AIDS Control Programmes for assistance. He explained that these individuals might never seek assistance because of the prevailing stigma and fear regarding HIV/AIDS in society.

ON SITE

Access to Health Information

From a number of focus group discussions and interviews, it was determined that Pakistani migrant workers were not exposed to preventative health information abroad, and they were only minimally aware of the health system in the destination country. Those interviewed all answered in the same fashion: "I don't know where to go" or "No one informed us." None of those interviewed had encountered a programme focusing on migrant workers' access to health information and services. One HIV-positive returnee shared his frustration at there being limited health information: "We did not know any preventive information, as no body told us. Alas, if some one told us before, we could save our lives."

Health Insurance

In Pakistan, insurance is mandatory for migrant workers according to the Emigration Ordinance (1979). In Rule 22 (a) it states "each person selected for employment abroad through an Overseas Employment Promoter or, as the case may be, the Corporation, or direct employment shall get himself insured with an Insurance Company on such terms and conditions, mutually agreed upon between the Director General and the said insurance company before his registration with the Protector of Emigrants." In 1982, the Bureau of Emigration and Overseas Employment (BEOE) entered into an agreement with the State owned insurance company State Life Insurance Corporation of Pakistan to cover migrant workers registered POE Office. It is mandatory for all departing migrant workers to be insured and submit of copy of their insurance certificate to the Protector of Emigrants, which is in charge of maintaining the proper record of the insurance policies.

Initially, the BEOE and the State Life Corporation agreed to cover migrant workers through a one-time fee of 250 Pakistani rupees, which would cover the migrant worker for up to 50,000 Pakistani rupees for one year. But no provision was made to allow for the renewal of this insurance. Now the premium has increased to 650 Pakistani rupees, the coverage is 300,000 and the insurance can be renewed for a further period of two years upon payment of a prescribed payment and documentary evidence of the work extension. The coverage is not

comprehensive, though. It only covers occupational injury, accident and death in the destination country. It was found that respondents paid their insurance fees at the POE Office during the pre-departure process, but they were not informed about the insurance scheme and did not know they could renew their policy if they stayed longer in the destination country. When asked about insurance, most interviewed were unaware that they even had insurance, which makes filing a claim impossible. Migrant workers also shared that employers and companies in the destination country made no mention of insurance.

Access to Health Services

Before leaving Pakistan, prospective migrant workers had no clear idea about health services in destination countries. Most of them departed with the idea that "Our employer will take care of us." Others assumed that "We can ask from other people. Our friend could help us in getting treatment, and this would not be any problem after going there." However, Pakistani migrant workers did experience challenges in accessing health services abroad. For minor illnesses, male migrant workers shared there were treatment facilities available at their company and that for more serious conditions they would go to the government hospitals. Distance appeared to pose an access problem for some: "We usually used to get medicine from the medical stores without doctor's prescription, because doctor was very far away from our work area," said one returnee. According to another migrant worker, "I told the store keeper that I am suffering from fever; he gave me the tablet because doctor's shop was very far." For undocumented migrant workers not having the official documents posed a barrier to accessing government hospitals. They had to seek treatment and care and private clinics and pay a considerably higher price.

Most reported they paid for their health service charges themselves while abroad. They said their employers were not cooperative in this regard: "I had to pay treatment expenses from my salary and, for this purpose, I had to stop sending money to my family when I was sick, because this was the only way to save money for treatment." Other frustrations Pakistani migrant workers shared included being charged more than locals and experiencing communication difficulties with health service staff.

On the issue of support while abroad for migrant workers, there are 14 Community Welfare Attachés at Pakistani embassies in nine different countries.

They are entrusted with looking after the welfare of Pakistanis overseas in a particular country. POE officials expressed that migrant workers abroad could receive assistance on health matters from the Community Welfare Attachés. In reality, the Community Welfare Attachés do not appear to be involved in any health related matters, including cases of deportation based on medical reasons. There are no formal links between embassies and any health institutions and programmes in Pakistan.

According to Pakistan's AIDS Control Centre, they have invited relevant government officials to participate in HIV/AIDS advocacy and awareness programmes to inform them about the services available at their centre, but contact has been limited and they do not formally coordinate with them on any matters.

REINTEGRATION

In Pakistan, reintegration programmes and services targeting migrant workers' health do not exist. The Overseas Pakistanis Foundation (OPF) was established in 1979 under the Emigration Ordinance to assist registered members overseas and their families in Pakistan. The aim of the OPF is to identify issues of concern for migrant workers and contribute to solutions to such problems and develop useful materials for emigrants. This is positive, but health has yet to appear high on their agenda.

Oftentimes, Pakistani workers are sent home because they have failed their medical exam. Frequently, they are not informed of the exact reasons for their deportation: "After medical test abroad, the authorities just deported me to Pakistan without informing me the reason of deportation. At that time, I asked many people that why I have to go back, but no one told me about it." In certain cases, there may be a delay in an individual being sent home. In the case of one migrant worker found to be HIV-positive, the authorities confined him for five months without telling him why he was being held. No health services or counselling were offered during this entire period.

There are no targeted health services in place to assist migrant workers returning with serious health conditions. These individuals just attempt to access the health system in Pakistan as they did before. Most returnees seek

treatment from doctors who reside near their residence, but a number seek the services of alternative healers, Hakeems (traditional healers) and Maolovis (spiritual healers). This being the case, they may not receive proper diagnosis, treatment and counselling, and unbeknownst to them they may infect their sexual partners with a life threatening infection.

Philippines

The Philippines is one of the leading labour sending countries in the world, both for land-based workers, as well as seafarers. According to the 2004 Annual Report of the Philippine Overseas Employment Administration (POEA), there were approximately 3.38 million documented overseas Filipino workers (OFWs) and 1.5 million irregularly documented overseas workers in 197 countries. In 2004 alone, a total of 933,588 migrant workers went abroad, of which 704,586 were land-based workers and 229,002 were seafarers. Of the number of overseas workers in 2004, 75 per cent were women.

Across time, Filipino migrant workers have experienced various problems during migration, including having their rights violated. One response of the Philippine government to these problems was the enactment of the Republic Act 8042 or the Migrant Workers Act in 1995. The Law outlines the establishment of services for OFWs before they leave, but while they are onsite and upon their return to the Philippines, it has limited provisions related to health services for OFWs. It only refers to the setting up of an OFW resource centre located within Embassy compound. Its services are supposed to include counselling and "welfare assistance, including procurement of medical and hospitalisation services." However, none of the migrant workers who participated in this study availed of these particular services.

The gaps in the Migrant Workers Act were partly filled when the Philippine HIV/AIDS Prevention and Control Act of 1998 was adopted. The AIDS Law outlines the need to provide HIV/AIDS education for OFWs, especially with the current HIV/AIDS statistics in the country showing that 34 per cent of registered people living with HIV/AIDS in the country are OFWs, according to the National Epidemiology Centre. The AIDS Law also provides specific guidelines for HIV antibody testing, which all migrants are required to undergo. Overall, though, the experiences shared by OFWs showed that having laws and policies do not necessarily guarantee that health information and services are adequately accessible.

PRE-DEPARTURE

Access to Health Information and Services

Overseas Filipino workers are required to undergo a pre-departure orientation seminar (PDOS). It is a one-day orientation that discusses, specifically, the requirements of the job, the labour contract, the laws and restrictions in the destination country, the climate and the culture, and how to remit money home. When there are issues that arise that affect the lives of migrant workers, such as human trafficking and HIV/AIDS, these may also be integrated in the PDOS. The inclusion of HIV/AIDS education in the PDOS is a recent development mandated by the Philippine AIDS Law. However, there are still OFWs who attest that they have not been given HIV/AIDS information during their PDOS. Thus far, HIV/AIDS is the only health-related subject included in the PDOS. Interestingly, OFWs point to the fact that the PDOS, as a structure, is the not the most effective means of delivering HIV/AIDS information.

> Let's talk about the PDOS. The [HIV/AIDS module] is barely an hour. You wouldn't be interested to listen to it because you're already contemplating on what will happen to you when you are abroad or whatever. You will not absorb it. It will never register in your mind, really. (Migrant worker who had worked in Saudi Arabia)

Upon reaching the destination country, many OFWs go through a post-arrival orientation. This may be provided by the counterpart agencies or brokers onsite, or by their employers or supervisors. These orientations serve to familiarise the worker with the work he or she is about to undertake. This is also the venue in which the OFWs are warned about the rules they need to follow in the destination country. One domestic worker recalled that the brokers would always remind them to work hard and to not complain about anything if they did not want to get terminated. The advice and information from educators or employers in the destination country is primarily delivered to ensure that OFWs are orderly and law abiding. It has little to do with protecting OFWs well-being and safety.

Medical Testing Requirements

A medical certificate is required for all OFWs applying for work abroad, to establish whether an applicant is fit to work. Although there is a set of basic medical examinations conducted for all workers, the kinds of examinations

required vary depending on the job category, the requirements of the employer or the destination country. Furthermore, all female OFWs are required to have a pregnancy test, and certain employers may also require a drug test.

For the purpose of this study, the medical testing procedure was examined to determine whether it is being utilised to provide potential migrant workers with health-related information. It was found that no health information was given during the test. In fact, many migrant workers who participated in the study were not even given the results of their medical examination. If the migrant worker passed, the results went directly to the recruitment agency. Prior to the exam, migrant workers had to sign the medical examination report giving their permission to furnish the agency with the findings. In the event of a failing result, migrants workers were directed to either return to the clinic for confirmation and treatment, or they were told they failed the test and could no longer proceed with their applications.

Although OFWs do not receive health-related information from the structural protocols they encounter during the migratory process, this does not mean that they have no knowledge about health. Filipino migrant workers amass a good deal of information on how to cope in their new environment through knowledge previously acquired throughout their lives in the Philippines, and through more informal channels in the destination country, namely their peer network and their employers. It was also discovered that OFWs rely heavily on the advice and information provided by migrant workers who have been in the destination country the longest.

ON SITE

Access to Health Services

The accessibility of health care services for migrant workers in destination countries is contingent upon a number of factors: type of work, destination country, employer(s), language, immigration policies, legal status, costs, availability of services, quality of services, etc. These variables constitute factors that either enable or hinder migrant workers' access to health. Where the utilisation of health services is impeded, health-seeking behaviours may not follow the same patterns as the local population of the destination country.

Many OFWs bring medicines from the Philippines, so they do not have to purchase medicines when they become ill or injured onsite. Moreover, in destination countries, they do not readily consult with physicians or go to health clinics.

> In my case, I really hid my condition from my employers. I went abroad on September and it was really cold and this (calf) became swollen so at night I would wrap it with ginger. My fear then was that if I told my employer, they might terminate me. I was still on three-month probation. So I did not go to the doctor until I could no longer walk. (Filipina domestic worker in Hong Kong, SAR of China)

Hesitation to reveal their illnesses, even just minor ailments, is not only due to fear of losing their jobs, it can also be a function of the nature of their work. In most destination countries, domestic workers only have days off during weekends when health clinics are usually closed. The cost of consultation and medicines also hinders OFWs from seeking services, as they would rather save their earnings and send them home to their families.

The accounts of OFWs who used health services abroad show that their employers played an important role in facilitating their access to such services. Domestic workers are usually accompanied by their employers to the family physician. While some OFWs said their employers took care of their medical expenses entirely, others said that the cost of medication was later deducted from their salaries. Employers taking their employees to a trusted family physician can be regarded positively, but it is also limiting if the worker has no agency in the decision.

> [I had] flu and allergy. When I iron clothes, I did not notice that my hands were already bleeding because of the detergent, especially during winter.They [employer] brought me to a private doctor and they paid for it. When I went to another doctor, my employer got angry with me."You should be the one to pay," because I did not go to their own doctor. My employer refunds my medical bill, only if I go to their own doctor. (Filipina domestic worker in Hong Kong, SAR of China)

Unfortunately, there are OFWs who are forbidden by their employers to go out, even when they are sick. If they have friends who can help them or if they are able to call the embassy for assistance then they may be taken to the clinic or hospital. Otherwise, they have to endure their ailment and suffer.

> In Singapore, I had a stomachache after eating jackfruit. It was bad for me because I had menstruation; I was feeling dizzy. I called my employer at work.They told me to stay at home because they did not want me to go out. (Filipina domestic worker in Singapore)

Land-based workers who work for larger companies are generally more fortunate because medical clinics are provided for and are even located within the work compound. Seafarers also have basic first aid services on board their vessels, and for those working on passenger cruise ships there are doctors on board. In the event of a serious illness or accident, seafarers may be taken to the nearest hospital with the necessary facilities. It is sometimes the case, though, that a captain of a ship will refuse to detour to the nearest port so that a seafarer can see a doctor.

> It depends on the captain. There are very strict captains who do not allow [you to see a doctor] because of the additional expense. (Filipino seafarer)

It can also happen that because of certain policies of the manning agencies or the companies that recruit migrants to work on the ships, the seafarers refuse to seek medical attention and treatment, choosing instead to endure the situation, rather than risk being repatriated.

> They wanted to take me to the hospital but I didn't want to go because if they take you to the hospital, the ship will sail and leave you behind. The agent in that port will take care of you, and then deport you back to Manila, to the Philippines. That goes down on your record. I was afraid of having that in my record, so even if it's really, really painful, I forced myself to work, to walk. I was so scared of being left behind at the pier. (Filipino seafarer)

With regard to the cost of the medical services, certain job categories like seafarers and land-based workers, especially when working for multinational companies, are covered by health insurance. Female domestic workers interviewed said that according to their contracts their employers are supposed to provide for medical insurance. Some of them said that their employers paid for their medical expenses, but others said that the costs were taken out of their salaries, suggesting discrepancies in how medical coverage is delivered to female domestic workers. The entertainers who worked in Japan said they had insurance, but that it only covered accidents which happened in the line of work; and that when they needed to go to the hospital for non-work-related

conditions, the costs were deducted from their salaries. Undocumented OFWs had an extremely difficult time accessing health services, and, if they were able to, they usually had to pay more, as a result of going to private clinics to avoid detection.

Quality of Health Services

For OFWs who have accessed health care services in the destination country, the tendency is to compare this to the services they have experienced in the Philippines. The most striking observation from OFWs who have worked in countries with advanced technology was their mention of the abundance of machines in the hospitals. Although they commended the efficiency of the procedures, thanks to the high-tech equipment, this also caused a degree of concern.

> One time I said to the doctor, "It's always machines here." There is no doctor who will look you over or interview you first, before handing you over to the machines.When I had problem with my eyes, it was straight to the machine. It was expensive. (Filipina entertainer in Japan)

The availability and quality of services also depended on the destination country. Other OFWs mentioned that they encountered doctors more meticulous than those in the Philippines. For example, a migrant worker employed in Hong Kong, SAR of China said that the doctor in Hong Kong, SAR of China provided a thorough physical examination.

Language poses a barrier not only in accessing appropriate health care, but also in the quality of health care delivered. Based on the feedback from migrant workers, this is one of the most common problems faced when accessing health care services in destination countries.

> In Taiwan, Province of China, even doctors speak very poor English. When you tell them you have a headache, they tell it's because of the change in the weather… I had the flu. The doctor gave me seven kinds of pills… They did not explain to me what the pills were for.The doctor couldn't speak in English. (Filipina domestic worker)

Other migrant workers do not face this kind of problem, because they can speak the language in the countries where they work. Unfortunately, OFWs may encounter other problems in health care facilities, such as those experienced

by Erwin, who was confined in a government hospital in Jeddah for 11 months due to his HIV status.

> The room where I was detained was dirty and smelly… The nurses neglected the patients in that room. There were those who needed their diapers changed, the old or bed-ridden patients, but the nurses wouldn't do it. I think they found us disgusting… The room had a capacity for five beds.There were eight at the time.The water was not clear, because of the rust from the pipes.We were provided with food, but we had no choice. If you're not used to their food, it's not easy to eat. Drinking water was not enough. They only gave us one bottle every meal. (Filipino worker who had worked in Kuwait)

In most cases, OFWs who test positive for HIV abroad are immediately deported without the benefit of counselling, treatment or referral to a Philippine Embassy for assistance. There have been cases of HIV positive OFWs who, like Erwin, were detained and then later taken to the airport in handcuffs, as if they were dangerous criminals. Some migrant workers are not even allowed to organise their belongings or get their salaries before being deported. Because migrants are considered carriers of disease, the policy of destination countries is to remove them as soon as possible.

The overall quality of health services largely depends on the available resources and policies in a given country, but the pressing issue for migrant workers is whether they are able to access the best health care a destination country can offer. Essentially, are migrant workers able to access the same quality of care as the local population? In most instances, the answer is 'no': migrant workers do not enjoy the same standards as citizens. In some cases, like Malaysia, even when OFWs are able to pay first class rates, they still only receive third class service.

CONCLUSION

It is the responsibility of governments of origin countries to provide their migrant workers with the necessary information needed to protect and promote their welfare before they leave to work abroad. Though there is an official orientation program for OFWs in the Philippines, it does not include a satisfactory health component. Fortunately, the Philippine government has come to realise the need for this, and it is currently working with NGOs and communities to improve the programme.

Overseas Filipino workers state that health services are available in destination countries, but being able to access them is another matter. In sharing with migrant workers who participated in this study, accessibility of health care services is a continuum: it can be quite easy for some, but health care can be virtually inaccessible for others. It was determined that several factors impact OFWs level of accessibility: type of work, costs, insurance coverage, language, nature of injury or illness, attitude of employers, legal status, and migrant workers' own attitudes towards their health. It is therefore extremely important to consider how to create an enabling environment for migrant workers, so they are able to have full access to the available health services.

Sri Lanka

Migration for employment has been an ever increasing phenomenon in Sri Lanka since the late 1970s. In the late 1970s, a key policy measure was adopted enabling Sri Lankans to leave for work overseas without an exit permit or restrictions. This was hoped that this would bring in much needed capital though remittances and provide employment to unskilled and semiskilled workers, particularly youth and women. Today, Sri Lanka has a population of 19.3 million and a workforce of 8 million. More than one million Sri Lankans are employed as contract workers outside Sri Lanka.

Sri Lankan nationals travel to a number of different countries for work: Bahrain, Cyprus, Hong Kong, SAR of China Special Administrative Region, Jordan, Kuwait, Lebanon, Malaysia, Maldives, Oman, Qatar, Republic of Korea, Saudi Arabia, Singapore, and United Arab Emirates. Ninety-five per cent of migrant workers travel to the Gulf region. In Sri Lanka, female migrant workers account for 75 per cent of the total migration outflow, and most Sri Lankan migrant workers are in their twenties and thirties. The overwhelming majority of those going overseas are young female domestic helpers heading to the Gulf.

Sri Lanka has ratified the International Covenant on Economic, Social and Cultural Rights (1966), thereby acknowledging the 'right to health' for all, including marginalised groups such as unskilled migrant workers. In signing this Covenant, Sri Lanka is obligated to adopt a national health strategy to effectively realise this right; but Sri Lanka has failed to develop and implement a plan to target the specific health needs of Sri Lanka migrant workers going abroad and returning.

Sri Lanka signed the Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001; however, Sri Lanka has yet to follow-up on many of the commitments it made at UNGASS. Sri Lanka has not met the 2003 and 2005 goals of "ensuring access to HIV/AIDS programs to all migrant and mobile populations." Additionally, Sri Lanka has yet to establish a national HIV/AIDS law and corresponding policies.

Having signed the International Convention on the Protection of All Migrant Workers and Members of their Families (1990), Sri Lanka has committed to protecting and ensuring migrant workers' health and labour rights at every stage of the migratory process. In 1985, under Act 21, the Sri Lanka Bureau of Foreign Employment (SLBFE) was established to promote and regulate migration and provide for the welfare and protection of migrants. Regrettable, migrants are all too vulnerable to exploitation, abuse and violence, especially female domestic workers who work in the informal sector. While SLBFE is seen as being 'migrant friendly' in terms of facilitating emigration and the flow of remittances, the focus has not been on protecting the rights of Sri Lankans working overseas or on improving migrant workers' conditions.

PRE-DEPARTURE

This report is based mainly on the experiences of prospective and returnee female domestic workers from Sri Lanka, though stakeholders and male migrant workers were also consulted.

Access to Health Information

In Sri Lanka, pre-departure training has been compulsory since 1998 and is provided by the Sri Lanka Bureau of Foreign Employment (SLBFE), in addition to some registered licensed agents. But this pre-departure training is only available for females going abroad to be employed as domestic workers. There are 23 official training centres in Sri Lanka. The training is free, but participants are expected to pay for food and transportation costs. The training generally takes place over the course of 12 days, with one additional day being used to counsel families; but for those going to Cyprus, Hong and Singapore, the training is 21 days because of added English language training.

The pre-departure curriculum is prepared by the Training Division of the SLBFE. The training focuses on preparing domestic workers to satisfactorily serve their employers and conduct themselves appropriately and in accordance with the laws, values and norms of the destination country. Trainers interviewed expressed that "It should be improved in terms of health rights related areas." Positively, the session does include a session on HIV/AIDS and STIs. According to a trainer, the time to discuss health and HIV/AIDS is two hours long, but it was felt this amount of time could not cover all the implications of HIV/AIDS.

It is therefore not surprising that Sri Lankan returnee domestic workers, when describing their pre-departure programme, demonstrated a lack of awareness about health issues and HIV/AIDS. One female returnee, speaking about the pre-departure programme, said: "Not much [health] detail. Yes, at SLBFE training, they taught us to be careful having regard to our employment relationship." When returnees were asked if they received sufficient information about HIV/AIDS during their training, all responded, "Not enough." A Sri Lankan female returnee from Lebanon commented, "I had it in 1999. It was two-week long training. We were given instructions about equipments, training on talking in Arabic, child care, how to save, and how to handle money transactions, how to handle electronic equipments." Regarding the health and HIV/AIDS component, the same woman said, "We were given advice on what toilet to use and to take some common medicine like Panadol with us." Even with a health component, there is clearly room for improvement. Also problematic is the fact that the pre-departure programme does not reach male and undocumented migrant workers.

There are some recruitment agents who have initiated pre-departure training for Sri Lankan males. Such training focuses on skills development, but a section on HIV/AIDS has been included. A 29-year-old Sri Lankan man heading to Korea received two-weeks of pre-departure training, and his comments suggest the section on HIV/AIDS was delivered with a decidedly moral bent.

> We were taught drill, putty, Korean language, Korean meals and climate, working style, work condition, how to behave with employer, and many more things. One day a doctor came and took class for 4 hours.They gave some idea about Korea, asked to stay away from drug addiction, sexual diseases and be careful about food, because Koreans eat dogs. Yes, he told about AIDS. He told to be controlled and be safe. There is no medicine for AIDS. If one gets it, he must die. He said always you have to be safe by yourself, use condom. He told us it is very good if there is no sexual life. There is no need to go for sex. One can get it not only by sex, but by blade, if used after cutting another person with AIDS. We were told about itching disease and about drinking water. Koreans drink hot water.That was all.

Before migration, Sri Lankan women and men have limited access to the health information they need to protect them. This limits their awareness, power, opportunities for protecting their health rights, and ability to adopt preventative health measures. Fortunately, Migrant Services Centre (MSC) has developed a day-long pre-departure programme to disseminate health information to and

counsel both female and male prospective migrant workers. After this training, one male migrant worker shared his thoughts on the course: "We were given the information on identifying problems of health, prevention of STD and HIV/AIDS. She [facilitator] has discussed about HIV and STDs, how these spread and how it can be prevented. It was new information for me and was very interesting." This training appears to be a worthwhile venture, but at this time it is still only able to reach a limited number of Sri Lankans going abroad.

Mandatory Medical Test

Prospective migrant workers in Sri Lanka have to undergo a mandatory medical test to determine whether they are medically 'fit'. In total, there are 10 private medical clinics approved by the Gulf Cooperation Council (GCC), which are collectively known as the GCC Approved Medical Centres Association, Inc. (GAMCA). These clinics are all based in Colombo, the capital, and the medical certificates issued by the GAMCA clinics are the only ones honoured by embassies when processing employment papers. For those who have to come to Colombo to have tests done, it is expensive and time consuming. Speaking of the mandatory medical test, a recruitment agent had the following comments:

> The GCC panel of Doctors may be broadened, as there are only 10 testing centres for whole country in Colombo. We feel there is an area of over crowding, so State agencies may be invited to undertake testing. And it will be convenient to workers, particularly, if there is a re-check to be done, and they are living away from Colombo.

Similar to other countries in Asia, prospective migrant workers are not informed about the tests they are having done on them. Most distressingly, a number of prospective female migrant workers have been given the contraceptive medroxyprogesteron to prevent pregnancy. This is administered intravenously, without their full knowledge. One young domestic worker reported, "350 SR rupees taken for injection. I don't know what it is for." Another lady who returned from Kuwait and Oman said, "I was not told anything. I was given injection." The concept of pre- and post-test counselling is not widely known at these panel clinics, thus those administering the tests must be educated. At the present time, persons who fail their medical tests are not referred to health and/or social services.

Health Insurance

The Sri Lanka Bureau of Foreign Employment has established a Workers Welfare Fund, which provides insurance, scholarships and loans for migrant workers. In October 2004, the insurance scheme was established, but it is not comprehensive, only covering migrant workers in the event of an occupational accident, disability or death. Many Sri Lankan migrant workers are not fully aware of the insurance or what it covers: "I have insurance Sahana. Do not know what it covers. Only yesterday night the recruitment agent gave me the document. After going to Korea, I will send it to the family in Sri Lanka, so that they can claim in case of death." Female migrant workers who are unaware of Sri Lanka insurance scheme are rendered more vulnerable by the fact that domestic work is not covered under the Labour Laws, particularly in the Gulf Countries. Unfortunately, most Sri Lankan migrant workers leave the country thinking all their health needs will be met by their employers, but this is not always the case.

> In Kuwait, after nine months, I got haemorrhoid. My brother was also working in Kuwait, and he got me ticket to come back. I was given the traditional healing of ginger boiled in hot water, by my madam. But I got worse. I asked Mama (employer) to take me to the doctor, but she won't and brought me the medicine. But I got worse.Then I came back.They wanted me to stay, but I came back to Sri Lanka. Here I had treatment and got well.

ON SITE

Health Services

There are limited legal assurances in place to protect Sri Lankan migrant workers while overseas. No bilateral agreements address Sri Lankan migrant workers' rights and access to health. Migrant workers are dependent upon their employers, particularly female domestic workers.

> They [employer] will take us to the doctor, as per their wish. We are not allowed to go alone. If we are ill, we can tell them, but usually they will bring the medicine themselves. We do not know where the hospital. Do not know the language.We are not allowed to go out.

If they are ill, they explained they self-medicate with Panadol and medicinal balms brought from home. Females migrant workers shared they suffered from backaches, breathing difficulties, headaches, vomiting, and fever. These conditions were attributed to the extreme climate, the tremendous amount of work involved in caring for a large extended family, working long hours, and having limited rest or sleep. On top of this, they are vulnerable to abuse and harassment by employers.

> When we are sick, they kick and tell us to work. They say, "We have taken you by paying money.We can't work.You are the one who have to work.We have paid the agency for you and so you have to work."

> Mama used to say,"You have to work.You have to work 24 hours." If I felt ill and Mama found me resting, she would give me more and more work to keep me awake.They used to crush the ironed cloth by hand, throw it to floor and ask to iron again. I got burnt ironing, very tired and ill (showed her burned hands). No freedom. Without sleeping in the night, I had to iron clothes.They won't allow us to sleep. How much we work is not enough. I used to sleep around one o'clock at night and wake-up 4 in the morning.

Sadly, in addition to abuse, sexual harassment and rape are all too common. In 2003, the SLBFE Annual Report showed a total of 1206 harassment complaints were filed by migrant workers in the domestic sector, most of them by females.

Proactively, the Sri Lankan government has installed Labour Attachés in Sri Lankan Missions abroad who are assigned to intervene and arrange settlements for problems between employers and Sri Lankan employees. However, the majority of domestic workers do not have knowledge of or the freedom to seek assistance from these individuals. Moreover, the Attachés have not been trained on health matter and Sri Lankan Embassies are not set-up to handle migrant workers' health concerns. Overall, Sri Lankan migrant workers share their right to health is grossly neglected.

> We should get appropriate information to channel specialist doctors to obtain medical treatment.There should be a scheme for us to visit health clinics once in two months.There should be a health camp even once a year.The SLBFE must organise a dialog for the new migrants to share experiences of returned migrants.

> When you are abroad they do not consider the training given in this country. They do not give any consideration to medical examination. There are no solutions to problems faced by migrant domestic workers. There are some places where sick people are not cared for. Getting treatment is human right. Employers have to give it. They must look after our health.

Along with physical illnesses, mental health is also felt to be a serious issue by Sri Lankan domestic workers. Sri Lankan domestic workers are often young mothers who left their children back home in their effort to achieve greater financial stability. Discrimination, abuse, fatigue, negligence, and the inability to access health care services, layer to become a source of stress. For many, being cut off from one's family can lead to feelings of loneliness, hopelessness and depression.

REINTEGRATION

Migrant workers typically undergo a health test upon arrival in the destination country and then they are generally tested every 6 months or a year after that. If deemed 'unfit', they are deported almost immediately. When they arrive back in Sri Lanka, there is no formal mechanism to facilitate their contact with the appropriate health authorities. Many return without their conditions being correctly diagnosed and treated.

One female migrant worker, who tested positive for HIV while abroad, shared that she had no idea where to go for help when she returned to Sri Lanka. She started working at a tea factory, but fell ill and sought help from a doctor nearby. When she did not recover, and developed further symptoms, the doctor asked her to do a blood test. After the test, the doctor told her she was HIV-positive and directed her to the Infectious Diseases Hospital in Colombo, where she was able to received counselling and medication. Starting on World AIDS Day in 2004, the Sri Lankan Ministry of Health began a programme to deliver free antiretroviral therapy to 100 people. Presently, only 50 people are utilising the service, which is available in the capital of Colombo. Regrettably, proximity to Colombo is posing a problem for HIV positive returnees who live in rural areas – to travel to Colombo regularly is expensive, time consuming and exhausting. Migrant returnees have ceased their antiretroviral therapy based on this access issue.

RECOMMENDATIONS

For Sri Lankan migrant workers' health rights and access to health to improve, a number of measures need to be adopted. Sri Lanka must adopt a National Health Policy and Plan of Action targeting migrant workers and their families, focusing on both preventative health messages and health services. A National AIDS Law should also be formulated, ensuring comprehensive coverage and accessible, affordable treatment for migrant workers. A formalised referral system should be established between recruitment centres and appropriate health services, so migrant workers have access to quality treatment and care. Efforts should also be directed towards making health services less centralised in Colombo, so more migrant workers are able to access them. Additionally, special efforts should be directed towards protecting the health and well-being to female migrant workers going abroad, given that destination country labour laws rarely cover work in the domestic sector, and they are more vulnerable, working in the home. Abroad, Sri Lankan Embassies, Consulates and Missions should be staffed with individuals knowledgeable on migrant workers' vulnerabilities, and they should have links with the appropriate health and social services in both the destination country and Sri Lanka.

Vietnam

Since the late 1980s, the Vietnamese government has increasing encouraged its citizens to work abroad to help bolster the Vietnamese economy. According to 2004 government figures, there were 166,118 males and 62,034 females working abroad, with the majority working in Japan, the Republic of Korea, Malaysia, and Taiwan, Province of China. These workers have made a sizable contribution not only to the foreign countries where they are employed, but to the Vietnamese economy as well. In 2002, US 1.4 billion was remitted to the Vietnamese government through taxation and US 220 million was remitted to dependents back home.

In the past, Vietnam's foreign employment procedures were handled almost entirely by the government, but the government is currently trying to move towards a more supervisory and monitory role in this area. Recent energies have been directed towards developing relevant laws and polices and attempting to regulate private recruitment and training agencies. Yet in reality many 'private' companies are government Department registered businesses with strong ties to the government. According to a government employee, only four out of 124 recruitment agencies are actually 'private', as per the common understanding of the term. Recruitment agencies in Vietnam vie for foreign company contracts. Problematically, it was discovered that Vietnamese agencies follow no minimum standards criteria in assessing the quality of the foreign companies interested in employing Vietnamese workers.

Most Vietnamese migrant workers spoken to reported being pleased with their work experiences abroad and stated they would work abroad again; but upon further questioning divulged hardships endured while away. It was felt that respondents minimised negative experiences for a number of reasons: to preserve their self image, having previously experienced poor working and living conditions in Vietnam, the cultural trait of accepting and adapting to difficult conditions, and wanting to please rather than cause disharmony. They generally felt lucky to have such an opportunity to go abroad and did not want to jeopardise this, so poor conditions were generally accepted and managed.

PRE-DEPARTURE

Access to Health Information

Vietnamese Labour Law (Article 134 A No. 2) stipulates that Vietnamese employment agents are legally required to "arrange orientation training and education for workers before their departure for overseas employment, in conformity with the provisions of the laws." Vietnamese Law does not contain any provisions on the dissemination of any health related information.

Pre-departure training is supposed to consist of basic language training relevant to the destination country; information on the cultural and societal context of the destination country; and care giving skills, if a necessary requirement of the job. Pre-departure trainers receive standardised training provided by the government. Interestingly, when CARAM Vietnam first introduced a pre-departure training package to the government and recruitment agents, it was assessed by these parties to be worthwhile venture, but the component on health issues and risk taking behaviours was thought to be a waste of time and energy.

Positively, some recruitment agencies have been proactive on this front, choosing to teach a component on health.

> We spend three periods for the health section.Health is very important: 'We are healthy, we can work'. I tell them not to smoke and drink, train them on the industrial lifestyle, such as eating and sleeping on time, not stay up late. We also train them on labour safety, birth control, drugs, and gynaecological disease. (Vietnamese recruitment agency manager and trainer)

> Two to 30 learners are in each class, mixed men and women. However, we separate them in some sections; especially in the health section, we teach men and women separately about female diseases. And how to keep hygiene while sitting at work for a long period because women often do sewing. (Vietnamese recruitment agency manager and trainer)

Problematically, trainers explained sexual and reproductive concerns as being a principally female issue, which may serve to blame women for such conditions and cause men to minimise their own level of risk. It was also found

that trainers delivered information at a level that was too complex for some potential migrant workers, given level of education and limited knowledge of disease transmission. Additionally, the health component was sometimes delivered with men and women both present, and this was thought by potential migrant workers to be awkward and stifled discussion.

> If men and women were separated, it would have been easier to discuss. If we were alone, maybe we would have had a lot of questions. How can we ask questions in front of women? Therefore, we just kept things general. (Male Vietnamese migrant worker)

Two additional cultural issues have been identified as being barriers in delivering pre-departure health information. The first is the teaching of health rights in pre-departure programmes. It is felt that this is a difficult topic to teach, because such an idea does not exist in Vietnamese language and culture. In Vietnam, health is understood by most through the ideas of good karma, good luck or one's destiny, not as being one's inalienable right. Secondly, health is not thought about in terms of prevention, especially for those coming from rural areas. Vietnamese generally take a reactive approach to health, with traditional and spiritual healers often being sought, in addition to modern medical services.

Medical Test

Prospective Vietnamese migrant workers have minimal exposure to health services before going abroad. One of the main modes by which they come in contact with the medical services is through the mandatory medical test, which is required by destination countries. Of the Vietnamese migrant workers interviewed, no one could explain in detail what they were being tested for and why. No pre- and post-test counselling was provided to them.

Test results are sent directly to recruitment agencies and these agencies inform potential migrant workers of the results. If migrant workers do not pass, they are not told the reason for this, but are told to contact a doctor or go to the hospital. Without immediate information and counselling migrant workers may not seek medical assistance. In the case of someone testing positive for HIV, there is a legal requirement that this person must be reported to the People's Committee, upon which time attempts are made to contact him or her. Interestingly, the testing procedure might not take place in certain instances, as it was shared that doctors have been asked to sign medical forms in English stating that

migrant workers have passed their medical tests. This can be problematic in that Vietnamese migrant workers are often tested again when they arrive in the destination country. If they fail their medical test upon arrival, they are almost always immediately flown home, and are then made to pay back the costs of their flight to the recruitment agency.

ON SITE

Living and working conditions vary between destination countries. Most Vietnamese migrant workers found their circumstances abroad moderately favourable, but a number found their experiences excellent, while others declared they suffered terribly. Almost all Vietnamese migrant workers complained of having a curfew, if mandated, and of having their freedom of movement restricted. They said they were able to cope because of the money they were making and because they knew their lives would only be like this for a finite period of time.

Vietnamese migrant workers shared they worked long and irregular hours, the labour was demanding and they felt isolated. In the factories or private homes where many worked, they could rarely communicate with their superiors or co-workers due to language barriers. A number commented that their employers were cruel and unsupportive and would threaten them with deportation. This caused stress among those interviewed.

A few Vietnamese workers shared in greater detail the abusive conditions of their work. For example, a female migrant worker explained it was her responsibility to take care of a disabled child and six other family members. She would begin work at 6 am, helping the child to exercise. She then quickly had breakfast and began cleaning the house. Lunch occurred at 12 pm, after which she would continue to clean. She was not allowed to rest at lunch; she could only eat her food. Four times per day she had to oversee the child's exercises, each session being an hour long. She expressed the most difficult part of her job was the mornings when she went to the bathroom, as her employer would sexually harass her, pinning her hands and touching her all over her body.

Those who suffered tended to do so slowly, over a long period of time. They complained of many conditions associated with stress and overwork, namely

headaches, dizziness, stomaches, and backaches. They would not associate these conditions with negative side effects of their employment, but would rather attribute their 'aches and pains' to difficulties with food, weather and noise. Self-medicating was the most common coping mechanism, and only if chronic conditions deteriorated or if the situation was immediately acute, as in the case of a broken bone or deep cut, would they seek treatment at the hospital. Sometimes, even if a condition was serious, they would suffer in silence.

Access to Health Information

Vietnamese spoken to had almost no access to health information in the destination country. The common barriers of language, lack of information, minimal freedom, and limited exposure to public health campaigns caused this, but it was found that Vietnamese migrant workers were also not primed to receive preventative health messages. Over the last 15 years, public health campaigns, whether for HIV/AIDS, nutrition or malaria, are not thought to be successful because they are deemed to be propaganda by the public. As stated before, Vietnamese feel health is guided mainly by luck or fate, rather than by societal contexts and personal actions. This is felt to be the 'Vietnamese way'.

Until an illness or injury became severe, migrant workers interviewed did not attempt to collect information on where health facilities were located and how to access them. However, some shared they did try to locate someone in the destination country who spoke the local language and also Vietnamese, in case there was ever an emergency and a translator was needed.

Access to Health Services

Vietnamese migrant workers reported a number of barriers in accessing health care facilities abroad: restricted mobility due to employers, not being in possession of the proper documentation, not knowing where health facilities are located, no knowledge of the local language, high cost of services, inability to get time off work, limited knowledge of their rights, and distance to facilities. In addition, migrant workers paid for health insurance, but they were not educated on what this entailed.

The story of one Vietnamese female migrant worker's experiences in Japan illustrates various 'access to health' difficulties:

> A few days after arriving, __ had an unusual discharge, and it continued for some time. She could not ask for medicine because she could not speak the language. She looked for a Japanese-Vietnamese dictionary, but she could find none. After two weeks, the Vietnamese agent came to visit. She told him, but was only given paracetamol, which she knew was not what was needed.
>
> She rang home to ask for something to be sent over. Her employer deducted the phone fee from her wage. She tried to find a phone outside, but was caught by the police with no papers. She told the police where she worked.The company took care to the police charges, but three days later she was sent back to Vietnam at her expense.
>
> Her medical problem was fixed in Vietnam, but the Japanese company informed the Vietnamese agent about what happened to her. This Vietnamese agent contacted the Vietnamese People's Committee in her home province. They contacted her family. She is still paying off her huge debt.

Vietnamese migrant workers who did come in contact with foreign health service providers did remark that they received quite good care and it was, in most cases, superior to prior service experiences in Vietnam. For the most part, though, Vietnamese migrant workers self-medicated. When asked specifically, Vietnamese migrant workers shared that STIs were generally a problem and expressed that most are reluctant and embarrassed to seek treatment until symptoms become unbearable.

REINTEGRATION

For a number of Vietnamese returnees their experiences abroad were positive, and many looked forward to working abroad again. For those deported, as the result of a failed medical exam or for other reasons, returning home was an emotionally trying event. It was described as being "shameful" to be returned early to one's family. To return early was to let one's family down, especially financially. Additionally, to return home with a condition such as HIV/AIDS or TB was thought to be a "disgrace," because these diseases are viewed as "dirty." There are no services in Vietnam, whether medical, social or financial, to specifically assist migrant workers in transitioning back into life in Vietnam.

DESTINATION COUNTRIES

Cambodia

Many Cambodian nationals travel abroad to work in Asian countries, particularly Malaysia and the Republic of Korea. At the same time, a significant number of Asians relocate to Cambodia in search of work. This research focuses on Cambodia from both a destination and origin country perspective, though much of the research assesses the experiences of Vietnamese women who have relocated to Cambodia and engage in sex work.

DESTINATION COUNTRY PERSPECTIVE

Globalisation processes, including the free market economy, have increased the presence of foreign companies, embassies and international organisations in Cambodia. Foreigners involved in such activities are generally residing legally in Cambodia. This is not the case for others who live and work in Cambodia without proper documentation. For example, there are many Vietnamese women who travel to Cambodia to seek various employment opportunities, oftentimes in the effort to support their family back home. Many of these women become involved in the sex trade and encounter numerous problems in Cambodia, including the inability to access adequate health information and services. There are no specific laws and policies in Cambodia to protect migrant workers' rights, their freedom from discrimination and their access to health, especially if they are undocumented.

ON SITE

Access to Health Information

Based on information shared during a focus group discussion with Vietnamese 'massage girls' and sex workers in Phnom Penh, there is a substantial amount of information circulated on health and HIV/AIDS in the local Khmer language, but they are unable to access it because they do not read Khmer. They do not

receive a great deal of health information from the owners of the massage parlours. The owners simply accompany them to the health care centre when they have a health problem. The lives of these women are very much controlled by their bosses, and they are dependent on them; though the women do share some information between one another.

> When I got sick, the boss take to private Vietnam clinic, which is near by Wat Phnom, and he pay for me, but I don't know the amount paid. (Vietnamese 'massage girl' in Phnom Penh)

> The information on HIV/AIDs or reproductive health are heard from one by one, and nobody disseminates to us. We had aware on how to prevent our selves and using condom through explanation of my friend and owner. Anyway, I never concentrate information on HIV/AIDs or STIs because of our owner will manage for us when we get sick. The owner will allow us to borrow 200 or 300 to buy the medicine. Food and water are in charged of owner. (Vietnamese 'massage girl' in Phnom Penh)

> I have been live in Khmer since I was 17 years old with my aunt, she sell the cafe at _. Because of the difficulty of our living life and no money send to the parents in Vietnam, and also being invited by my friend, so I decided to do this job as sex worker in the shop where located near _ __. I wasn't shy, because I had asked to get experience of this work from the previous person about the hygiene in order to prevent of getting pregnant by using condom. I know how to take care myself through the elder because I don't know Khmer language. I can't understand the information on TV and also have no time to watch it because I am so busy with my work. (Vietnamese sex worker in Phnom Penh)

It must be noted that, for the most part, Vietnamese sex workers interviewed primarily focused on their job and making money to send home, not on issues connected to accessing health information. As one Vietnamese 'massage girl' explained, "Nowadays, I just earn money without thinking anything, because my owners already do for [take care of] me."

Knowledge of Health Services

Vietnamese sex workers in Cambodia do not receive adequate information on where and how to access health services. This has to do with a combination of factors, namely their undocumented status, language barriers, their employers controlling where they go, the line of work they are in, and there being a lack of targeted health materials for migrant workers in Cambodia.

Vietnamese sex workers shared that new arrivals in Cambodia rely on Vietnamese sex workers who have been there longer to accompany them to health centres. For serious conditions, the brothel or massage parlour owner will refer them to a specific institution and might also take them there. Although one woman shared that they know of a health centre because she had received this information from a NGO worker during a community outreach education programme on sexual and reproductive health: "Previously, I had tested at private clinic 'Vietnam', but after that your staff [CARAM Peer Educators] referred us to 'free of charge' clinic." During this programme she also learned about STIs, HIV/AIDS, birth spacing, condom use, and negotiation skills. It was also learned that sometimes, even if a woman knew of a public health facility, she might prefer to seek medical assistance at a Vietnamese health clinic in Cambodia, because it was easier to communicate at these clinics.

Access to Health Services

Accessing Cambodian health facilities were a dilemma for Vietnamese sex workers due to language barriers in communicating with the health care staff. Oftentimes, friends who could speak Khmer would accompany them to translate.

> We mostly went with my friends because they came to live in Cambodia for long time, so they can speak Cambodian, and if we met Cambodian Doctors, we can speak with them. (Vietnamese 'massage girl' in Phnom Penh)

It was also shared that the high cost of health care at public institutions was a barrier to seeking treatment, as was the discriminatory treatment they received there.

> I think that big health centres like _ Hospital always have enough equipment and specialisation doctor. It is a good place where we want to go, but because of the money, and feeling which we get discrimination from doctors, so those places are not the places where we need when we have a health problem. (Vietnamese massage girl in Phnom Penh)

Even given the high cost and discriminatory treatment, some women explained they would pay more to receive treatment at large public facilities, because they found the medical treatment superior and the equipment more modern. In addition, in the case of serious accidents and illnesses, where health costs

would be considerable, women commented on the use of moneylenders: “The person who can help us is only the moneylender for emergency case”; “The interest rate is from 20 per cent to 30 per cent, but we must borrow because if we do not borrow, we have not money to solve [medical] problem.”

Quality of Health Services

It is understandable that people desire to receive high quality medical care. Unfortunately, because of their occupation as foreign sex workers, the Vietnamese sex workers interviewed felt they experienced discriminatory treatment by staff at public clinics and hospitals in Cambodia. They explained that doctors would charge them more than the prices on the price list set by the Cambodian government. They also felt the health care staff ‘looked down on them’, purposely made them feel uncomfortable and said inappropriate things.

> If the doctor know that we are Vietnamese, called Yaun [discriminatory term for Vietnamese]. They look us from the top to the bottom, and look down us that we have no money. So, it is very difficult to go to hospital, except when we have illness seriously. (Vietnamese massage girl in Phnom Penh)

Health Seeking Behaviour

The Vietnamese sex workers explained they typically prefer going to the pharmacy in Cambodia rather than the clinic or hospital. Their reasons for choosing pharmacies over Cambodian medical establishments included the ease of accessing the pharmacy, the longer hours of operation, no official documents being needed, and their being able to use the pharmacist to diagnose their ailments. Generally, Vietnamese sex workers were aware they would receive better care at a hospital, but the perceived advantages of using the pharmacist were greater. In addition, a number of women mentioned their preference of using traditional Chinese medicines.

> Since I have come to Cambodia, I have not had any serious illness; and when I have a bit sickness, I will go to buy medicine at the clinic. (Vietnamese massage girl in Phnom Penh)

> I like to buy Chinese medicine because if I take that medicine, I will feel better.And one more, it is my habit because my parents also take it too. (Vietnamese massage girl in Phnom Penh)

ORIGIN COUNTRY PERSPECTIVE

In Cambodia, the government has encouraged individuals, and particularly women, to work abroad to help alleviate poverty in the country though remittance payments.

PRE-DEPARTURE

Pre-departure Training

While people migrate to Cambodia for work, as discussed above, Cambodian citizens also travel abroad for employment purposes. According to Cambodian Law (sub-Decree 57 [Article 14]), before going abroad, potential migrant workers must partake in a pre-departure training course. The government stipulates that the course must cover the employment system, culture and common law in the destination country, and be carried out by CARAM Cambodia, a local NGO.

The training takes place over two days and fortunately, though it is not legally required, CARAM Cambodia covers the following topics during the training: human anatomy, including the reproductive system; HIV/AIDS and STIs, including modes of transmission, vulnerable groups and prevention of infection; how to use condoms correctly; general hygiene; and pregnancy and birth spacing. Potential migrant workers interviewed found the course informative, easy to follow and engaging, because of the use of visuals and 'real life' scenarios.

Mandatory Medical Testing

Although no specific law in Cambodia prohibits mandatory HIV testing before being permitted to work abroad, Cambodia's AIDS Law outlines that "an HIV test should not be part of an employment test" and that "no justification whatsoever shall be given to have an employee get an HIV test." Mandatory HIV testing still takes place, though, because destination countries required this before they accept foreign workers. The Cambodian Ministry of Labour oversees the medical test and it is carried out at a Cambodian Labour Hospital, through some recruitment centres use private doctors because they are less expensive. Prospective migrant workers shared they received almost no information about

what they were being tested for. This was also reflected in the words of a doctor who conducts mandatory health tests: "Pre and post counseling has never been provided to migrant workers for blood testing…I just tell the company they are infected HIV/AIDS; it is the company's responsibility to tell the migrants."

ON SITE

Health Rights Abroad

Cambodian returnees explained they experienced difficulties in accessing health information and services and that these conditions were exacerbated by long hours of work, controlling employers, demanding work contexts, and high costs. Given these difficult circumstances, it is unfortunate that Cambodian embassy staff are not trained to handle the specific vulnerabilities and needs of migrant workers. Moreover, Cambodia does not have a national health insurance scheme for individuals traveling abroad to work. Positively, Cambodian Law does state that the Receiver Party looking for Cambodian workers must specify: start and termination date of work; nature of work; location of work site; number of workers and skills required; salaries and other remunerations, including lodging, food, clothing, medical care and other basic living necessities; and means of transport to and from work. Yet the degree to which this Law is strictly adhered to is questionable.

In sum, the government of Cambodia has an obligation to protect and ensure the health rights and access to adequate and appropriate health information and care of both migrant workers in Cambodia and Cambodian nationals working abroad. From the research, it is apparent that groups, such as Vietnamese sex workers, encounter barriers to sustaining good health in Cambodia, and action must be taken on this issue. At the same time, Cambodians working abroad are rendered vulnerable, suggesting more needs to be done to protect them during every stage of migration. Law and policy development needs to happen at the national level, but a great deal could be achieved if countries work together in a regional manner – e.g. MoUs, bilateral agreements, regional dialogues, information sharing, combined monitoring efforts – to protect and ensure migrant workers' access to health.

Hong Kong Special Administration Region of the People's Republic of China (SAR of China)

Hong Kong, SAR of China is an attractive destination country for migrant workers from across Asia. According to government statistics, at the end of 2004, there were 19,155 foreign professionals, 218,430 foreign domestic workers and 11,037 other foreign workers in possession of valid work permits in Hong Kong, SAR of China. For the most part, work permits are granted to professionals and foreign domestic workers. Of the foreign domestic workers employed in Hong Kong, SAR of China in 2004, 54.8 per cent were from the Philippines and 41.2 per cent from Indonesia. There are also an indeterminate number of migrants working in Hong Kong, SAR of China without valid work permits.

This research is focused on the 'access to health' experiences of documented domestic workers, with some additional information provided on sex workers in Hong Kong, SAR of China. Data were collected through two sources: Hong Kong, SAR of China government publications and fieldwork (focus group discussions and in-depth interviews). Field research consisted of two focus group discussions with nine domestic workers from the Philippines, two focus group discussions with 12 domestic workers from Indonesia, in-depth interviews with four employers of foreign workers, and in-depth interviews with six staff members of NGOs who work on issues connected to foreign domestic work. Six doctors were also asked to share their experiences in treating foreign patients.

ON SITE

Laws and Policies

In Hong Kong, SAR of China, the Occupational Safety and Health Ordinance provides for the safety and health protection of employees in the workplace, both in the industrial and non-industrial sector. This Law protects all

employees in the

workplace, regardless of citizenship and documentation status, in the event of an incident at work requiring medical attention. For those migrant workers who are documented, they have access to the heavily subsidised public health care system, thus their health care should be equivalent to that of locals. Additionally, standard employment contracts for foreign domestic workers outline that registered employers must ensure that any medical care and treatment is covered for the duration of his or her employment. Foreign workers without valid work permits are unable to access the government health system to the same degree and they do not have access to government health subsidies. Almost always, they forced to shoulder costs when accessing health services in Hong Kong, SAR of China.

Access to Health Information

There are no government mandated post-arrival programmes for migrant workers in Hong Kong, SAR of China. Since 2004, though, all foreign migrant workers with valid work permits are given a booklet – "Your Guide to Services in Hong Kong, SAR of China" – upon their arrival at the immigration counter at the airport. This booklet is published in five different languages. The immigration officer provides the version they think the migrant worker would be able to read or asks the worker his or her preference.

This booklet contains important information about Labour Laws in Hong Kong, SAR of China and various health related messages, including information about the health care system in Hong Kong, SAR of China, the address and hours of operation of major health institutions and the charges of various services. Foreign domestic workers who have read the booklet have reported that the information is useful. Unfortunately, many of the workers from Indonesia reported that they do not have a chance to read their copies because the recruitment agency staff takes their copies away.

On the other hand, domestic workers from the Philippines are usually able to maintain their copies, but many reported that they have not read it. In the words of one migrant worker: "I will read it, when I need the service." This suggests that the book is primarily used when the situation presents itself. Overall, this booklet is not widely available. It is only distributed at the immigration counter at the airport. An NGO worker who works with sex workers explained that she once asked an officer of the government bureau that publishes the booklet for 10 copies in various languages and found that the bureau office was out

of stock for some languages, meaning the government might not think the distribution of this material is a high priority.

In Hong Kong, SAR of China, preventative messages (e.g. safe sex, hand washing, road safety, prevention of bird flu, and health/diet) produced by the government or NGOs are usually disseminated to the public through TV commercials, billboards and leaflets. It was found that very few foreign workers reported receiving preventative health information through these public channels. Migrant workers often do not have the chance to watch TV and they are unable to read textual materials given the language barrier. Most health leaflets are printed in Chinese and English, but even for those who are able to read these languages, they had not read the pamphlets provided at the NGO centre where they were being interviewed. The only health materials that were published in a wide range of languages were the ones produced during the SARS crisis in 2003.

A number of NGOs take a more direct approach to delivering health information – they delivery preventative health messages in the migrant workers' languages in the locations where migrant workers gather. They arrange seminars and workshops for them. But the NGO workers report their frustration at only being able to reach a small number of workers at a time. The NGO serving sex workers using the same information dissemination strategy reported that it was difficult to reach sex workers because they are so mobile, as they might only stay in Hong Kong, SAR of China for a few months. Another issue was the fact that most of the organisations working with migrant workers were Christian faith based organisations. Thus some of the migrant workers of other faiths reported hesitancy in becoming involved in their activities.

Access to Health Services

According to migrant workers, as well as employers and NGO workers, migrant workers resort to self medication for minor illnesses: "I know how to take care of my illnesses; I know where to buy the medications I need." Some NGO workers believed that employers did not encourage their employees to see a doctor. Other NGO workers believed that employers rarely knew about their foreign employees' illnesses because migrant workers were afraid to disclose illnesses, due to the fear of employment termination.

Domestic workers, employers and NGO workers all felt that if a condition was serious or if an employer encouraged their employee to consult a health service

provider, migrant workers would do so. Typically, domestic workers would ask their employers before seeking professional consultation. Sometimes seeking health services would be delayed until employers were available to accompany them to the appointment. Normally they would go to the health practitioner recommended by their employer, though a few were allowed to consult with a preferred doctor. Most domestic workers spoken to had not seen a private care physician; rather they had been to government clinics or practitioners of Chinese medicine.

Domestic workers from Indonesia were usually accompanied by their employers to the government clinics and employers paid the fees directly. Some domestic workers from the Philippines were also accompanied by their employers, while others went alone and had their health expenses reimbursed later. None of the domestic workers or employers who participated in the study reported that employers did not pay the medical fee for the workers. In contrast, NGO workers reported they had clients whose employers did not reimburse the medical expenses when paid by the workers. One woman mentioned she went to a clinic alone and paid the fee herself because she did not want her employer to know she was sick. NGO workers also confirmed that domestic workers consulted doctors when they were able to get time off and often paid for this treatment out of their own pockets.

Regarding the cost of health care in Hong Kong, SAR of China, both domestic workers and NGO staff felt the medical fees of private clinics are quite high. They are equivalent to a day's wages for a domestic worker. But public outpatient clinics, though costing less, are open only on weekdays and the waiting time is long. These conditions hinder migrant workers from accessing health services on their own. NGO workers reported that high medical fees hindered some foreign sex workers from having their STIs treated. They had to wait until they returned to their country of origin to have their infections treated. NGO workers also reported that some sex workers did not believe in the doctors in Hong Kong, SAR of China.

None of the migrant workers interviewed mentioned being hospitalised or brought into the hospital's Accident and Emergency Department. NGO workers reported that some foreign workers were afraid of hospitals in Hong Kong, SAR of China because they felt medical students were using them as 'guinea pigs' for their studies. Interestingly, this is also a belief shared by some locals. A doctor working in the Accident and Emergency Department of a public hospital shared

that foreign workers generally have more serious conditions when they seek help, compared to locals, though other doctors interviewed did not observe significant differences in health conditions between foreign workers and locals.

On the point of language being a barrier to accessing health services, domestic workers from the Philippines shared they could communicate with doctors because their English language abilities were high. Domestic workers from Indonesia reported they were able to communicate sufficiently with doctors, because they had taken a three month language course. NGO staff explained that those who had difficulties conversing in the local language would be accompanied to the doctor by their employer or an NGO worker. Only one person interviewed had difficulties accessing health services, and this was due to language problems. In this situation, the migrant worker wanted to have an HIV test from a government facility. Because of the regulation of providing counseling before an HIV test, the facility required the migrant worker to call a hotline by herself for preliminary assessment and counseling. However, due to the confidentiality regulation the NGO worker was not able to assist her with the translation. Because the migrant worker was unable to call the hotline, she was not able to access this service, suggesting the hotline system of assessment and counselling should be critically assessed.

From the doctor's perspective, they observed foreign workers being accompanied by someone who could translate on their behalf. In certain cases, where language difficulties were more of an issue, they relied on physical examinations and body language to diagnose ailments. None of them felt migrant workers' health was jeopardised because of communication barriers. They also suggested that hospital staff who spoke the needed language could be located, if the need presented itself, though none had done this. Yet NGO workers reported that some doctors used medical terms that migrant workers could not understand and also shared that some migrant workers felt they were treated poorly compared to the local population. Also shared by both migrant workers and NGO staff alike was the belief that the quality of the medical facilities and services available was equal to or better than those in the migrant workers' home towns or cities.

INFORMANTS' RECOMMENDATIONS

Informants shared a number of suggestions in how to improve migrant workers' access to health services: increase migrant workers' salaries, increase the quality and amount of targeted health messages for migrant workers and increase relevant NGOs' knowledge of pertinent health issues. Interestingly, most migrant workers and NGO staff rejected the proposal of requiring employers to purchase a more comprehensive insurance scheme for migrant workers. This is due to the belief that this might cause a reduction in migrants' salaries. This concern is based on the fact that in 2003, the minimum monthly salary of domestic workers was decreased to 400 Hong Kong, SAR of China dollars when the government decided to impose a levy on employers when new employment contracts for domestic workers were issued.

Japan

According to Japanese government statistics, at the end of 2004 a total of 1,973,747 registered migrants were living in Japan. Japan is also estimated to have more than 200,000 undocumented foreign residents. Of the total migrant population, about 500,000 have 'special permanent resident' status. Those among this group were forced to move to Japan from Korea and China during the Second World War. They are generally called 'old comers', while the so-called 'new comers' migrated to Japan during the mid-1980s. Many new arrivals come to Japan to work and improve their standard of living.

Japan's current immigration control system is based on one's 'status of residence'. Under this system, foreigners are classified according to the activities and work they are involved in while in Japan. The Immigration Control and Refugee Recognition Law stipulates 27 different types of residency status. According to this Law, foreign workers in Japan are only permitted to work in the education sector and various technical fields.

Japanese Law does not specifically address the health of migrant workers. Japan finds itself conflicted. On the one hand, the government has a responsibility to safeguard its citizens and provide publicly funded health and welfare to its citizens, where migrant workers are perceived to jeopardise these institutions, as a disease threat and a financial burden. On the other hand, Japan also has a responsibility to fulfil its international obligations to protect, promote and ensure the human rights of all people, including migrant workers. In reality, migrant workers health rights are not on the government's policy agenda and, as a result, their specific health needs are often not satisfactory met.

ON SITE

Access to Health Information

For migrant workers in Japan, there are different sources of preventative health messages. Migrant workers may informally ask their co-workers, family members or Japanese friends about different health issues. They may also go seek advice from health service providers in Japan. Health information is also available at certain restaurants, temples, churches, and embassies. Moreover, there are newspapers written in the different languages, which migrant workers can access, and there have been some local government initiatives, whereby educative health materials have been created in various languages.

However, having several potential sources of information does not necessarily mean that appropriate health information will reach migrant workers in Japan. It was observed that migrant workers often do not share their knowledge on health services and misinformation on health was known to be spread. For example, one female migrant worker shared she heard that a traditional medicine was an effective AIDS treatment. A primary reason for incorrect health knowledge was migrant workers seeking support from co-workers and friends, rather than NGOs and government health service providers. It was determined that they do not go to these more formal channels because they do not know of their existence.

This situation calls for a more aggressive campaign to let migrant workers know of existing health materials. Simultaneously, current materials must be continuously improved. Migrant workers must have detailed information on the services are available to them, the location of health facilities and the costs. They should also be educated on the mechanisms available to them in accessing health services in Japan: insurance, referral procedures, health hotlines, and interpreters. Migrant worker should also be provided with detailed information on living and working conditions in Japan, along with Japanese Laws and Regulations. Ideally, this information should be delivered before they come to Japan and again upon their arrival. It should also be available at resource centres across Japan and on the Internet. Migrant workers' access to educative materials should be monitored and where gaps are identified, efforts should be made to remedy this situation.

Thus far, the Japanese government, private companies, employers, NGOs, migrant workers, and other stakeholders have not effectively come together to work on a coordinated response to ensure that appropriate health information reaches both documented and undocumented migrant workers in Japan. The Japanese government, in particular, must take a leading role in recognising that having the same rights as citizens is not enough. Laws, policies and programmes must address migrant workers as a vulnerable population facing more access to health barriers compared to locals.

Access to Health Services

Access to health care services is problematic for both documented and undocumented migrant workers in Japan. Reviewing Japanese laws and policies on health, one would think that documented migrant workers would have no difficulty in accessing health services, given they have equal rights. In practice, this is no the case. A number of barriers negatively impact migrant workers seeking health care services in Japan: costs, prior exposure to poor quality of treatment, predisposing health beliefs, minimisation of health condition, peer pressure, language and cultural barriers, and lack of trust in the Japanese health system. As a result, migrant workers opt to buy medicines they are familiar with, use herbal remedies or ask their friends and family to send medicines to them in Japan. Thai migrant workers shared they would either return home or endure their illness.

It was found that the most common barrier for migrant workers accessing health services was the cost, especially for undocumented migrant workers. Migrant workers acknowledged that the standard or care and treatment in Japan was superior to their own countries, but explained that the costs were incredibly high.

> If it is not serious, I buy medicine at the pharmacy and take them. If it is the level that there is fever or headache, I buy medicine at the pharmacy. But, in the fact I want to go to a hospital, even though I don't feel very sick. Because a treatment fee is very expensive…It seems a robbery to me. (Undocumented male migrant worker)

The Japanese government does have some options for medical insurance. One option is the National Health Insurance, which self-employed individuals, farmers and unemployed Japanese citizens can subscribe to. Another option is

the Employee's Health Insurance, which is affiliated with the Health Insurance Society. Employees of larger companies tend to subscribe to this insurance plan. There is also the government managed health insurance scheme, which is mainly subscribed to by the employees of small to medium sized companies.

National Health Insurance is applicable to migrants contingent upon their documentation status, with undocumented migrant workers not being eligible for this. According to Japanese Law, companies that have one or more full-time employees must enrol their employees in the Employee's Health Insurance. In this case, nationality and documentation status are not questioned, and undocumented workers may be covered.

Furthermore, according to Japan's Laws regarding TB, sick travellers and the death of a traveller, there are some subsidies for uninsured workers. It is also the case that local governments shoulder part of the medical costs in the event that a patient cannot pay due to unavoidable conditions.

However, even with these insurance scheme and subsidies, migrant workers are unable to benefit because the majority do not know they exist. Employers are often equally unaware and fail to ensure their workers. Some migrant workers are cognisant of insurance schemes due to difficulties during the application process or being unable to pay the premium.

> I had not had knowledge about insurance. I went to public office of T-district and completed all applications and procedures. After that, the bill, of unpaid bill, of 350 thousand Yen came to me. I haven't paid it. (Male migrant worker in Japan)

Some migrant workers who are not insured or do not have full coverage try to negotiate to pay their medical fees back in installments. Hospitals that allow this would normally require a guarantor for the individual. In such cases, migrants have to ask their employers, though in certain cases Japanese friends or documented migrant friends might act as the guarantor. Also, some migrants try to solicit donations from friends and family members. A conversation between two undocumented female migrant workers touches upon these difficulties of paying for medical services in Japan.

> A: I have to pay it in installments. I heard it several times that those who can't afford can pay it in installments.

> B: Also, there are cases that we get our friends to donate money and then we pay a medical fee from the collected money.

Unfortunately, there have been cases where health services deny treatment because migrant workers cannot afford to pay the medical fee. Given these instances, it is vitally important that migrant workers be made aware of existing insurance schemes and subsidies provided by some local governments.

In conclusion, it is vitally important that the Japanese government, in conjunction with other relevant parties, take a proactive stance towards improving migrant workers' rights and access to health information and services. It is essential that the specific characteristics of migrant workers – gender, age, country of origin, work context, documentation status, and health status – are taken into consideration during the development of policies and programmes. It is also imperative that migrant workers be consulted during the design of these initiatives, as they have the deepest understanding of their own vulnerabilities and what needs to be improved.

Malaysia

Malaysia enjoys a booming economy and is recognised as one of the 'tiger' economies in Asia. Yet with a population of only 26.5 million, and with Malaysians generally unwilling to do 3D jobs (work that is regarded to be dirty, dangerous and demanding), the country has been unable to meet its labour demands. Today, Malaysia is a primary destination country for migrant labour from over 12 countries in Asia. Migrant workers are found in sectors where unskilled and semiskilled workers are in demand, namely the domestic, agricultural, manufacturing, or construction sectors. In Malaysia, there are presently more than 1.3 million documented migrant workers and an equal or greater number of undocumented workers.

Despite the presence of such a large number of migrant workers, Malaysia has not ratified any international instruments pertaining to migrant workers' rights, such the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Even where the Malaysian government has ratified the International Convention on the Rights of the Child and the International Convention on the Elimination of All Forms of Discrimination against Women, reservations have been made which limit migrant workers' and their families' basic rights to health, education and shelter. Only the state of Sabah has ratified the ILO Migration for Employment Convention (97), which outlines the right for migrant workers and their families to have adequate medial attention throughout the migratory process.

A review of the health laws, policies and regulations in Malaysia show that health as a public concern is identified, but there is a lack of emphasis on the protection of the health rights of migrant workers specifically. For decades, migrant workers in Malaysia have been blamed for the presence of infectious diseases, particularly when the prevalence of certain diseases, such as HIV/AIDS, increases. This belief is reflected in Malaysian laws and policies, which attempt to protect the local population, while simultaneously controlling the migrant worker population. An example of this is the mandatory medical test for incoming prospective migrant workers.

The medical test is problematic in that it creates a false sense of security amongst Malaysians, who believe infected individuals have not been permitted to enter the country, meaning local Malaysian are not at risk. It also ignores the fact that migrant workers are vulnerable to being infected by the local population. Migrant workers in Malaysia must undergo the test annually to have their work permits renewed, and each year a significant number of migrant workers are deported for failing, which shows that migrant workers are becoming infected while in Malaysia.

ON SITE

Access to Health Information

A number of variables impact upon migrant workers when they come to live in Malaysia: they are by themselves and without their friends and family, which causes loneliness; they are in a new environment, encountering foreign languages and different cultural norms and practices, which can be stressful and overwhelming; and their work and living contexts may be detrimental to their health. These experiences affect them deeply and a new, and sometimes hostile, environment can create fear. Given these circumstances, they may not seek out what little health information is available in Malaysia.

Migrant workers in Malaysia are rendered vulnerable to HIV/AIDS and STIs, as a function of the Single Entry Policy and Prohibition of Marriage Policy. Most migrant workers are in their reproductive prime and desire intimacy, and the fact that Malaysian policies make it more difficult for migrant workers to have a regular sexual partner, contributes to their vulnerability due to the limited health information available to them. In this context, preventive health messages are crucial for the migrant workers, so they are better able to make informed decisions regarding their sexual and reproductive health.

Migrant workers' responses, when probed on the issue of HIV/AIDS, showed that most only had partial or incorrect knowledge of the disease. Nearly every migrant worker interviewed explained they did not receive any pre-test counselling before the mandatory medical test, which includes a test for HIV. Many of them did not know why the test was being conducted. Rather than having HIV/AIDS explained, they were left ill informed. As Bangladeshi migrant

worker stated, "I do not know why my blood was taken. He is the doctor; he knows why it is taken. Doctor didn't tell."

For the most part, migrant workers' health information was obtained through informal channels, such as friends and the media. None of the migrant workers shared that they received health information through formal channels, i.e. government education programmes designed for migrants either by source countries or Malaysia.

> AIDS is related to blood.I know because one of my friends in Bangladesh is HIV positive, because he has been involved in bad behaviour. It depends on our behaviour." (Male Bangladeshi migrant worker)
>
> I know a bit about AIDS. If somebody do wrong things and go to no good places, they will get it. (Male Indian migrant worker)
>
> I don't know about AIDS. I have never heard. Nobody taught me about it. (Female Indonesian domestic worker)

Interestingly, according to those interviewed, health information was not deemed important till they were seriously ill. The initial lack of importance migrant workers placed on health information is most likely linked to the fact that there are other issues that take priority in their lives. Often migrants come to work in Malaysia because they incurred a lot of debt in their home country; therefore, many focus solely on their work to earn as much money as possible to pay their debts and support their families back home. Consequently, health information is not a priority for migrant workers when they are healthy. Regardless, the Malaysian government still needs to develop health education programmes targeting migrant workers, in order that this population remains healthy and informed.

Overall, there is a big gap in terms of the health information migrant workers in Malaysia require and what they are currently able to access. The only current attempt made by the Malaysian government to equip migrant workers with any health information is the compulsory pre-departure Induction Course, which came into effect on 1 March 2004. However, it was understood from various Foreign Diplomatic Missions in Malaysia that different countries are at different stages in actually implementing the Course. Under the requirement, all migrant workers have to be educated on communication skills, Malaysian culture and Malaysian laws and regulations prior to leaving for employment in Malaysia.

A review of the Induction Course content shows there is lack of emphasis on health information, as the following excerpt from a handbook given to Burmese migrant workers coming to work in Malaysia demonstrates:

Do's
- Act as citizen of a civilized nation
- Obey your supervisor and managers
- Be respectful to your supervisors

Don'ts
- Don't do anything that may spoil the name of your country
- Don't go on strike
- Don't quarrel or fight with your own countrymen or with foreigners

While great emphasis is placed on teaching migrant workers to be proper, law abiding 'citizens' and workers, no information is provided to enable them to manage their health, beyond the statement, "Take care of your health."

This lack of health information may even be strategic. According to a representative of a Foreign Diplomatic Mission in Malaysia, health information is intentionally not included on embassy websites, so as to not offend the Malaysian government.

> The general details are put in our website. It is a very extensive website, and it is meant for the workers and employers. I think the other embassies do the same, not putting health tips, etc., because it might embarrass the host country.We think that the workers are clean and well kept.

Fortunately, initiatives have been carried out in Malaysia by NGOs working with the migrant workers to increase migrant workers' awareness of their rights and health issues. For example, Tenaganita established the Peer Educators Programme with different communities of migrant workers, where the migrants themselves are involved in sharing information with their peers. However, due to the limited number of NGOs involved in such activities and the lack of resources available, reaching out to a large number of migrant workers becomes extremely difficult.

Barriers to Accessing Health Information

Migrant workers face a number of obstacles in accessing what limited health information is available to them in Malaysia.

- **Language**

Most of the health information available in Malaysia is either in Bahasa Malaysia or in English, though certain materials are also available in Tamil and Chinese. The health promotion and education programmes on the Malaysian national radio and television, along with various health pamphlets and posters, are carried out in the four main languages in Malaysia. However, there are no health materials available in Bengali, Nepali, Vietnamese, Khmer, or Burmese, the primary languages spoken by many migrant workers in Malaysia. A sizable number of migrant workers learn to speak basic Bahasa Malaysia, after their first year in the country, which is an asset; but less are able to read materials in Bahasa Malaysia, making textual health materials inaccessible.

> I do not know where to go and who to ask, because I do not know the language in this country. I do not know English much as well. Because of that, I cannot ask anybody. I didn't get the opportunity to talk to others, we only have time to go to work and come back. (Foreign worker in Malaysia)

- **Work Environment**

Migrant workers typically work very long hours, and, as a result of this, they do not have time to access health information.

> Where do we have time to watch [TV]? Come back from work, cook, eat, sleep, work again, if can get time we will watch. (Bangladeshi migrant worker in Malaysia)

For domestic workers, who have to work in isolated and confined households, access to health information becomes even more difficult, if not impossible. One Indonesian domestic worker claimed that even if there were available newspapers and magazines, she would not be able to read them due to her demanding working schedule: "No, even if somebody buys, cannot read because we are working."

- **Legal Status**

Migrant workers' legal status determines their freedom of movement within Malaysia and their ability to access health programmes and services. When migrant workers in Malaysia do not have valid documents, they face the risk of arrest, imprisonment and eventual deportation. Undocumented or irregular migrant workers are legally determined to be criminals. Undocumented migrant workers in Malaysia live in great fear of the police and being harassed and attacked by the local community. This causes them to live an underground existence. It prevents them from seeking health information and participating in any programmes and activities organised for migrant workers. At the same time, it also makes it difficult for those who want to help them to reach out to them. According to a representative of the Cambodian Embassy in Kuala Lumpur, undocumented workers often hide in the jungle during daytime due to the fear of being arrested by the police: "Undocumented workers, they try to hide from the police, so they live in the jungle in the daytime. They just hide in the forest nearby in the mountain."

Access to Health Services

There are available health facilities throughout Malaysia, and there are cases of migrant workers who have been able to access them. For example, migrant workers in the manufacturing sector, particularly when working for larger companies, are referred to a panel clinic or hospital, and employers handle insurance claims. This is the ideal situation. Unfortunately, there are many barriers that impede migrant workers' access to affordable and adequate health services in Malaysia.

- **Lack of Information**

Migrant workers receive almost no information regarding where and how to access health services in Malaysia from their employers and the Malaysia government. Pre-departure training sessions contain no information regarding the health infrastructure in Malaysia, and employers generally do not concern themselves with educating their employees on this point. Many migrant workers believe that their employer and the agency will take care of them, but soon learn that if a health crisis erupts, employers and agents are primarily concerned with costs and losses in productivity. As such, migrant workers turn to their peers,

particularly if they are originally from the same country, for help and advice. Because migrant workers often do not know where to go when they are ill and injured, they end up self-medicating. They will take over-the-counter drugs or seek traditional medicines familiar to them. As Kris from India explained, "I do not know where to see the doctor. So I buy medicine." It was found that many Indonesian migrant workers in Malaysia use the medicine 'Jamu', which they bring from home. In addition, some relied on Malaysians who spoke the same language to buy medicine for them, and still others used an alternate strategy of waiting until they came in contact with others from the same origin country: "I do not know where to go. We have to wait for Tamil people. When we come across helpful Tamil people, we will ask them to buy medicine for us." (25-year-old from India who had been in Malaysia for less than six months)

- **Language**

Language is one of the major barriers in accessing treatment and care in Malaysia for migrant workers. Migrant workers are unable to explain their health problems to doctors and doctors are unable to explain treatment processes to migrant workers. This was clearly reflected in the sharing by a representative of the Cambodian Embassy in Kuala Lumpur:

> Communication problem with the language. They cannot explain how they feel, you know. Even my wife, even our staff also, when I took my wife to the hospital when we got some feeling bad, some flu, we cannot say what we are feeling because of communication, language. We don't know how, what is the disease and what kind. How to explain in the proper language. One day I got a phone call from a Western or European man asking for a Cambodian doctor here, who can speak Cambodian. I said I have no idea because there is no Cambodian doctor here or Malaysian doctor who can understand our language. It's very hard you know. I think he has an employee or girlfriend or something have problem with the health, got sick, and he bring to somewhere, but cannot understand what she speak to the doctor. So, he rang me looking for a Cambodian doctor or Malaysian doctor who can understand our language. I said,"I don't know."

Language was also seen as a great barrier by health care professionals in providing treatment to migrant workers: "Yes, of course, first practical problem is language," shared the head of the infectious diseases at __ Hospital, when asked if there exist any difficulties in providing treatment to migrants.

- **Cost of Treatment**

In Malaysia, foreigners are charged higher rates than Malaysian citizens. This policy has been enforced since 1994. The high cost of treatment hampers migrant workers in seeking diagnosis and treatment, and results in migrant workers self-medicating and delaying professional assistance until the situation becomes acute.

For migrant workers seeking treatment in panel clinics, any charges incurred by migrants are borne by the employer. However, migrant workers interviewed explained that companies set a ceiling cost on treatment and regulate the number of times a migrant worker can go to the doctor and have their costs covered. Any additional costs are then borne by the migrant worker. As a Bangladeshi migrant worker in Port Klang, Malaysia explained: "There was a memo three months ago. If I go to the clinic and if it's more than 40 ringitt, I have to pay on my own. Can only go the clinic twice a month." In some situations, it was also understood that migrant workers' salaries were deducted for services and treatment obtained from panel clinics.

> I have a friend who had a slight injury on one of his fingers. When he received his pay slip at the end of the month, 20 ringgit was deducted from his salary. After hearing that 20 ringgit was charged to treat a minor injury (20 ringgit is about 200 Rupees), we thought a lot about it, and we refrain from going to a doctor. (Migrant worker from India)

The high cost of treatment imposed on foreign workers is not justifiable, as they pay very high government taxes in the form of a levy imposed by the Malaysian government. For example, a construction or restaurant worker pays 1800 ringgit a year for the levy, even though he or she might earn only 700 – 800 ringgit per month.

In Malaysia, the Workmen's Compensation Act (1952) allows migrant workers to claim compensation for work related injuries. Under the Act, it is compulsory for migrant workers to be covered by the Foreign Workers Compensation Scheme (FWCS), but this is not comprehensive, protective insurance coverage, as it only provides coverage in the event of a work accident. In addition, a large number of migrant workers remain uninsured in the country. In June 2005, only 600,000 of the 1.3 million foreign workers with work permits in Malaysia were insured by their employer under the Scheme.[1] Those interviewed for this Report

had little or no knowledge of the FWCS. Although the FWCS is not ideal, the Malaysian government still has a responsibility to inform migrant workers of its presence and monitor its application to protect and ensure migrant workers' health rights.

- **Legal Status**

Undocumented migrant workers do not seek services and treatment at Malaysian government hospitals due to the fear of being arrested. This happens because health professionals at these institutions are obliged to inform the relevant government agencies of undocumented migrant workers. This fear of seeking treatment was clearly reflected in words of two undocumented migrants from India:

> We cannot enter hospitals. Permit and passport is needed. But we do not have it; everything is being kept by our agent.
>
> They ask for passport and permit. Friends told us. So we stay away, because we are scared.

In addition, undocumented migrant workers who have accidents at work do not have any insurance, and employers are reticent to take them to the doctor, as employers may face legal action for employing undocumented workers.

- **Medical Testing**

Mandatory medical testing was established specifically for foreign workers based on the Malaysian Immigration Act (1959), section 8(3), and is a prerequisite for the application of an Employment Visa (work permit) in Malaysia. Furthermore, as of 1 August 2005, all migrant workers are required to undergo a mandatory medical examination within a month of their arrival in Malaysia.[2]

Migrants are tested for more than 15 infectious diseases, including HIV/AIDS, TB, leprosy, hepatitis B, psychiatric illness, epilepsy, cancer, STIs, malaria, and pregnancy (if female). If migrant workers test positive for one or more of the diseases, they are deported home and their work permits are not renewed. Immediate deportation denies migrant workers their freedom of mobility and their access to adequate and appropriate health care. When this issue was posed to a doctor specialising in the field of Infectious Diseases, she admitted

that treatment and counselling for these migrants, particularly in the case of HIV/AIDS, is difficult due to the deportation policy.

According to the doctor, initiating treatment for HIV positive migrants in Malaysia is difficult unless follow-up treatment upon deportation is guaranteed and there is someone to take care of them, which is usually not the case. It was also understood from an interview with a representative of a Foreign Diplomat Mission that his Office is never informed once a national of his country is deported for any infectious diseases: "Deportation for diseases, they inform the employer. Source country agents are to take back. The High Commission does not know. They do not have to go through the High Commission." It is therefore nearly impossible to monitor and ensure that correct follow-up treatment, support and care are in place for migrant workers in the source country once they are deported from Malaysia.

CONCLUSION

At present, migrant workers make up nearly 10 per cent of the population within Malaysia. Interventions to promote and protect the health of the entire population must target both foreigners and locals simultaneously. It is equally important that the Malaysian government, NGOs, employers, migrant workers, and other relevant stakeholders are informed of migrant workers rights and that decisive action be taken to protect and ensure them.

References

1 600,000 foreign workers insured, New Straits Times, 21st June 2005

2 Medical Check Within a Month, New Straits Times, 2nd February 2005

Thailand

Thailand is a destination country for migrant workers, with most arriving from Thailand's neighbouring countries of Burma, Cambodia and Lao People's Democratic Republic. While Thai individuals also travel abroad to work, this research principally focuses on migrants working in Thailand, and specifically the experiences of Burmese migrant workers.

Of the destination countries in Asia, Thailand could be considered one of the forerunners in beginning to recognise the importance of migrant workers' rights, their access to health and the issue of health insurance for them; but there is still much that needs to be done. Having signed the International Covenant on Economic, Social and Cultural Rights (1966), Thailand is obligated to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," and to a degree this 'health for all' rhetoric permeates Thai National Law and Policy; but Thailand has not ratified the key international instruments concerning international migration (e.g. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families [2003]) and, not surprisingly, Thailand's national policy development is not comprehensive on this issue, resulting in migration policies and programmes being marked by omissions and ambiguities.

One of the key issues for the Thai government is irregular or undocumented migration, which has become one of the major social, economic and political issues in Thailand.[1] In 2004, the Thai government undertook a major effort to regularise unauthorised migration. The Ministry of the Interior registered 1,280,000 workers from neighbouring countries. Over 817,000 migrant workers subsequently paid to enrol in the health insurance scheme and 814,000 applied for work permits from the Ministry of Labour.[2] Problematically, though, the process of obtaining a one-year work permit, which includes health insurance via the National Universal Health Care Scheme, is drawn out and expensive: it costs a significant amount at 3,800 baht (a month's wages for many), and to complete the entire process usually requires a minimum of five visits by the employer and/or employee to government offices and the hospital or health clinic.

This process also involves a mandatory medical test, which includes a test for TB, syphilis, elephantitus, leprosy, drug addiction, alcoholism, and mental disorders – with migrant workers being deported if they have one of these conditions. In Thailand, migrant workers are not tested for HIV, although migrant workers leaving Burma for Thailand are tested. Many migrant workers forego obtaining a valid work permit because the process is costly and time consuming, which is unfortunate given that the Alien Labour Policy maintains that undocumented migrant workers are subject to deportation.

On the positive side, if migrant workers are able to obtain a work permit, they are registered in the National Universal Health Care Scheme and are afforded the same rights as locals. They are issued a health insurance card and pay only a 30 baht service fee every time they go to certain medical establishments, regardless of the type of treatment they require ('30 baht scheme').

The Thai government has been more cognisant than other Asian nations on the issue of illegal labour migration, as Thailand signed a MoU in 2002 with the government of the Lao People's Democratic Republic on cooperation in the employment of workers. It signed a similar MoU with the government of Cambodia in May 2003 and one with the government of Burma in June 2003. The MoUs express concern about the negative social and economic impacts caused by illegal employment and outline that countries need to collaborate to ensure that each worker meets the requirements for a visa, a work permit, health insurance, contributions to a savings fund, taxes, and an employment contract.

With regard to programmes and projects, various non-governmental groups and organisations have been established in the region to work on the issue of migrant workers' access to health. Unfortunately, the Thai government has not taken up this issue to the same extent; though the Thai Ministry of Public Health's new 5-year plan includes a component on 'migrant workers' in its health prevention, promotion, education, and care plan.

Overall, there is a great deal to be done in Thailand with regards to ensuring and promoting migrant workers' health rights and access to health information and services. A number of laws and policies are in place (or not in place) that limit migrant workers' rights and have the potential to negatively impact their health. According to the Thai Constitution (1997), all people in Thailand are protected,

but it is still debated as to whether the Constitution applies to everyone residing in Thailand or just Thai citizens. Another point is that migrant workers are not legally allowed to move outside the province they are registered to work in, unless they have permission from the Governor of that province. This can render them undocumented and vulnerable, if they relocate without permission. Also, the government does not have the authority to regularly monitor conditions and wages at workplaces. For example, according to the Kanchanaburi Labour Office, a workplace can only be inspected if a formal complaint has been filed by another company or employee.

ON SITE

It should be noted at the outset that the information collected for this report was gathered primarily among registered migrant workers from Burma residing legally in Mae Sot, Chiang Mai and Bangkok. The material presented principally addresses migrant workers' access to health services in Thailand and the quality of services they received, not their pre-departure and reintegration health experiences.

Living and Working Conditions

Many migrant workers in Thailand are employed in factories where workers are expected to sleep in rudimentary structures located on or near the factory grounds. Many migrant workers are assigned to one room, resulting in overcrowded, unsanitary conditions and minimal privacy. In the event that a migrant worker is sick, one factory worker in Bangkok explained that they are simply not allowed to sleep in the accommodation area, and no separate sleeping arrangement is made available. In addition, migrant workers also spoke about not having access to clean drinking water.

When migrant workers are ill, employers rarely allow sick leave: "Where I work, the employer doesn't give permission to take a leave if someone is sick, but forces you to continue working even though you want to see the doctor." Employers demand that they continue to work and migrant workers oblige because they fear being dismissed. One Burmese migrant worker told a story about a man who needed to go to a follow-up appointment at the TB ward to have a check-up and get more medicines for his infection. This man's employer

did not allow him to go because there were too many orders to fill and said that this was more important than his health. The man went anyways, and when he came back to the factory the employer had given his machine to someone else, and he was demoted to the night shift.

As a consequence of migrant workers' long, irregular hours of work and lack of days off, they are unable to independently seek out health care services. As a Burmese male construction worker from Chiang Mai explained: "It is not possible to go to the hospital during lunch breaks or early in the morning, because of the long waiting hours at the hospital. Going to the hospital takes an entire day." Another male construction added, "We finish work at five, but then the doctor has left the hospital."

Migrant workers are also limited by the fact that their employers offer little choice in the health services they can receive. A female migrant worker explained that if someone gets sick at her factory, the employer does not take them to the hospital, but instead to a private clinic near the factory. Unfortunately treatment at this clinic is expensive (approximately 360 baht) and the migrant workers are expected to pay for it. Sometimes factories have their own health centre, but the staff is perceived to be unskilled by the migrant workers. They do not trust these clinics, but are offered no other choice in health services. In other cases, a health care worker will visit the factory, but they are also understood to deliver unsatisfactory services at a high price. As Burmese male factory worker from Mae Sot explained:

> I work in a small factory, like a 'home factory', and there I only earn 40 baht per day. I don't have enough money to travel to the health care clinic. Instead there is a medic who regularly visits the factory and gives treatment to those who are sick. I have no idea what for treatment we get, and I think that maybe we don't get any real medicine at all. But we have no other choice. The treatment costs 200 baht and we can pay for this later.

Access to Information

Migrant workers in Thailand in need of health services are placed in a helpless situation, as a consequence of not being adequately educated about their rights, how to apply for the Thai Universal Health Care Scheme and how to access the Thai health system. An NGO worker explained that many migrants do not know how to register for a work permit and how to get health insurance,

because this process is quite complicated. Another NGO worker explained that even though some migrants do have health insurance, and are entitled to access the '30 baht' scheme, they do not know how to access this programme and, unfortunately, continue to pay the full price at both public and private institutions. In addition, many employers are reluctant to have their foreign employees in contact with certain NGOs that educate migrant workers on their rights, as employers maintain power and control over their workers by keeping them in the dark about their rights.

Access to Health Services

- **Cost**

Migrant workers, particularly those without health insurance, are reluctant to seek treatment and care because of the cost. According to a Burmese male factory worker in Bangkok, many migrant workers, intent on making as much money as possible, choose to suffer instead of going to the hospital. In addition, transportation costs to the hospital can be sizable, and if multiple trips are required, the cost can simply be too much. A male factory worker mentioned that "many people can't go to the hospital or clinic because it is too expensive with transportation."

- **Documentation**

In Thailand, migrant workers are also hesitant to seek medical assistance because they are afraid of encountering the police on the way to the clinic or hospital. Even for migrant workers with the correct work permit and health insurance card, they are often only permitted to carry a photocopy of the official documents, because their employers hold the originals. In the situation that a police officer stops a migrant worker with a photocopy, the police may call the employer to ascertain if the individual works there, but if the employer cannot be reached or fails to confirm that the individual works there, a bribe (100–150 baht) is usually expected to be paid. If the migrant worker cannot pay the bribe, they then face arrest. A Burmese factory worker in Bangkok explained that if a migrant worker is arrested, sometimes the employer pays to get them out of jail, but this amount is later cut from the migrant worker's salary.

The migrant workers interviewed explained that having access to their health

insurance card is difficult, but extremely important if they are to have the freedom to independently access Thai health services. It was explained that in Mae Sot employers generally hold the health insurance card, but this is different compared to Chiang Mai, where migrant workers are more often allowed to maintain position of their health insurance card. In Mae Sot, migrant workers explained that because they are unable to have control of their health insurance card, and given that it is a hassle to have employers give them their card to go to government health institutions, they go to private clinics and paid considerably more.

- **Self-medicating and Alternate Medicine**

As a result of the barriers in accessing health services, many migrant workers in Thailand, particularly those who are undocumented, go to the pharmacy as their first choice in seeking treatment. This is problematic in that a person's condition can deteriorate rapidly without the proper care and treatment, and self-medication may actually be detrimental to one's health, if the wrong medicine is being taken or certain medicines are combined.

Migrant workers are also trying other forms of medicine. Burmese migrant workers report using Chinese medicine, and others report going to what they refer to as "fake doctors." Fake doctors are a distressing phenomenon, as they are providing medical services without the proper training and credentials. In Mae Sot, there are many fake doctors providing treatment to Burmese migrant workers. Burmese migrant workers are going to these individuals, because they do not require health insurance cards and charge less. Fake doctors also exploit the fact that Burmese migrant workers prefer injections as treatment compared to pills, as they believe injections are a more beneficial and aggressive form of treatment. Fake doctors provide these injections at a low cost, but little is known about what they are injecting and if they are using sterilised equipment.

- **Quality of Health Services**

For those migrant workers who do manage to gain access to health services in Thailand, there are still problematic issues with regards to the quality of treatment and care they receive. Migrant workers from Burma frequently described their overall experience at health facilities in Thailand as being less than satisfactory, and even cited this as a reason for not seeking help from such institutions. They

described the treatment at public facilities as being particularly poor, when compared to private clinics and hospitals, explaining that the staff at the private clinics were friendly and took the effort to explain what was going on to them. They also stated that the private clinics are more convenient because they are nearby and official documents are not required. However, private treatment is more expensive, and many migrant workers cannot afford this.

> I don't like to go to the hospital even though I'm covered by the 30 baht scheme. In the hospital they treat you carelessly and discriminate against us because we are migrant workers. The hospital is also far away from where I work, and therefore I prefer to go to a private clinic nearby.This is more expensive, but it is also more convenient, and they care more and give better treatment.The private clinic is about three times the price of the hospital.

In talking about their treatment at pubic health institutions, Burmese migrant workers felt they received poor treatment. They also felt there were often not enough translators and, when they were available, their translation abilities were inadequate. Further, they felt discriminated against because they were foreign and frustrated by the excessively long waiting hours. Language difficulties proved to be a principle complaint from Burmese migrant workers, as they were upset at being unable to articulate their condition. Beyond personal frustrations, this is a dangerous obstacle to proper treatment due to the increased likelihood of misunderstanding and misdiagnosis. As an NGO worker in Bangkok explained:

> Language is a major problem in any hospital, because the migrant workers can't explain what their problems are.There are no translators, and many Thai doctors can't speak English. This causes there to be many misunderstandings between migrant patients and the doctors.

In conclusion, though Thailand has taken steps to bring forth the health of migrant workers as an important national issue, there is still an enormous amount of work to be done. Continued progressive law, policy and programme development is needed, and government support and expansion of existing independent programmes and projects is required. Monitoring and evaluation of all of these processes is equally important. The Thai government should also make efforts towards simplifying the process for migrant workers to obtain a work permit and health insurance and ensure that training and resources are in place for health staff to address the specific needs of migrant workers.

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CHAPTER FOUR

REGIONAL ANALYSIS

Community clinic
for migrant workers
in Bangladesh.

CHAPTER FOUR:

REGIONAL ANALYSIS

"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

(ICESCR, Article 12)

Individuals from many Asian countries travel to other countries in Asia and the Middle East in the effort to find employment opportunities to improve their economic situation and that of their dependents. They aim to elevate the overall quality of their lives. Unfortunately, the legislative and policy environment in the countries where migrant workers relocate does not provide the necessary mechanisms to ensure that migrant workers are adequately protected – that their human rights, and health rights in particular, are recognised and ensured.

The regional analysis will consider the law and policy environment pertaining to migrant workers and their health rights in seven destination countries: Japan, the Republic of Korea, Malaysia, Thailand, Jordan, Bahrain, and Saudi Arabia, in addition to the Hong Kong, SAR of China Special Administrative Region; and nine origin countries: Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, the Philippines, Sri Lanka, and Vietnam. A selection of countries from the Middle East has been included in this section, as increasingly Asian nationals are travelling to these parts for work, but a deeper analysis of the experiences of migrant workers who have worked in this region is beyond the scope of this report. In addition, it should be noted that the categories of 'origin' and 'destination' country have been used to reflect the position from which the research for this Report has been undertaken, along with reflecting the main direction of labour migration in a particular country. Such designations are not meant to suggest that the flow of labour migration occurs in one direction, because this is decidedly not the case.

Of the countries reviewed in this section, including the Hong Kong, SAR of China Special Administrative Region, Bangladesh, Cambodia, the Hong Kong, SAR of China Special Administrative Region, India, Indonesia, Japan, Jordan, Nepal, Philippines, the Republic of Korea, Sri Lanka, Thailand, and Vietnam have ratified the International Covenant on Economic, Social and Cultural Rights (1966). States party to this Covenant "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12 [1]). International mechanisms of this type reframe basic health needs as health rights. Thus becoming healthy and remaining so is regarded not merely as a medical, technical or economic issue, but as a matter of social justice and concrete government obligations. By ratifying the ICESCR, countries are legally bound to recognise and protect the right to health in their national laws and policies and adopt a national public health strategy for the realisation of the right to health for everyone.

To varying degrees, countries have made efforts to meet their obligations, with certain countries including basic provisions in their laws and policies to address the health of migrant workers. Legislation in Nepal, for example, outlines that "if the proposed foreign employment is against the value, dignity or health of the worker" the government will not issue its permission for the employment position; and Cambodian law recognises the need for provisions in migrant workers' contracts for medical care. While some countries have taken proactive steps, there is still much to be done on the side of implementation and monitoring, and destination country governments, principally interested in protecting the health and welfare of their citizens have a long way to go.

Even for those States reviewed that have not ratified the ICESCR (i.e. Bahrain, Malaysia, Pakistan, and Saudi Arabia), they are still bound to protect and ensure the health of the entire population, regardless of sex, race, colour, language, religion or conviction, political or other opinion, national, ethnic or social origin, nationality, age, economic position, property, marital status, birth, or other status. Meaning a distinction must not be made between the health and welfare of citizens and non-citizens. In addition, migrant workers, regardless of their documentation status and what stage of the migratory process they are in, are entitled to enjoy equal access to adequate and affordable health care. The Universal Declaration of Human Rights (1948) clearly articulates the 'right to health' for all (Article 25 [1]) and describes the particular attention that needs to be afforded women and children (Article 25 [2]):

> 1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
>
> 2) Motherhood and childhood are entitled to special care and assistance.All children, whether born in or out of wedlock, shall enjoy the same social protection.

Though declarations have no legal binding effect, the UDHR is an exception because of its universal acceptance. It is therefore a valid standard and is widely regarded as carrying the status and authority of international customary law.

In reviewing the national laws and policies in the countries represented in this Report through the lens of international human rights mechanisms, it becomes apparent that national laws and policies generally do not recognise and guarantee migrant workers' access to health information and adequate and affordable health services. Overall, national laws and policies in Asia are either not in place, do not go far enough or actually impede migrant workers' access to health information and services. There is minimal acknowledgement on the part of States and key stakeholders of the tenuous and unique realities faced by migrant workers, and the necessary proactive steps needed to overcome specific obstacles to health are not taken. As a consequence of these failures, migrant workers' health and well-being suffers greatly, as exhibited in their narratives of labour migration, many of which appear in this chapter.

ORIGIN COUNTRIES

This section is a regional overview assessing the degree to which Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, the Philippines, Sri Lanka, and Vietnam protect, promote and ensure migrant workers' right and access to health. This section will also consider whether origin countries' health initiatives for migrant workers are effectively implemented, drawing on migrant workers' experiences to determine this.

All the origin countries reviewed, except Pakistan, have ratified the International Covenant on Economic, Social and Cultural Rights (1966). These origin nations

are legally obligated to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12 [1]). In signing this Covenant, these countries are bound to ensure that the right to health for all is reflected in national laws and policies and adopt a national public health strategy and plan of action for the realisation of this right. Countries having signed the ICESCR are also legally responsible for preventing third parties from interfering with or violating the fundamental health rights of all, including migrant workers. Even Pakistan is obligated to ensure that everyone has the right to a standard of living adequate for health and well-being, in accordance with the Universal Declaration of Human Rights (1948). Countries must ensure the basic determinants of health are met for all: an adequate supply of nutritious food, clean drinking water, basic sanitation, and sufficient housing and living conditions.

Of the origin countries reviewed, the Philippines is the most active in protecting and promoting the rights of migrant workers and their families, with the most overt display of this being the Migrant Workers and Overseas Filipinos Act (1995). Other origin countries have also included basic provisions in their legislation on migration. Nepalese Foreign Employment Law states that "if the proposed foreign employment is against the value, dignity or health of the workers" the government will not issue permission for that employment. Cambodian law acknowledges the need for the provisions on health care in labour contracts with foreign employers, while Indonesia legally recognises the need for health care facilities for ill and injured returnee migrant workers. Such legal recognition of migrant workers' vulnerabilities are positive, but, as the following paragraphs illustrate, further work needs to be done at the regional and national level, and the gap between law and policy and effective implementation needs to be closed.

PRE-DEPARTURE ACCESS TO HEALTH INFORMATION

The origin countries that have ratified the ICESCR are obligated to disseminate accurate and appropriate health information, including sexual and reproductive information, and institute preventative health campaigns based on this material. At the same, these governments are responsible for ensuring third parties do not limit access to this material. While origin country governments reviewed have developed general public health policies and initiatives, limited work has

gone into disseminating targeted health information to migrant workers before they go abroad and upon their return, and to monitor and evaluate the efficacy of the few policies and programmes in place.

Pre-departure Training

The majority of the origin countries reviewed are obligated by national laws to provide some form of pre-departure training for migrant workers, but the extent to which this is carried out is questionable. Moreover, there are concerns over the quality of the pre-departure programmes and the components devoted to health.

In Bangladesh, the Emigration Rules (2002), in Section 4 (clause r), outline that there must be "briefing to the outgoing overseas employees before issuance of emigration clearance"; and the Recruiting Agent's Conduct License Rules (2002) include provisions stating that recruiting agents in Bangladesh must ensure the attendance of selected potential workers for briefings before their departure and that recruiting agencies shall publish educative videos, pamphlets and cassettes. In reality, pre-departure orientations are limited in Bangladesh. The Bureau of Manpower, Employment and Training (BMET) is the only government agency which conducts any briefings, and these are done from a single centre in the country. The Bangladesh Association of International Recruiting Agencies (BAIRA) has taken steps to organise pre-departure training sessions, particularly for potential female domestic workers, but few recruitment agencies have actually done this and, when they do, they tend to focus on the 'dos and don'ts' in the destination country. As an NGO worker who conducts pre-departure training sessions at recruitment agencies shared:

> All the migrant workers do not get opportunity to attend this training. There are about 800 recruiting agencies and many other sub-agencies… Whereas we provide the training in 10 to 12 recruiting and technical training centres.

In Nepal, since 2004, the government has made pre-departure sessions for potential migrant workers mandatory, where an orientation certificate must be given to the Labour Department to obtain permission for employment abroad. Yet problems exist in Nepal in that not all potential migrant workers attend, trade for orientation certificates has sprung up, the only place to receive official training is in Kathmandu, and the preventative health information provided

is weak. Some recruitment agencies in Kathmandu provide training, but the sessions are short and they are geared towards making sure migrant workers from Nepal behave appropriately, as this quote from a Nepalese migrant worker highlights: "Nepal authoritybriefed us: 'dos and don'ts' in destination country. Around 15 minutes." In Pakistan, law dictates that potential migrant workers must go through a pre-departure briefing, though there is no health component requirement. Any health information delivered is usually not comprehensive and adequate.

> Our briefing officer informs them in a nutshell about the preventive measures for HIV, but no specific information is being provided on the health risks and vulnerabilities of migrant workers. They are only told to behave as true Muslims in the destination country. (Pakistani Protectorates of Emigration Official)

In Pakistan, also, pre-departure briefings frequently do not take place.

> It is not necessary that all prospective migrant workers essentially attend the training. It depends on the briefing officer, if he has the time…If two or three people come at a time, they get their registration without the briefing.

This fact was echoed by a number of Pakistani migrant workers: "No one provided us with this kind of [health] information. You are the first and only person who talks to us about health problems"; "We did not know any preventive information, nobody told us"; "We have not heard anything about it"; "There was no programme or meeting held for this purpose"; "We don't know from where to get [health] information"; "We are going on the basis of having faith…no one told us anything about health problems during this process; we just know whatever we know already."

The government of India has not legally mandated that a pre-departure programme for migrant workers be in place. The only move in India towards this stems from pressure from the Malaysian government. Consequently, in 2005, the Indian Ministry of Overseas Indian Affairs launched an Induction Course for those going to Malaysia. No health information is shared during this Induction Course. In both Vietnam and Cambodia, potential migrant workers are required to partake in pre-departure training, but no health information is provided. Fortunately, in both of these countries, NGOs, such as CARAM Cambodia and Mobility Research and Support Centre (CARAM Vietnam), have worked with

these governments to assist in delivering information on HIV/AIDS and STIs.

In a positive move, the governments of Indonesia, Sri Lanka and the Philippines have included a health component in their pre-departure training programmes for potential migrant workers, but the training is far from ideal. In Sri Lanka, pre-departure training is only available for potential female domestic workers; in the Philippines, the only material typically covered in the health component is HIV/AIDS; and in Indonesia, the accuracy and depth of the health information disseminated is questionable. This is reflected in the words of an Indonesian migrant worker:

> Usually, we have session where we told to take care of our tidiness.We also have to take care our food. Only eat good food and have a good sleep.Therefore, we won't get any headache. Information was given by head of the centre. Do not buy unhealthy food.

From reviewing the laws and policies devoted to pre-departure training for migrant workers in the origin countries studied, it is obvious that migrant workers have minimal opportunity to acquire important preventative health information before going abroad. Laws and policies on pre-departure training either do not exist or are not fully developed, meaning there is minimal detail accounting for the delivery of accurate and appropriate health information. Furthermore, limited concern has been directed towards monitoring whether current laws and policies are implemented effectively. Origin country governments are either unaware, are not greatly concerned or do not have the resources to resolve implementation issues. Regrettably, a lack of monitoring, combined with an unwillingness to redress the situation, results in potential migrant workers not receiving health information or receiving incorrect health information. In Indonesia, for example, it was discovered that erroneous information on modes of HIV transmission is being delivered; and, in Nepal, minimal government action is being taken against the practice of recruiting agencies purchasing pre-departure orientation certificates from officially recognised training centres, because effective monitoring mechanisms fail to exist.

Barriers to Accessing Health Information

Limitations of the pre-departure programmes have been discussed above, but issues of cost, time and distance also impact migrant workers' attendance at pre-departure trainings, however flawed they may be. Pre-departure training costs

are typically borne by potential migrant workers, either directly or indirectly, even in cases where such programmes are supposed to be government funded. In Indonesia, for example, even though the pre-departure orientation seminar should be financially supported by the Director General of Placement and Training of Migrant Workers (DGPTMW), as a government sponsored initiative, no fund has been allocated for this activity. Instead, each migrant worker must pay 50,000 rupia to attend the session. This amount is initially taken care of by the recruitment agency, but it is later deducted from what is owed to the recruitment agency and cut from their salaries. This was explained by the head of a training centre in Indonesia: "We never charge fees. Initially, they are not charged. Well, they have the salary cut."

Not surprisingly, if migrant workers can avoid attending a relatively expensive training session, this presents an attractive option. Moreover, because pre-departure sessions are often held in the capital or other major cities, those living in rural areas have to make their way to the city to undertake this training. This can be a time consuming, expensive journey. So, again, if this can be avoided, this choice is appealing. Given this context, the illegal market in pre-departure orientation certificates is booming in many origin countries in Asia. One distressing result of this being they miss a potentially important source of acquiring health related information.

Societal and cultural norms also pose another barrier to migrant workers receiving important health information. Even if trainers want to include preventative messages on HIV/AIDS and STIs, they can face restrictions and demands for the material to be left out. In Bangladesh, as an NGO worker explained, there is pressure from the government and certain recruitment agencies to not include sexual and reproductive health information, though creative ways are found to include this material:

> There are some restrictions to discuss about sexual health and HIV/AIDS. Therefore we have not been able so far to take any separate session on this issue. Instead, we have given verbal instructions [to the teachers] to discuss on these subjects and reproductive health during the personal hygiene session.

In Surubaya, Indonesia, a recruitment agency was forced to cancel a session on HIV/AIDS prevention for potential female domestic workers following ardent protests from parents and families who accused the agency of encouraging casual sex. At the same time, there are health care professionals who are reluctant to introduce migrant workers to preventative health information,

fearing it will promote and condone 'immoral' behaviour, as one physician in Pakistan explained:

> We don't inform migrant workers about the use of condoms, because this will open the box of Pandora. People will start using condoms instead of staying away from sex workers...We only want people to be scared [of sex].

The culture of silence surrounding sexual and reproductive health in Asia has disastrous consequences, especially for migrant workers who are among the most vulnerable. Many remain ignorant of modes of disease transmission and preventative health measures, and those in the position to educate are afraid to speak out or are stopped from doing so. Certain ideas about sexual and reproductive health have become so entrenched they influence how this material is received. In a focus group discussion in Pakistan with male migrant workers, no one had heard about sexual and reproductive health and STIs. In sharing material on these topics with them, the men became defensive, and one man declared,"We are not females, why should we try to know about it. This issue is particularly related to women, we don't have any concern for that."

Ideas such as this pose a real barrier to prevention. Males possibly deny they are at risk or pose a risk to others. At the same time, many Asian cultures support the notion that 'good' women should be ignorant about sexual matters, with governments, educators and parents propagating this belief, worried that exposure to preventative information will lead to female promiscuity. Such attitudes and beliefs strengthen the need for increased awareness amongst the general public, as well as vulnerable groups, but also highlight the need for material to be delivered in a manner sensitive to culture and gender.

Another barrier to accessing health information is the manner in which it is delivered at both public and private centres. Potential migrant workers may not receive the pre-departure lecture, but instead be provided with an educative pamphlet. This is helpful for those who are literate, but for those who are not, this format is useless. An additional access barrier is the lecture style in which pre-departure sessions are often delivered. A few potential migrant workers have openly described the lectures as "boring," which may reduce their uptake and retention of the information. Speaking to this point, a doctor on the Philippine National AIDS Council utilised the following analogy:

> My analogy for the PDOS [Pre-departure Orientation Seminar] is that it's like riding a plane. We know that when we board the plane, there is the danger that it might crash…the PDOS is like the safety demonstration given by the flight attendants, wearing the life vest, blowing into the cylinder…That's the PDOS for us. Very few people actually listen to what the flight attendant is saying.When we look at it, there is an illusion of safety in the PDOS, because if the plane crashed you still die even if you have a life vest.

It would be useful for programme developers to strategise on making the material as real as possible and to use methods that involve increased audience interaction, whether role playing, games or brain storming exercises, as these methods have shown to improve knowledge retention.

Alternate Modes of Acquiring Health Information

Given the present limitations in acquiring health information prior to departure, potential migrant workers rely on alternate channels. Most know relatives or friends who have worked abroad, and these individuals become a source of knowledge about foreign working and living conditions, health services abroad and common health conditions encountered. Health information is also absorbed through national public health campaigns via radio, TV, newspapers, pamphlets, and posters.

In addition, NGOs and CBOs have established targeted health programmes for migrant workers to fill the gaps in government initiated pre-departure programmes. In Indonesia, more than four NGOs provide health information through discussion groups, textual materials, lectures, and voluntary medical counselling and testing. In Bangladesh, NGOs have developed comprehensive skills building programmes targeted at potential female migrant workers, where programmes range in length from 15 to 21 days and include language training, information on the migratory process and detailed health information. The head of a NGO in Bangladesh explained they "have a separate session on health. We discussed personal hygiene, reproductive health, unexpected pregnancy, HIV/AIDS and STD, and even mental health." But there are limits to NGO and CBO efforts given human and financial resource constraints and, in certain cases, friction with the government.

PRE-DEPARTURE ACCESS TO HEALTH CARE SERVICES

Mandatory Health Testing

Before going abroad, one of the primary instances in which potential migrant workers come in contact with health care facilities is through the mandatory health test. Even though most origin countries reviewed state that mandatory health testing is prohibited, with mandatory HIV testing being banned in all countries mentioned, potential migrant workers are still expected to undergo a general medical test and, in most cases, an HIV test. This takes place as per the requirement of the destination country. Medical exams typically test for HIV, STIs, TB, malaria, leprosy, syphilis, hepatitis, cancer, epilepsy, psychiatric illness, illegal drug use, and (if female) pregnancy.

In line with international health testing procedures, all medical tests are to be conducted by professionally trained health care personnel and be carried out in an appropriate manner. Yet migrant workers have shared they have been forced to undergo group medical exams where they have to remove their clothes in front of one another and have experienced inappropriate treatment from health professionals.

> The younger women, it's okay because they have nice bodies. They're flawless. So, we once complained to the doctor: "Why did you group us with these kids when we're already 40?" They get angry:"Then don't work abroad!" Or they tell your agency about you. Then the agency will also tell you not to fuss. Sometimes, we have to beg for some consideration. That's really how it is…You keep begging the agency. (Female migrant worker from the Philippines)

In accordance with international standards, pre- and post-test counselling are to be provided to all being tested. Following obligations based on the ICESCR (which all origin countries, except Pakistan, have ratified), governments of origin countries must have policies and legislation to protect migrant workers against discrimination in receiving health information, treatment and care. In addition, origin governments are obligated to institute policy guidelines on the training and monitoring of health care staff to respect migrant workers' rights and account for their vulnerabilities. Regrettably, origin governments reviewed have not reached the training and monitoring stage. There is no specific policy in place to control and act against discrimination and inappropriate treatment

towards migrant workers, as a special group in need of particular attention and protection.

Testimony from migrant workers revealed that they are not adequately counselled before and after their medical tests, meaning they are provided with no information on the numerous tests performed on them.

> No one give us counselling or any other information. They took our blood, urine and other tests, but we have doubt whether they have tested our blood or not, because they don't test in front of us. We come to know about three or four days after, they have not given us any information before testing. (Male migrant worker from Pakistan)

In Pakistan, when a doctor was questioned on HIV pre- and post-test counselling for migrant workers, it was suggested that information on HIV/AIDS is common knowledge. He also hypothesised that if a migrant worker had a question he or she would simply ask. Yet it is evident from what has been shared that migrant workers' knowledge of HIV/AIDS is limited or incorrect, which has the added impact of making it difficult to formulate questions to ask.

If a potential Pakistani migrant worker does not pass the medical test, they are typically told by the testing centre they are 'unfit' for employment abroad and the infection or condition they have. No details are provided. It is suggested to them that they contact their doctor or, in HIV cases, they are referred to the AIDS Control Centre for further information and treatment. There is no formal referral process set up between medical testing centres and the AIDS Control Centre, thus there is no official mechanism to follow-up with those who do not pass.

Similar circumstances were uncovered in Indonesia. Indonesian informants shared that no pre- and post-test counselling was provided. They were unaware of being tested for HIV: "The truth is we were never told that we were being HIV tested. Blood test just to know that our blood is dirty or not." If a potential migrant worker is determined to be HIV-positive after a retest, they are, if fortunate, referred to Pokdisus-RSCM, a non-profit working group on AIDS. Here they are provided with education and are assisted in accessing health care and treatment services. In Indonesia, as in most origin countries, medical results go directly to recruitment agencies that are then responsible for delivering the results. Problematically, migrant workers tend to only be told if they passed or

failed. Indonesian agency staff interviewed put forth that it was the responsibility of migrant workers to ask why they failed. Thus there is a real possibility that those who fail do not learn of their condition and receive appropriate treatment. Moreover, the practice of sending the test results directly to recruitment agencies is a breach of international standards with regards to privacy and confidentiality in the handling of patient information.

In Nepal, pre-test counselling was not observed; however, post-test counselling occurred if potential migrant workers did not pass. In the majority of Nepali cases, results are again given directly to the recruitment agency. This procedure conflicts with Nepal's National Policy on AIDS and STD Control (1995), which outlines that results of tests carried out in the course of AIDS and STD control programmes must be kept private and confidential. If potential migrant workers are found to be unfit, they are called back to the testing centre, provided with detailed health information and are referred to the appropriate hospital. Yet follow-up with these individuals does not occur. If the condition is easily treatable, medicine is given and, if cured, they are eligible for foreign employment in a few weeks.

Health Insurance

Ideally, comprehensive, affordable health insurance should be readily available for all migrant workers regardless of their documentation status; it should cover them during every stage of migration and both on and off the worksite; and the process of acquiring health insurance, filing a claim and receiving coverage should be straightforward, with migrant workers being educated on how to do this. If health insurance happened like this for all migrant workers, their access to health care would be greatly improved. This is not the current reality.

With the exception of Cambodia, all origin countries in the Report have some form of insurance for migrant workers. However, insurance generally only covers incidents at work requiring medical care, disability and death. Meanwhile, so little is known about insurance processes by all parties – recruitment agents, employers and migrant workers – that filing a claim and receiving compensation rarely occurs.

In Indonesia, according to Ministerial Decree No. 157/2003, migrant workers abroad have to be insured by their employers. It is outlined that insurance

should cover accidents in and out of the workplace; the cost of treatment and medicines; death caused by accidents or illnesses, including funeral costs and returning the body to Indonesia; unpaid salary; and some coverage upon the termination of the contract by one's employer. The Decree determines that the insurance premium is to be paid by the employer, but migrant workers usually end up paying the premium before they go abroad.

For Indonesian migrant workers to make an insurance claim they must first get an explanation letter from the Indonesian Embassy or Consulate, then they have to get a recommendation letter from Indonesia's Directorate General of Placement and Training of Migrant Workers (DGPTMW). After acquiring these documents, they can submit a claim to the insurance company. If the insurance company agrees to pay the claim, the insurance company has to get another recommendation letter from DGPTMW. If this happens, payment can then be given to the migrant worker. For Indonesian migrant workers, claiming insurance abroad is a tedious and time consuming process, especially if they are not educated on these processes, if their health is compromised and if they have limited freedom and resources to undertake tracking down the correct documents. In most instances, employers actually handle migrant workers' insurance claims. Some Indonesian migrant workers, who were made to pay for their own health care abroad, shared that they suspected their employers of taking their insurance claim money. Migrant workers from other countries also suspected their employers of doing the same thing.

In Bangladesh, the Emigration Rules (2002) outline a general policy for the provision of insurance. The Bureau of Manpower, Emigration and Training takes 1000 taka from each outgoing migrant worker prior to their departure. Bangladeshi migrant workers are not informed as to why this amount is being taken. No Bangladeshi migrant worker spoken to had any knowledge of the insurance programme, making it impossible to file a claim. At the same time, Bangladeshi recruitment agencies are also uncertain as to how the insurance programme operates, as reflected in the words of the head of an agency:

> From the government, there is one kind of thing regarding insurance.To cover insurance, we know that the government cuts a certain amount. There is a policy like this, but I don't know how much they implement that thing. I won't be able to tell you that matter.Whether any migrant worker files any claims upon return, that also is not in my knowledge. I think that it is a responsibility of the insurance agency to see whether a person is receiving his insurance upon return. But the truth I am telling that, we do not see matters like this.

On 25 December 2003, the insurance programme under India's Central Government, the Pravasi Bharatiya Bima Yojana, came into force. It covers workers in the event of death or permanent disability leading to loss of employment abroad; return of the body to India; hospitalisation on the grounds of accidental injuries and/or sickness/ailments/diseases occurring during the period of Insurance, provided the medical treatment is taken in India; and, under certain conditions, a one-way ticket home. Problematically, minor ailments and injuries requiring simple treatment in the destination country are not covered. It is equally problematic that governments in India and labour agents have not popularised the Scheme, so migrant workers are unaware of its existence.

In Pakistan, migrant workers pay their insurance fee as a part of the pre-departure process at the office of the Protector of Emigrants, but they are generally unaware they are insured (though only for major accidents). When asked about insurance, most Pakistani migrant workers did not know about the insurance coverage. According to a stakeholder, "80 per cent of Pakistanis who leave the country for employment abroad belong to rural areas and mostly are uneducated. These migrant workers are not aware that they can claim for insurance amount in case of injury, disability or death." Similarly, in Sri Lanka, there is a basic insurance policy, covering death and serious illness or injury, for those who register before going abroad, but migrant workers are minimally informed on this matter. The same is true in Nepal, where insurance is just for accidents at the workplace and, in this case, recruitment agencies maintain all insurance papers, while migrant workers are unaware they are insured. In Vietnam, as explained by an NGO worker: "The workers paid for insurance before leaving Vietnam, but few seem to know what this meant."

In the Philippines, in line with the Standard Employment Contract mandated by the Philippine Overseas Employment Administration, employers of overseas Filipino workers are to provide for migrant workers medical and dental insurance and even their medicines. But NGO workers in the Philippines expressed it is doubtful that employers provide for this, as contracts can be changed upon arrival in the destination country and migrant workers are ill informed on contract contents. Filipino migrant workers pay dues to the Overseas Workers Welfare Administration (OWWA), which provides health benefits, but again many Filipino workers do not know of the OWWA's health coverage. Among the 302 domestic workers who participated in the survey done by the Philippine NGO ACHIEVE, only nine knew they were insured.

If the insurance protection overseen by origin countries fails to be comprehensive and is difficult to access, the health insurance situation for migrant workers in destination countries is worse. No destination country offers migrant workers comprehensive health insurance should they become ill or injured. Both origin and destination countries in Asia need to critically evaluate their existing insurance programmes for migrant workers, both in terms of coverage and usability. The protective capacity of present schemes is shockingly weak. Moreover, migrant workers have the right to know insurance coverage exists and be educated on how to access the system.

REINTEGRATION

There are almost no programmes in place for migrant workers transitioning back into their countries of origin. No origin country has a comprehensive reintegration programme covering health information and care services, counselling for migrant workers and members of their families, legal and insurance advice, and financial and employment assistance. This is unfortunate because reintegration can be extremely difficult, especially if illness, abuse or detention occurred while abroad. Returnees may require immediate medical assistance, but not have the capital or know where to turn should specialised treatment and care be necessary. Reconstituting relationships, especially with one's spouse, may be uncomfortable and stressful, and there are the added pressures of finding employment. The realities of returning to one's former way of life can be exhausting. The return to one's previous life may not even be an option, as people and contexts change over time. For migrant workers who arrive back with chronic health conditions, such as HIV/AIDS, life becomes incredibly challenging in the face of discriminatory and stigmatising treatment, particularly if such actions are coming from health care professionals, friends and family.

The Philippines has done the most work on assisting migrant workers through the reintegration stage. The Overseas Workers Welfare Administration Board Resolution No. 038 (Section 6) states that a reintegration programme shall be overseen by the Philippine Department of Labour and Employment in coordination with local NGOs. It is detailed that community organising and capacity building shall be incorporated into the programme and that livelihood loans will be made available. Philippine reintegration efforts are reaching returnees but

implementing government Agencies, such as the Overseas Workers Welfare Administration, do not keep track of the returnees they assist. No monitoring takes place after Agencies' programme services have been rendered. Given that much of the work is referral oriented, it is difficult to gauge their level of access to adequate and appropriate health care.

In Indonesia, Act No. 39/2004 on Job Placement and Protection for Indonesian Migrant Workers in Foreign Countries details that recruitment agencies are responsible for returnee migrant workers' reintegration, including the provision of health services for migrant workers in need of health services. Regrettably, the NGO Solidaritas Perempuan discovered that several agencies paid little heed to migrant workers' well-being upon their return. They were sent directly home by the agency. In certain cases, Indonesian NGOs had to intervene and push recruitment agencies to claim migrant workers' insurance. What is also unfortunate is that the hospital to which returnees are referred, the Raden Soekanto Central Police Hospital, is located in Jakarta, meaning that only migrant workers returning to Jakarta, or routing through Jakarta on their way home, have access to this facility. Fortunately, some Indonesian NGOs assist returnee migrant workers in accessing health services, but again their efforts are mostly concentrated in the major cities, thus migrant workers returning directly home to rural areas often do not come in contact with appropriate care and treatment services.

In Cambodia, India, Nepal, Sri Lanka, and Vietnam, returnee migrant workers access health institutions in the same way they did before going abroad. India also encourages returnees to go for voluntary medical testing, so they know their health status and particularly their HIV status. In India, some spouses, mostly women, hold meetings to discuss issues related to having a partner working abroad. In a focus group discussion with the spouses of male migrant workers, women shared they had gone for health testing and encouraged their husbands to go also.

In Pakistan, the only reintegration assistance provided comes from the Overseas Pakistanis Foundation, which provides small loans and donations to returnees and assists them with their insurance. For those returning to Pakistan with HIV/AIDS, seeking assistance can be extremely difficult given the negative perception of this condition, even amongst health care personnel. HIV-positive returnees are afraid to disclose their seropositive status:

"We cannot inform doctor about our HIV positive status; if we tell him, he may hate. When I feel dizziness, I normally lay down on the floor. For fever, I take medicine from private clinic." Pakistani returnees have little way of finding out about the services provided by the AIDS Control Centre.

The harrowing story of a Bangladeshi returnee, who discovered he was HIV-positive after returning home, highlights the damaging and discriminatory treatment endured at the hands of some health care professionals.

> In the same way as before, this time also my blood was taken and X-ray and sexual organ was tested without any briefing.A few days later, as I went to take the report, the medical centre's doctor asked me to give blood again. After taking blood, I was asked to come in a specific day. That day, as I went to take report, they again asked blood. As I asked the reason, they informed me there is problem.As I went third time to bring report, I was told that I have to wait to talk with the doctor.
>
> As per the doctor's saying, as I went in the morning to bring the report, nobody spoke anything to me. Everybody went away by telling me to sit in a room for the entire day. Being helpless, I had to sit in that room. I waited from 10 in the morning till 5 in the afternoon. During this time the medical centre's people showed disrespect to me in various manners. At 5 in the afternoon, 3 doctors came to call me and said, "You are positive.There is no other bad person like you people in the world."
>
> As soon as the doctor entered the room he told me, "You have gone abroad, did filthy, dirty work and now have come back with AIDS. Didn't it happen to mind as you do filthy, dirty work that you can have AIDS?" The doctor told me in the tone of scolding, "There is no medicine for this disease. From now on your own glass, plate, clothes, food, everything has to be kept separate. Do not allow anyone to share the food that has been eaten by you, because you have got AIDS. Nobody lives, if has AIDS." One of the doctors said, "If the government comes to know then will imprison you."
>
> I only understood that the doctors are speaking very angrily, but what is AIDS, I did not understand anything then about that matter. I had no idea about what is 'positive'. Before medical test, I was not given any idea about what kinds of tests will be done. Even the medical report was not given to me. I only understood that I became unfit in the medical. Next, after some time later, one person from an NGO named SHISUK came to the medical centre and took me to their office.There they informed in detail, to me and my brother.

To speak more on the issue of HIV-positive returnees, a number of the origin countries reviewed, have National AIDS Laws which outline that HIV-positive individuals must not be discriminated against in the contexts of work, school, insurance, and, most importantly, health services. In addition, origin countries that have ratified the ICESCR are obligated to take measures to protect all vulnerable or otherwise disadvantaged groups of society, including migrant workers living with HIV/AIDS.

It is worrisome that findings suggest that the health care sector can be implicated in fuelling the continued discrimination of HIV-positive individuals in Asia. For example, research in India has revealed that nursing students and senior nurses feel uncomfortable talking, shaking hands or being in the same room with an HIV positive person. The study reported not only inadequate knowledge regarding prophylaxis against HIV, but discriminatory attitudes among one third of the senior nurses surveyed, with about a quarter unwilling to provide care to a person with HIV/AIDS.

It is no wonder that HIV-positive returnees encountering negative reactions from health care staff, the contingent responsible for taking care of people's health and welfare, then choose to keep their condition a secret from everyone, including friends and family. This is negatively impacting as returnees isolate themselves, deny their condition and fail to be educated on modes of transmission and may thus unwittingly infect others. Their isolation will keep them from seeking out those who have specialised training in HIV/AIDS, whether certain health clinics or divisions in hospitals, NGOs, CBOs, and counsellors. Moreover, without contact with these institutions and organisations, accessing the antiretrovirals (ARVs) will be nearly impossible, as ARVs are already difficult to access given their limited availability, cost and the conditions of free treatment.

DESTINATION COUNTRIES

In determining whether migrant workers' underlying determinants of health – nutritious food, clean drinking water, basic sanitation, and adequate housing and living conditions – are nationally promoted, it is apparent that minimal consideration has been afforded this issue in nearly all seven destination countries reviewed. In addition, no destination countries are making great investments to ensure that migrant workers receive adequate health information and services. Overall, destination countries are not actively promoting and ensuring migrant workers' health rights. More time, money and energy has been devoted to the issues of mandatory health testing, migrant workers' documentation status and employment concerns, which reflect a greater concern for the local population and infrastructure of destination countries.

ON SITE ACCESS TO HEALTH INFORMATION

In considering the issue of access to health information for migrant workers, it should be noted that Japan, the Hong Kong, SAR of China Special Administrative Region, the Republic of Korea, Thailand, and Jordan have all ratified the ICESCR. This means these nations have a binding legal obligation to all residents to ensure the provision of sexual and reproductive health information; refrain from censoring, withholding or intentionally misrepresenting accurate health related information; ensure that third parties do not limit people's access to health related information; establish and promote prevention and information campaigns for behaviour related health concerns, such as STIs and HIV/AIDS; provide education and access to information about the main health problems in the community, including methods of prevention and control; and ensure the dissemination of appropriate information relating to healthy lifestyle and nutrition, and availability of health services.

To raise HIV/AIDS education as an example, the destination countries reviewed, to varying degrees, have taken the initiative to develop and implement policies addressing access to HIV/AIDS prevention and care information. Typically, the focus has been on men who have sex with men, sex workers, intravenous drug users, pregnant women, and adolescents, with less effort thus far being directed towards in the delivery of HIV/AIDS information to migrant workers.

Regrettably, most health policies and programmes have not taken into consideration the unique circumstances of migrant workers (e.g. cultural differences, language barriers, isolated working conditions), thus migrant workers fail to benefit from many national health education efforts. As a consequence of this gap, migrant workers do not receive adequate information about HIV/AIDS. In Malaysia, for example, based on the answers obtained from the migrant workers when asked about HIV/AIDS, it was noticed that the majority only had partial or incorrect knowledge of the disease; and this information was primarily acquired through informal channels.

> AIDS is related to blood. I know because one of my friends in Bangladesh is HIV-positive, because he has been involved in bad behaviour. It depends on our behaviour. (Male Bangladeshi factory worker in Malaysia)
>
> I don't know about AIDS. I have never heard. Nobody taught me about it. (Female Indonesian domestic worker in Malaysia)
>
> I know a bit about AIDS. If somebody do wrong things and go to no good places, they will get it. (Indian migrant worker in Malaysia)

Post-arrival Programmes

The Republic of Korea has a required post-arrival orientation session, but there is no requirement that any health information be disseminated. The Hong Kong, SAR of China Special Administrative Region has no post-arrival orientation, but they do provide incoming documented migrant workers with a booklet, "Your Guide to Services in Hong Kong, SAR of China," at the immigration counter at the airport. This booklet does contain some valuable information on the health care system in Hong Kong, SAR of China, but Indonesian migrant workers entering Hong Kong, SAR of China reported that they had their copies seized while still at the airport by their employment agents.

The Malaysian Department of Occupational Health and Safety has taken some initiative in attempting to address health and safety at the workplace – including developing a Code of Practice on prevention, management and education of HIV/AIDS – but, as guidelines, companies and organisation are not legally bound to follow them. In Japan, the government has no policies with regards to post-arrival programmes for migrant workers, though some categories of migrants receive some health training as a consequence of the work sector they are entering. The Ministerial Ordinance based on the Immigration Control and

Refugee Recognition Act stipulates that 'off the job' training on occupational health and safety should be included for trainees (including foreign trainees) in the orientation for the Industrial Training Programme. But this health training does not cover knowledge of disease prevention, the maintenance of general health and accessing the health care system in Japan.

In a positive move, the Thai Ministry of Public Health has decided to specifically address migrant workers in their health prevention, promotion and care activities in their five-year plan, but this plan is still being formulated. It is also not surprising to note that none of the destination countries require that any health information be delivered to migrant workers on an ongoing basis during the course of their stay in the destination country. As a result of these gaps, most migrant workers exist in a situation similar to that expressed by an undocumented, female migrant worker in Japan: "I was ignorant; I didn't know how the health system in Japan was."

Alternate Modes of Acquiring Health Information

In the absence of government health education programmes targeting migrant workers in destination countries, migrant workers frequently mentioned that they acquired information through alternate channels, including information sources in/from their home countries. The media is one such example.

> I got information on AIDS from Indian television before I came to Malaysia (Male, Indian working in Malaysia)

> I read about AIDS from newspaper. I always read Thinathanthi and Malimurasu (Tamil newspapers that can be purchased in Malaysia) (Female, Indian working in Malaysia)

In Japan, migrant workers from Thailand reported obtaining health information from Thai newsletters, restaurants and temples. In Malaysia, documented male migrant workers from Indonesia reported that they encountered health posters and brochures at the hospital that contained information on how to take care of their health. They were able to access this information because Bahasa Malaysia and Bahasa Indonesia are quite similar.

> The brochures contained health care, for example, so if we would like to have sex... we must use condom to prevent AIDS. If we...mmm...if we don't want to get AIDS, use condom.

In contrast, all the female migrant workers from Indonesia interviewed said that they never saw any health-related material in the destination country they were working in. This finding can be principally attributed to the isolated conditions of their work; their limited exposure to the health care system; and the fact that most of them had worked in the Middle East, where less health materials are available and the language is quite different.

Family and friends play an equally important role in providing migrant workers in destination countries with health information. In Japan, Thai migrant workers reported that they received most of their health-related information from their Thai friends and co-workers, Japanese friends, and/or family members. These contacts were also perceived to be the most important and valuable source of information for them. Similarly, a female, Nepalese domestic worker who had worked in Hong Kong, SAR of China spoke about how migrant workers would gather to share information; but she also mentioned how this was difficult to do in certain countries.

> Every Sunday, we have week off and all Nepalese gather at the Park [in Hong Kong, SAR of China]. Likewise the Filipinos and Indonesians also gather at places in week off days. During that time we share different information and we update ourselves…Where as in Saudi who is also a domestic worker is barred to get information, as she is not allowed to go out of the house, and could see a hospital when she was taken for a medical test.

Another Nepalese migrant worker also mentioned receiving advice from fellow migrant workers, but, as shown by the quote below, the information is of questionable use value.

> First we need to take rest and then should bathe.They also said there are some liquids available, and they told it is used for cleaning the toilet, but other people drink it since it takes to quench your thirst for alcohol. Don't drink that, it is not good for heath, and after 7 o'clock don't eat outside.

NGOs and CBOs proved to be another mechanism by which migrant workers in destination counties are able to access health information. In Malaysia, initiatives have been carried out by NGOs working with the migrants to educate and increase their awareness on health issues and their health rights. For example, Tenaganita initiated the Peer Educators Programme with different communities of migrant workers, where the certain migrant workers are trained, and are

then involved in sharing health information with their peers. However, due to the limited number of NGOs involved in such activities, reaching out to a large number of migrant workers is extremely difficult.

Barriers to Accessing Health Information

In addition to the lack of targeted health information for migrant workers, migrant workers' attempts to access health information are obstructed by several factors, as described below.

1) Language

Most of the health information available in Malaysia is either in Bahasa Malaysia or in English, with certain materials being available in Tamil and Chinese as well; but thus far there is no health information available in Bengali, Nepalese, Vietnamese, Cambodian, or Burmese – languages spoken by many the migrant workers in Malaysia. In addition, health promotion and education programmes over the National Malaysian radio and television are only carried out in the four main languages of the country. Some migrant workers learn how to speak some Bahasa Malaysia and/or English within a few months of stay in the Malaysia; however, not many are able to read health materials in these languages. Therefore comprehending textual materials like signboards, posters and pamphlets in Bahasa Malaysia or English is not possible.

> I do not know where to go and who to ask, because I do not know the language in this country. I do not know English much as well. Because of that I cannot ask anybody. I didn't get the opportunity to talk to others, we only have time to go to work and come back. (Migrant worker in Malaysia speaking about access to health information)

In Japan, a documented, female Thai migrant worker articulated her inability to go to her health check-up due to her being unable to read Japanese.

> The letter of health check comes from the public office, but I cannot understand where it is held. In letter the place of the health check is written, but it is not sure for me. Probably I can take test with low fee but I don't go. I can't go. I can't understand Japanese, and also my husband doesn't take me there. So, I don't go.

2) Labour Context

Migrant workers typically work long, and sometimes excessive and irregular, hours. This is another major factor hampering migrant workers' access to health information in destination countries. The time they have at home after returning from work is just enough for them to cook their meals and sleep before returning to work for the next shift. Migrant workers barely have time to watch television or read newspapers, magazines or pamphlets, therefore any health information they could absorb if they understood the main languages in the destination country they barely have time to access.

> Where do we have time to watch [television]? Come back from work, cook, eat, sleep, work again. If can get time, we will watch. (Male Bangladeshi migrant worker in Malaysia)

For domestic workers who work in the isolated conditions of the household, where they are 'on call' nearly every hour, access to health information becomes even more difficult, and to certain extent impossible. An Indonesian domestic worker in Malaysia claimed that even if there were available newspapers and magazines containing health information, she would not able to read them, due to her demanding work schedule: "No, even if somebody buys, cannot read because we are working."

3) Documentation Status

Migrant workers who work and remain in the country without the proper documents often live in fear of being arrested and deported for their undocumented status. This fear prevents them from coming forward to seek access to crucial health information. Undocumented migrant workers shy away from participating in public health education programmes and activities. They generally avoid contact with any official or professional with connections to the government, including health workers, police and lawyers. According to a representative of the Cambodian Embassy in Kuala Lumpur, the undocumented workers often hide in the jungle during the day due to the fear of being arrested by the police: "Undocumented workers, they try to hide from the police so they live in the jungle in the daytime. They just hide in the forest nearby in the mountain."

At the moment, there are no efforts being made by the Malaysian government, or the governments of other destination countries, to reach out to these groups of migrant workers and provide health information to them. They are thus extremely vulnerable to health problems, as a consequence of their limited access to knowledge about preventative health message and health services.

Overall, there is an absence of law and policy to ensure that migrant workers' receive adequate health knowledge. They do not learn about prevention and care for various infections and diseases; the health situation in the destination country; health insurance and the cost of health care; the location and availability of health facilities; healthy lifestyle and nutrition; and their health rights. All of which are topics essential to migrant workers' maintaining their health status. Oftentimes, their only exposure to the health sector is the mandatory medical test and if they require diagnosis and treatment of an injury or illness – both of which are contexts in which minimal health-related information is shared.

IMPEDING THE RIGHT TO HEALTH

Freedom of Movement

There are certain laws in destination countries that are a serious detriment to migrant workers' access to health. Examples of this include laws that restrict migrant workers' freedom of movement. In the Republic of Korea 'running away' from a designated workplace is considered a criminal offence without 'justifiable reasons', and once found, migrant workers are subject to detention and deportation. In Bahrain, leaving an employer's residence is a criminal act for a domestic worker. If this occurs, a police search is launched, and the migrant worker's photograph is published in the local newspaper. In addition, any person who hides or protects the worker is committing an offence. In Saudi Arabia, a passport is not an acceptable form of identification; instead the government issued iqama is the identification document that all foreign workers in the kingdom are required to carry. Without this document, migrant workers have almost no freedom of movement, are subject to arrest at any time and cannot be admitted to hospitals for medical treatment. In Saudi Arabia, women are also not allowed by law to travel within the country or abroad without being accompanied by a male relative.

Thus, if an employer demands that a migrant worker does not leave the living and working premises, and does not take him or her to the hospital, proper medical treatment is not possible.

> One day I had stomach ache and had fever. I vomited blood.The young son of my owner saw that and told his mother. I told her that I don't want to stay there. I wanted to go home. I did not have any medicine. They started ill treatment (chi! chi! dur dur!), gave me food in different plate. They did not give me any medicine. I wasn't allowed to go out by myself… But I hadn't seen the hospital and they didn't take me. (Female Nepalese domestic worker)

Many migrant workers discussed their uncertainties about moving freely, and their fears about being found without the proper documents and facing potential detention and deportation.

> That was the problem, going to the hospital was risky because there could be police there…if we were found without documents… we could be jailed for months, and would have to repeat the process. (Male migrant worker from Indonesia)

Laws such as this limit the ability of migrant workers, and particularly female migrant workers, to seek medical, social and legal assistance. Usually employers have possession of migrant workers' legal documents, meaning migrants live in fear of leaving, as they would become 'illegal' without them. As such, some migrant workers continue to work in situations where violence and negligence occurs. If they escape these circumstances, rather than being legally protected, they are simply defined as criminals, without the specific circumstances of their cases being assessed.

Violence against Women

It is equally unfortunate that nearly all the destination countries reviewed have taken minimal action to protect women from sexual, physical and emotional violence. Japan is somewhat the exception, having the Law for the Prevention of Spousal Violence and the Law for the Protection of Victims, but again these Laws do not cover female migrant workers specifically. Life for female migrant workers in Saudi Arabia is particularly difficult, as the legal system can effectively harm them. If a woman becomes pregnant, even if it is the consequence of rape, she is unable to obtain a legal abortion (unless she has a specifically defined

medical condition). In addition, the Saudi Ministry of Health issued a Directive in 2003 prohibiting hospitals from admitting pregnant women who are not accompanied by a man willing to acknowledge paternity. For female migrant workers in Saudi Arabia who become pregnant and desire to avoid arrest and deportation, access to appropriate health care is nearly impossible.

In situations of this sort, where women have minimal power and information, they resort to unsafe measures to have an abortion, as a domestic worker from the Philippines explained:

> Domestic workers, in particular, have little access to reproductive health information and services. Most clinics are closed during our days off. Many of us do not even know how to get to the clinics.Those who get pregnant and continue with their pregnancy risk getting terminated by their employers. To avoid termination from work, some domestic workers resort to unsafe, yet expensive, abortions.

Labour

In destination countries only certain groups of migrant workers are covered under National Labour Laws. There is also no policy explicitly guaranteeing access to health and the determinants of health for migrant workers amongst these policies. This is unfortunate given that many employers are also responsible for providing adequate meals and housing while 'off the job', a dynamic that can impact migrant workers' health status dramatically.

Though migrant workers' inclusion in current National Labour Laws would not directly ensure migrant workers' access to health, it does afford those covered some power and confidence in seeking legal, medical and other assistance. In a positive move, Article 3 of Japan's Labour Standards Law outlines that: "An employer shall not engage in discriminatory treatment with respect to wages, working hours, or other working conditions based on the nationality, creed, or social status of any workers." But, unfortunately, many employers in destination countries continue to treat migrant workers as a disposable commodity and force them to work under conditions that negatively impact their health, regardless of the laws in place.

> I am 21-years-old, but got strong back aches after six months of work on a wooden furniture assembly line as a carpenter, and three months later I could no longer work, so I was sent home. (Vietnamese male sent home from Malaysia)

> There are four thousand workers in our factory. One hundred and fifty of us shared the same room provided by the company. Later on, this caused 11 persons sick that were sent back due to health problems. (Male Nepalese migrant worker)

Employers are able to carry on mistreating migrant workers, because migrant workers are not adequately educated on their rights and there are minimal mechanisms to monitor employer abuses.

For those not covered under Labour Laws, seeking assistance can be extremely difficult. Problematically, undocumented workers are afforded no protection under any national Labour Laws reviewed here. They are viewed as criminals to be identified, detained and deported. Migrant domestic workers are also left off the Labour Law in certain countries, even if they have the correct documents. In Bahrain, Article 2 of the Labour Law for the Private Sector (1976) exempts "domestic servants and persons as such" from the purview of the law. Migrant domestic workers in Jordan, Malaysia and Saudi Arabia are also legally exempt under their respective National Labour Laws.

Undocumented workers and domestic workers have minimal legal recourse against employers who force them to work excessive hours and in conditions that are harmful and abusive, and who fail to pay their wages. In addition, in Bahrain there is no law that specifically prohibits trafficking in persons. These omissions are particularly harmful to women, who are more frequently concentrated in the domestic sector and more vulnerable to being trafficked.

Embassies

While embassies often serve as a safe haven and resource for migrant workers in need while abroad, embassy personnel are often ill equipped to effectively manage their unique vulnerabilities. Embassy staff are not trained to do so. No country mentioned in this report has law or policy to mandate the training of embassy and diplomatic staff on migrant workers' health rights and needs. Only the Philippines has established an HIV/AIDS and international migration orientation for government personnel deployed to foreign posts, which is carried out by the NGO ACHIEVE. But no policy on this point exists.

Sadly, female Filipino returnee migrant workers shared stories of foreign personnel who trafficked female migrant workers into the sex trade, in the

effort to raise the money for the migrant workers' airfare home. In the same vein, a female migrant worker from Cambodia, seeking assistance from the Cambodian embassy in Malaysia after severe employer abuse, shared that she was not appropriately assisted. Embassy staff only contacted the recruitment agency and explained that they should teach their workers to 'stay obedient' to their employers. Without training and monitoring, foreign government staff will not be successful in helping migrant workers. Moreover, stories, such as those described above, cause migrant workers to hesitate in seeking assistance from embassies, which should not be the case.

ON SITE ACCESS TO HEALTH SERVICES

As per the UDHR, all nations are obliged to ensure that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including the right to medical care. For those nations – such as Japan, the Republic of Korea, Jordan, and Thailand – that have signed the ICESCR they are party to a series of obligations. These nations are obligated to refrain from denying or limiting equal access for all persons (i.e. prisoners, detainees, illegal immigrants, minorities) to preventative, curative and palliative health care. They are obligated to ensure the provision of adequate health services for women in difficult circumstances, such as female migrant domestic workers living and working in isolated conditions. They are also legally compelled to regulate the activities of individuals, groups, organisations, and corporations so as to prevent them from violating the right to health of others.

No country reviewed here legally states that migrant workers, specifically, must be guaranteed accessible, affordable and acceptable health care. Thailand has the National Universal Health Care Scheme, giving registered migrant workers the same rights as locals, but migrant workers are not mentioned in particular. Bahrain has a set of health principles regarding accessibility, affordability, appropriateness, accountability, accreditation, and acceptability, which detail that care services should be available to all Bahrain residents – both nationals and non-nationals – but, being a set of principles, they are not legally binding.

While policies espousing 'equal health care to all' exist in destination countries, there is minimal work being done to ensure that such ideals are implemented effectively, particularly for marginalised and disadvantaged groups. Migrant

workers have great difficulties accessing health care due to lack of information, fear of losing their jobs, the type of job they are employed in, the high cost of health services, and gross neglect on the part of their employers. They suffer silently and resort to self-medication, and only go to the doctor when the situation becomes dangerously acute.

> We do not go to the doctor when we feel pain or discomfort. We rationalise that we do not need the doctor for minor ailments. We ignore it for as long as the pain or discomfort is bearable. If not, we resort to buying drugs that can be easily bought over the counter. Worse, we simply ask our neighbours or relatives and resort to self-medication. (Female migrant domestic worker from the Philippines)

> I have seen one person in the factory next to ours. One of his hands was cut during working with the machine.The owner did not give him any treatment. He himself did the treatment. Because of no proper treatment he got infection. Later his hand had to cut off up to his wrist. That man's home was in ___ district. One day the man came to us and said, "Brother, you are Bengali; I am also Bengali. One of my hands is gone. I heard that I would get 50,000 ringgit. But the owner neither did give me any money nor did any treatment. Please help me, give me some money by collecting from people. I will go back home." Later, we collected some money from the seven Bengali and nine Burmese persons that we had in our factory, and as the ticket's price was met, then we told him to go home purchasing the ticket. (Male Bangladeshi migrant worker in Malaysia)

Unsurprisingly, undocumented migrant workers are also not specifically mentioned with regard to being guaranteed available, affordable and acceptable health care. Due to their fears of being dismissed, in addition to being arrested and deported, they do not seek medical assistance until their health condition is very serious. In addition, law and policy in origin countries fails to account for the protection of undocumented migrant workers as well. Only Filipino Law explicitly mentions undocumented workers, stating they need to be adequately protected and safeguarded. India has historically even denied assistance to undocumented Indian migrant workers abroad. This is particularly problematic given that Indian females below the age of 30 are forbidden from migrating for employment. This forces Indian women below this age to work abroad without the proper documentation, thus rendering them extremely vulnerable. In sum, there is minimal protection for undocumented migrant workers, as the following stories demonstrate.

> Those who are undocumented cannot have access to hospital, though they know that there is a doctor and hospital was a few hours ride form the place they stayed, but the cost is very high.We were undocumented migrant workers.We were granted only three months visa.Till then we were considered documented, after that we were considered illegal or undocumented migrant workers. So, actually it was not easy for us to approach a doctor even if we are sick. When my husband had a summer boil on his left lap we were scared to tell our boss about the boil since in Japan they do not like workers taking leave.We were scared that if we tell them we might be terminated from work.When pain was too much, we lied to our Boss that it was infection caused by accident while working in the factory. The other thing is that in Japan factory owners or our boss, they do not like workers taking sick leave. We migrant workers usually did not take sick leave till the illness is tolerable for fear of getting terminated. We did not have any facility for sick leave.
>
> Again, late one night, my husband had a severe pain in his stomach. He requested his friend (roommate), also a Nepalese, to call the local ambulance. He dare not do it since we were all undocumented migrant workers.When the pain was too much my husband shouted, "I would rather give up to the police than die like this, please go and bring the ambulance." When both of us started crying, his friend had no choice. He brought the ambulance. (Female, Nepalese migrant worker who had worked in Japan)
>
> One day one of my friends and I was travelling, then a Tamil (Malaysian National) stopped us in the road and hit that friend in the head with a helmet. His head got fractured. My friend was illegal. He had no passport. Then I telephoned the owner of the factory where he worked. The owner came. When the condition was like this, then the owner said keep him in another house, don't let him enter into my factory.Then I said we have to take him to the hospital.The owner said he will need passport if taken to the hospital. Then I took him not to a hospital but to a private clinic.The private clinic transferred him and asked me to take to the hospital. But at that moment if I took him to the hospital, then the police will arrest him.Then I took him home and did treatment by calling in doctor, but it did not work.After seven days he died. After death, the dead body itself is also illegal. So, it won't be possible to send to Bangladesh. So we covered the dead body by earth inside the jungle. His mother said, calling from Bangladesh, "Where is my son? It's been many days since he is not sending any letters." We said,"He is fine." At last, one day I told his mother,"Your son has died." (Bangladeshi migrant worker in Malaysia)

In cases where migrant workers are detained pending deportation, which often occurs when undocumented migrant workers are found, access to adequate

medical care is not a guaranteed right. National energies have been directed towards erecting policies that deter non-citizens from remaining in the destination country without the proper documents. For example, as per Section 6 of the Malaysia Immigration Act (1959/63, amended 2002), a non-Malaysian citizen in Malaysia without a valid work permit or proper documents is subject to a maximum fine of 10,000 ringgit or a jail term not exceeding five years or both, and a mandatory whipping not exceeding six strokes.

Nations may have laws in place regarding torture, abuses and basic freedoms, but the right to health is not assured. Migrant workers become ill, and even die, as a result of the inhumane conditions and lack of medical care in detention facilities in destination countries.

> One Bengali got fever who used to live with me in the same room in the jail. After suffering quite a few days, he fell terribly ill one day. We were taken away from that room. That person was left alone in that room, he wasn't taken to any doctor. One day later that person died. (Male Bangladeshi migrant worker)

Only in Japan is there mention of health in the context of detention. According to Japan's Rules of Treatment for Detainees (Article 8): If the head or someone of the detainee facility recognises the necessity for medical intervention, they must provide for a medical doctor; and if it is found that the detainee has an illness or injury, adequate medical treatment must be provided for the detainee's condition.

There are also minimal provisions in these destination countries with regard to health insurance, and there is nothing in place for undocumented migrant workers. For documented migrant workers, Thailand has the National Universal Health Care Scheme, but this does not provide compensation of any kind and it is a complicated process to access, and one that most migrant workers are not aware of. Malaysia has the Foreign Workers Compensation Scheme, which all documented migrant workers must be registered; however, this covers only injuries sustained at the workplace. In Bahrain, foreign workers benefit from the health programme of the Social Security Scheme, but this programme, again, only covers work related injuries. In sum, no destination country has a comprehensive health insurance programme protecting migrant workers' health and providing benefits should migrant workers become ill or injured either at work or outside of work. In addition, migrant workers have little knowledge of how available health programmes operate, so they are unable to utilise them effectively.

Migrant workers often have to shoulder the cost of their health care, even when their employers are contractually expected to do so. In some countries, such as the Hong Kong, SAR of China Special Administrate Region, health services costs were felt to be so high that migrant workers would endure their costs for as long as possible and then return home to seek treatment. Oftentimes, medical costs are deducted from migrant workers already low wages, and they only find out upon receiving a lower salary than they anticipated.

> Once the company told us to take injection, we thought it was for free. So all of us went, but later the company deducted 98 ringgit from our salary. (Male Nepalese migrant worker in Malaysia)

Out of fear of losing their jobs, migrant workers remain silent and accept less pay.

HIV/AIDS

To address the issue of access to health care for those who have HIV/AIDS, destination countries take minimal action on this issue, beyond trying to identify, detain and deport those who are infected. There are no amnesty procedures for migrant workers who have HIV/AIDS. Certain countries, such as the Republic of Korea, outline that if a migrant worker is injured or ill due to work, he/she can stay in the country until he/she receives the necessary medical treatment; but if a migrant worker has HIV/AIDS, he or she is deported almost immediately (though hospitalisation make occur before deportation in order to stabilise the patient for the journey home).

It should be duly noted that those countries that have ratified the ICESCR have a binding legal obligation to prevent, treat and control epidemic and endemic diseases. Yet no destination country reviewed here legally recognises the specific needs and rights of HIV-positive migrant workers. In addition, there is no specific policy and legislation on access to treatment (i.e. Anti-Retroviral Therapy) for either documented or undocumented migrant workers. National governments have been more focused on developing and implementing law and policy on mandatory health testing and deportation procedures – issues that will be discussed in greater detail in a later section – than on protecting and monitoring the health rights of migrant workers.

Quality of Health Care Services

On the issue of quality of health care, countries that have signed the ICESCR are legally bound to ensure that medical practioners and other health professionals meet appropriate recognised standards of education, skill and ethical codes of conduct. The same countries are also expected to ensure that health services are culturally appropriate and that health care professionals are trained to recognise and respond to the specific needs of the poor and other vulnerable or disadvantaged groups in the population, such as migrant workers. At the present time, there has been almost no effort to train individuals working in the health care sector in destination countries to respond to the specific health vulnerabilities and information needs of migrant workers.

No destination country reviewed here has any policies for health care professionals taking into account the delivery of information and treatment to migrant workers. While general policies exist outlining equal health for all and no discrimination in health on the grounds of origin, race, language, sex, age, physical or health condition, personal status, economic standing, religious belief, education, or political view, there are no specific policies stating that health information and treatment must be delivered in a culturally sensitive and appropriate manner to foreigners. Guidelines or codes address the delivery of health care in very broad terms. For example, the Bahrain National Code of Professional Conduct for Nursing states that nurses should respect the "individual's value system and maintain the individual's self-respect and dignity at all times" (Value Statement 2.1). While the spirit behind such a statement is positive, statements such as these do not address the specific vulnerabilities of migrant workers, and nor are they legally binding.

Migrant workers encounter services in health care facilities that are anything but care-oriented. For example, a male migrant worker from the Philippines was confined in a government hospital in Jeddah for 11 months, due to his HIV status.

> The representatives from the Ministry of Health accompanied me to the Hospital, to confirm my [HIV] status. When we were there, I was told that I had to be confined in the hospital until they could talk to my employer.They said they had to conduct other tests, but they did not tell me what those tests were.They told me they needed three weeks to process my documents so I can go home, and in the meantime I

> had to stay in that hospital. But I ended up confined in that hospital for 11 months. I was never informed about the progress of the case. I was never called to testify. A friend brought my things. I was detained for 11 months in a room with migrants from all nationalities who were also HIV positive, and was never allowed to go out. After a week, I attempted suicide.
>
> Others stayed for about a week to two months.There were about 67 patients who came and went while I was there. I stayed the longest. The room had two doors, one was made of thick smoked glass then about two meters into the room, there was another door made of iron bars. People outside the room couldn't hear us even if we shout. One patient was having an attack, so we were shouting for help, but they couldn't hear us.We went to the toilet where there was a window with iron bars.We waited for people to pass so we could ask for help. It took about 15 minutes before we were able to ask a passer by to inform the nurse to come and help one of the patients. By then the patient was already vomiting blood.
>
> The nurses neglected the patients in that room.There were those who needed their diapers changed, the old or bed-ridden patients, but the nurses wouldn't do it. I think they found us disgusting. I ended up doing these things. In my 11 months stay, I became the caregiver for about 14 of the patients who were either weak or bed-ridden.

At the present time, policy and law does not ensure that migrant workers receive quality health care – specific policy that takes into account the difficulties migrant workers face in accessing health care and the certain illnesses and injuries they are more susceptible to. In this vacuum, NGOs have attempted to remedy the void by taking such measures as producing health pamphlets and posters in languages that different migrant groups read and speak, but these efforts achieve only minor success, as the energy and support of the government is not in place.

Mandatory Medical Testing and Deportation

Instead of providing migrant workers with accessible and adequate health information and care, national governments have invested their energies into erecting laws and policies that aim to identify, isolate and remove unhealthy migrants who are deemed a threat to the health and well-being of the local population. Mandatory medical testing and deportation are done even though studies have shown mandatory testing to be a counterproductive measure to halt the spread of infection, and deportation takes place in cases where infections are easily treatable and the individual can continue to work.

The Republic of Korea, Bahrain, Jordan, Malaysia, and Saudi Arabia all require potential migrant workers to undergo a mandatory medical test, which includes an HIV test, before they can enter the country. If a migrant worker tests positive for any of the infections tested for (e.g. HIV/AIDS, TB, hepatitis), he or she is denied entry. Thailand does not require potential migrant workers to be tested for HIV/AIDS, but the Thai government insists that migrant workers are checked for TB, syphilis, elephantitus, leprosy, drug addiction, alcoholism, and mental disorders. Japan is the exception, and does not have any regulations on testing potential migrant workers' health.

Once in the destination country, migrant workers have to repeat the medical test to have their work permit renewed. No health information is given to migrant workers during these health exams; they are generally not even told what infections/diseases they have if they are ill.

> I was sent back without prior information. I didn't know why I was sent back. (Male, Nepali migrant worker deported from Malaysia due to malaria, which was diagnosed in Kathmandu)

> I was said to be sick and contagious at the second annual check up. No more explanation was given. I really do not know why because the health result was not given to me. I was sent back home with two other Vietnamese workers, who also failed. (Female, Vietnamese migrant worker who was deported from Malaysia)

Migrant workers are not treated adequately. Instead migrant workers are stabilised, if required, and deported almost immediately. In Bahrain, for example, rigorous action is taken if a worker is found to suffer from an infectious disease. Ministerial Order Number 11/1976 states if the Medical Commission finds a migrant worker neither physically fit nor free from infectious diseases, the Commission shall notify the Ministry of Labour and Social Affairs of this fact within 24 hours. The Ministry Labour then requests the Directorate of Immigration and Passports to deport the worker at the employer's expense.

In sum, migrant workers' right to health is grossly neglected in destination countries, where migration policies focused on exclusion, containment and deportation take precedence over actions to counter the vulnerabilities migrant workers confront.

CHAPTER FIVE

RECOMMENDATIONS

Male migrant workers in search of work abroad often leave behind spouses that are unaware of the health risks associated with migration. Empowered migrant workers' spouses in Nepal speak up to raise awareness for AIDS Day in Nepal.

CHAPTER FIVE:

RECOMMENDATIONS

INDEX

Principle Recommendations

All governments, recruitment agencies, employers, and other relevant stakeholders must take active steps to protect, promote and ensure migrant workers' access to accurate health information and affordable, quality health care services.

Migrant workers around the world must be directly involved in the discussion, development, implementation, monitoring, and evaluation of laws, policies and programmes aiming to protect and promote migrant workers' access to health information and services.

INTERNATIONAL INSTRUMENTS

Countries must ratify international instruments to demonstrate their commitment to making positive advancements towards ensuring the rights of all people, including migrant workers at every stage of the migratory process. Countries must develop, implement and monitor laws and policies that reflect the letter and the spirit of these instruments, recognising that certain disadvantaged and marginalised groups, such as migrant workers, need special consideration to guarantee their health and labour rights are safeguarded.

- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)
- International Covenant on Economic, Social and Cultural Rights (1966)
- International Convention on the Elimination of All Forms of Racial Discrimination (1965)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)

1. Countries that have signed the above Conventions are obligated to recognise the difficulties migrant workers face in achieving the right to health, security and freedom, and must act accordingly to counter such barriers. Countries are obligated to:

1.1 Give sufficient recognition to the right to health for migrant workers in national political and legal systems

1.2 Adopt a national public health strategy and plan of action for the realisation of the right to health for all, including disadvantaged groups such as migrant workers

1.3 Ensure migrant workers' access to the underlying determinants of health (nutritionally safe food, portable drinking water, basic sanitation, and adequate housing and living conditions)

1.4 Establish and promote prevention and education/information campaigns for health concerns, such as STIs and HIV/AIDS, targeting migrant workers and the surrounding community

1.5 Provide a health insurance system migrant workers can afford

BILATERAL AGREEMENTS AND MEMORANDA OF UNDERSTANDING

Bilateral agreements and Memoranda of Understanding need to be instituted and monitored between origin and destination countries in order to protect and ensure the health, well-being and safety of migrant workers living and working abroad. To this end, consultations must be held between origin and destination countries to determine and commit to a set of minimum standards to ensure that migrant workers' health and labour rights are met.

2. Bilateral agreements and MoUs must include provisions pertaining to:

2.1 The protection of migrant workers' health and labour rights – an agreed upon set of minimum standards that countries are obligated to adhere to

2.2 Migrant workers' access to adequate, available and affordable health care

2.3 Migrant workers' access to accurate health information, including material on HIV/AIDS and other STIs

2.4 Affordable and accessible health insurance for migrant workers

2.5 Migrant workers' protection and representation in the event of an incident involving the justice system

2.6 Notification processes for family members regarding the health and legal status of migrant workers abroad

LAWS AND POLICIES

Right to Health

It is recommended that national governments acknowledge migrant workers' right to the highest attainable standard of physical and mental health. This should be reflected in national laws and policies, and because migrant workers face obstacles to achieving these rights, specific provisions should be in place to account for and remedy this. Simultaneously, national laws and policies that either directly or indirectly impede migrant workers' rights or access to health must be reviewed and amended accordingly. In addition, female migrant workers' and undocumented migrant workers' particular difficulties in accessing health information and services must be legally recognised, with decisive action being taken to counter these barriers.

National laws and policies must reflect international standards with regards to the delivery of health information and care, staff training, medical testing, and the handling of patient information. It is essential that the implementation of these laws and policies be routinely monitored and evaluated.

With reference to carrying out the above tasks, different government sectors (e.g. health, justice, police, education, finance, and development planning) must collaborate and share information in the effort to establish laws and policies to protect and promote migrant workers' health rights. At the same time, specific government departments need to be assigned the task of operationalising and monitoring certain policies, rules, guidelines, and directives, where these branches then have the responsibility to disseminate this knowledge to relevant government departments.

It is highly recommended that law and policy discussions on migrant workers' health rights not be abstract, but grounded by the realities of culture, society and the living and working conditions impacting migrant workers; and, most importantly, migrant workers must actively participate in and contribute to these dialogues.

Labour

3. It is recommended that the following law and policies be implemented to help protect and promote migrant workers' rights, health and safety in the labour context:

3.1 Governments must institute specific labour laws and policies for migrant workers in line with international labour standards, and monitor and enforce them accordingly. Laws should cover hours of work, days off, training, conditions of work, wages, maternity and termination benefits, freedom of expression and association, and unionisation. This information should be made readily available to migrant workers.

3.2 Governments should require and enforce the use of standardised labour contracts for migrant workers.

3.3 Where governments have excluded certain sectors of employment (e.g. domestic and agriculture) from national labour laws, this must be changed to ensure all sectors of work are covered.

3.4 Undocumented migrant workers' labour rights should be protected under national laws and policies.

3.5 Migrant workers must be able to legally maintain possession of their official documents.

3.6 Laws criminalising the exploitation, neglect, physical and sexual abuse, withholding of wages, and trafficking of migrant workers must be in place, and employers, recruitment agents and trainers must be monitored accordingly.

3.7 Where companies and recruitment centres are responsible for migrant workers' basic needs (i.e. food and shelter), they must be legally required to meet a minimum set of standards, including the provision that migrant workers must have access to adequate, available and affordable health services.

3.8 Professionals working with migrant workers (i.e. employers, trainers and recruitment agents) must be required to take a course outlining their legal obligations in working with migrant workers, including information on migrant workers' rights, health insurance and vulnerabilities.

3.9 Governments must make provisions for the safe and secure transfer of remittances.

3.10 Governments must establish a Migrant Workers' Welfare Fund to assist migrant workers and their families in need (e.g. legal costs, transportation to origin country, repatriation of deceased migrant workers); and governments must be transparent as to how this money is being spent.

PROGRAMMES AND INITIATIVES

General

To help improve the conditions in which international labour migration takes place, it is recommended that national governments develop and implement programmes targeting migrant workers and the surrounding community, in order to counter societal problems such as gender inequality, poverty, violence against women, illiteracy, and malnutrition.

Origin and destination country governments must work together and share information to develop and establish programmes to ensure migrant workers' access to health. It is also recommended that programmes to improve migrant workers' access to health information and care must involve collaboration and coordination between the public and private sector – between governments, companies, recruitment centres, embassies, health care institutions, NGOs, CBOs, unions, churches, and so on. In addition, the development, implementation and monitoring of all programmes and projects targeting migrant workers must involve migrant workers at every level and stage.

It is recommended that programmes and initiatives be as inclusive as possible to migrant workers in both their development and delivery. For example, the capacity of migrant workers who can no longer work abroad because of illness or injury, and who want to be involved in advocacy and education efforts, must be encouraged and enhanced, so they can better partake in the initiatives to assist their fellow migrant workers. In the delivery of programmes, migrant workers' families and spouses should also be targeted, so significant others can learn about the realities faced by migrant workers abroad and they can better support them while on site and upon their return. In addition, it is imperative that all health information and care programmes for migrant workers be 'youth friendly', as a great number of those working abroad are adolescents.

Access to Health Information

4. It is recommended that the following initiatives be adopted to increase migrant workers' health knowledge:

4.1 Health information delivered to migrant workers must include detailed information on HIV/AIDS and STI prevention and care, sexual and reproductive health issues, mental and occupational health, nutritious foods, basic medicines, and medical testing.

4.2 Health information for migrant workers should be readily available in different languages via pamphlets and brochures, posters, radio, television, Internet, and educational videos.

4.3 Those individuals delivering health information to migrant workers should receive specific, standardised training, so that they better understand health issues in the context of international labour migration and can anticipate migrant workers' concerns.

4.4 Migrant workers must be trained to deliver health information to other migrant workers.

4.5 Correct condom use should be promoted in a way that helps to overcome social and personal obstacles to their use. At the same time, high quality condoms should be readily available for migrant workers.

4.6 Prevention efforts should be focused in areas where there is an increased likelihood that HIV and STIs risk behaviours will occur (e.g. truck stops, bus and train stations, harbours, markets, and nightclubs).

4.7 Governments should ensure that health information delivered to migrant workers is standardised, correct and up to date. Governments of different countries should also work together to achieve this goal.

4.8 When health care professionals diagnose and treat migrant workers, this time should also be used to educate migrant workers on the prevention of health conditions and diseases.

4.9 Pre-departure, post-arrival and reintegration programmes must be mandatory for migrant workers, and they must include detailed, comprehensive information on disease prevention, how to access the health care system, their rights, and health insurance.

4.10 Community level interventions must be encouraged to ensure that migrant workers who do not attend officially mandated sessions are still able to access important health information.

4.11 The spouses and partners of migrant workers need to be educated on HIV/AIDS and STIs prevention and care, and have a place to voice their concerns about having a partner who works abroad.

4.12 Government and donor agencies need to support migrant workers' associations, companies, unions and other groups in helping to integrate HIV/AIDS and other health related material into their programmes and projects.

Access to Health Services

5. It is recommended that the following initiatives be implemented to improve migrant workers' access to adequate health treatment and services:

5.1 Migrant workers must have the same access to high quality treatment and care as the local population (e.g. access to ARVs and comprehensive sexual and reproductive health services).

5.2 Support services (e.g. counselling and referrals) should be instituted and improved to assist migrant workers.

5.3 Health care professionals must be trained to deliver culturally sensitive care and treatment to migrant workers, and be made aware of migrant workers' vulnerabilities and common health concerns.

5.4 Government officers, lawyers, the police, and embassy personnel need to be educated on migrant workers' realities and health issues, and be able to direct migrant workers to the appropriate channels to receive treatment and care.

5.5 Health care and treatment programmes for migrant workers need to be established in areas where the health infrastructure is less established (e.g. rural areas or along routes of travel).

5.6 Migrant workers' documentation status should not impact the quality of treatment and care he or she receives.

5.7 Language translators need to be available at public and private health care institutions.

5.8 Health care facilities should be open late on certain days to accommodate migrant workers' long and irregular hours of work; and health outreach programmes should also be in place to reach migrant workers who are unable to travel to hospitals and clinics.

5.9 Health care initiatives targeting migrant workers' must be embedded within larger national health care strategies.

5.10 STI detection and treatment should be essential components of HIV prevention programmes, as the presence of certain STIs increases the likelihood of HIV transmission.

5.11 Training and support must be in place for those who employ, recruit and train migrant workers, in order to improve migrant workers' living and working conditions and access to health services.

5.12 Health prevention and care efforts for migrant workers should be linked together to increase their effectiveness, limit costs, reach more migrant workers and reduce levels of stigmatisation and discrimination.

5.13 Confidentiality and privacy must be ensured at hospitals and other health institutions, as this will increase migrant workers' comfort and confidence in seeking help.

5.14 Programmes need to be implemented to improve the chance that migrant workers will be able to make follow-up treatment visits to health care facilities.

5.15 A mechanism must be in place whereby health institutions in different countries, at the patients' consent, can share information to improve the quality of care for migrant workers who travel back to their country of origin.

Health Insurance

6. It is recommended that the following points be put into practice to increase migrant workers' access to health insurance:

6.1 Governments must actively ensure that migrant workers have access to affordable, comprehensive health insurance plans. Current labour acts and laws do not provide adequate protection and compensation for migrant workers should they become ill or injured, and they should be evaluated and modified accordingly.

6.2 Health insurance must provide adequate compensation for illnesses and injuries sustained outside of the workplace, as well as for those accidents and illnesses which occur at work.

6.3 Health insurance for migrant workers should be affordable, and migrant workers should be charged no more than the local population.

6.4 Governments have the responsibility to help educate migrant workers on the existence of health insurance and monitor whether such plans are being effectively implemented.

6.5 Governments need to develop a health insurance scheme for undocumented migrant workers should they become ill or injured.

6.6 Work should be done towards making the claims process as efficient and straightforward as possible for potential parties involved (i.e. migrant workers, government actors, employers, recruiting agents, and health care professionals); and the information on these processes should be made easily accessible and available to all.

6.7 Governments should ensure that a resource is in place whereby migrant workers can directly access information about their health insurance coverage, along with specific claims information.

6.8 Origin and destination country governments need to work together to develop, implement and monitor health insurance for migrant workers.

INFORMATION ON MIGRANT WORKERS

7. It is recommended that the following information strategies be adopted, so migrant workers may be assisted with greater efficiency, and people can increase their understanding of migrant workers' experiences and vulnerabilities:

7.1 Information on ill, injured, deceased, detained, jailed, and/or deported migrant workers must be made available to embassies, relevant government agencies and family members.

7.2 Information on migrant workers (for example, statistics, laws, policies, programmes, codes of conduct, health insurance and rights) needs to be collected and organised in each country. This needs to be done in such a way that researchers, migrant workers, law and policy makers, health care professionals, and employers have access to this information in one place as an online database and resource centre.

7.3 More information needs to be collected on the complex relationship between international labour migration and health, specifically access to health information and care services, and occupational, mental and sexual and reproductive health. These research findings need to be shared internationally.

7.4 Information on the vulnerabilities migrant workers face needs to reach the public to increase their understanding of migrant workers' often difficult existence, in order to raise awareness and decrease discrimination and stigmatisation.

7.5 Health problems encountered by migrant workers must be documented, so this information can inform the development of policies and programmes aimed at benefiting migrant workers' health.

7.6 Knowledge highlighting migrant workers' social, economic and cultural contribution in both origin and destination countries must be disseminated to the public.

7.7 Quantitative and qualitative data collection techniques should be continuously improved, especially with regards to collecting information on how to reach migrant worker populations, such as undocumented workers, domestic workers and those travelling through border areas.

MANDATORY MEDICAL TESTING

8. It is recommended that the following points be implemented to secure migrant workers' rights, health and comfort in the context of medical testing:

8.1 Strict policy guidelines reflecting international testing protocols must be instituted by all countries for migrant workers. The guidelines must ensure confidentiality and privacy, and health care staff must be educated on these guidelines.

8.2 Pre- and post-test counselling must be made available to migrant workers in a language familiar to them and be carried out in a culturally sensitive manner.

8.3 Referral services need to be made available to migrant workers.

8.4 Medical testing should be carried out in a manner that is respectful to the comfort and well-being of the migrant workers being tested.

8.5 Voluntary, rather than mandatory, HIV testing should be promoted for migrant workers.

8.6 Programmes need to be established whereby medical testing should be used as a platform to educate migrant workers on preventative health information.

8.7 Migrant workers who test positive for curable infectious diseases must have access to affordable treatment immediately and upon their recovery be allowed to continue their work in the destination country.

8.8 Migrant workers should not have to pay for their mandatory health test, and testing should be available at a number of facilities, so migrant workers do not have to travel far to have the test done.

8.9 Medical conditions, including HIV/AIDS and pregnancy, should not be the grounds for migrant workers being deported. Adequate and affordable health care and treatment should be made available to them in the destination country.

EMBASSIES

9. It is recommended that the following points be adopted in order for embassies to better serve migrant workers in need of health information, medical assistance and/or legal counsel:

9.1 Health information and services should be one of the core services provided by embassies and consulates. Embassy staff should be trained to deliver basic health information, and informative health materials should be made available in pamphlet form.

9.2 A functional health referral system should be in place, and, where possible, it would be helpful to have a medical facility directly connected to the embassy.

9.3 Embassies should have links with relevant NGOs, CBOs, law groups, and government agencies in order to provide migrant workers with further support.

9.4 Ongoing capacity building for embassy personnel on the issues of HIV/AIDS, STIs and other health issues and international labour migration should be put in place or improved.

9.5 Embassies should provide services to assist migrant workers who voluntarily wish to return to their country of origin.

ANNEX:

SELECTED INDICATORS OF PARTICIPATING COUNTRIES

Demographic, Social, Health and Economic Indicators

Country	Total population (millions) 2005	Ave. pop growth rate (%) 2005	Life expectancy M/F	Maternal mortality ratio	Infant mortality Total per 1,000 live births	% Births with skilled attendants	GNI per capita PPP$ (2 003)	Health ex-penditures, public (% of GDP)	External population assistance (US$,000)	Access to improved drinking water sources
Origin Country										
Bangladesh	141.8	1.8	62.8/64.6	380	54	14	1,870	0.8	85,760	75
Cambodia	14.1	2.0	53.4/60.5	450	91	32	2,060	2.1	36,969	34
India	1103.4	1.5				43		1.3	99,471	86
Indonesia	222.8	1.2	65.8/69.5	230	38	68	3,210	1.2	48,084	78
Nepal	27.1	2.0	62.0/62.9	740	60	11	8,940	1.4	26,421	84
Pakistan	157.9	2.1	63.6/64.0	500	75	23	2,060	1.1	57,075	90
Philippines	83.1	1.7	68.8/73.1	200	26	60	4,640	1.1	36,120	85
Sri Lanka	20.7	0.8	72.0/77.3	92	16	97	3,730	1.8	15,862	78
Vietnam	84.2	1.3	69.1/73.1	130	28	85	2,490	1.5	21,441	73
Destination Country										
Hong Kong, SAR of China SAR, China	7.0	1.1	78.9/84.9		4		28,810			
Japan	128.1	0.1	78.7/85.8	10	3	100	28,620	6.5	128,068	100
Malaysia	25.3	1.8	71.4/76.0	41	10	97	8,940	2.0	700	95
Thailand	64.2	0.8	67.3/74.3	44	18	99	7,450	3.1	16,109	85

Source: UNFPA. 2006. 'State of World Population 2005'.

Migration and Migrant Workers' Indicators

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Budget allocated on health for MW	Insurance for MWs
			Sending Country				
Bangladesh[1]	Total: **3,924,027**(1976-2004) majority from 20 -35 age group Job categories Professional 181,405 Skilled 1,240,762 Semi-skilled 628,479 Unskilled 3,924,027 Top Destination KSA 1,336,899 UAE 369,936 Kuwait 221,667 Oman 133,447 Quater 61,066 Bahrain 61,890 Malaysia 113,677 USA 0,049 UK 52,014	Not Available	Estimated no. of **250,000** people migrate undocumented each year. Mostly in Malaysia, Gulf & other countries including Europe. Most work as unskilled workers, majority in construction sector, cleaner, factory work etc.	Remittance: 1976 to 2004 (Million) **US$ 31,683.30** Remittance as % of GNP: **32%** of total GNP in 2003-04 FY	Not Available	No	No
Cambodia	**37,599** MW in Thailand, **11,000** in Malaysia. M:72%, F: 28%, age: 21 - 30 Job categories M: Agriculture, fishing, mining, construction. F: Domestic workers, sex workers, construction *Source: Asian Migrant Yearbook 2002-2003*	Reintegrating: **1,324** Deported: **625** (1998-2005) *Source: CLS, HRD, RTU, Phillimore, MLC, RTH*	Total estimated Undocumented MW: **70,000** Direct sex workers: **3,872** Indirect sex workers: **8,418** *Source: Asian Migrant Yearbook 2002-2003*	Remittance: **$3,177,600** (maximum approximation)	Not Available	No	No

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Budget allocated on health for MW	Insurance for MWs
India	**155,500,000** (1999-2003) *Source: Ministry of Labor, Government of India*	Not Available	Not Available	2000-2001 (In Rs. Million) **587,560** *Source: Report on Currency and Finance, Reserve Bank of India*	Not Available	No	Central Govt.of India instituted an insurance scheme Pravasi Bharatiya Bima Yojana since Dec. 25/2003. It covers death, disability, maternity, transportation, hospitalization, disease, illness & dependents.
Indonesia	F: 995,817, M: 2,562,353 Total: **3558170** (1994-2004) Job Categories Domestic worker (M: 45,567, F: 256,184) Farm worker (M: 74,647) Construction (M: 5,557) Tailor (M: 3,327) Cleaning Service (M: 279, F: 727) [2]	Reintegrating: **200,000-250,000/year** Jan – Dec 2004: **352,264** Jan – May 2005: **115,794** Deported: 2004-Feb 2005: **2,907** *Source: Kompas Newspaper, 1 February 2005*	**150,000 – 200,000/year** (Female and Male) *Source: Yang Relevan adalah Perlindungan, bukan Melarang'*	2000 : US$ **1,31** Billion 2001 : US$ **1, 97** Billion 2002: US$ **2,17** Billion *Source: The Ministry of Manpower and Transmigration*	**15** US $ per MW *Law No. 20/ 1997 on Penerimaan Negara Bukan Pajak*	No	Rp. **400,000** (40$) per MW collected by insurance companies. Compensation: Pass away due to accident Rp. **20,000,000** & due to illness Rp. **10,000,000.** Total/certain part permanent deformity due to accident Rp. **20,000,000** Medical cost due to accident Rp. **2,000,000** Medical cost due to illness since the placement phase Rp. **20,000,000** [3]

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Budget allocated on health for MW	Insurance for MWs
Nepal	M **110,220** (99.54%) F **504** (0.46%) Majority 20-30 years Job Categories Unskilled, Semi-skilled and Highly Skilled labor in Service, Production, Construction, Agriculture Destination Countries Malaysia, Qatar, Saudi Arab, UAAE, Kuwait, North Korea, Hong Kong, SAR of China, Bahrain, Jordan, Oman, South Korea *Fact Sheet Jan-Dec 04, Department of Labour, Kathmandu.*	Deported: **Around 100** *Source: Officials of Foreign Employment Associations*	F: **30,000-40,000** M: **500,000** Mostly in India, Malaysia and Gulf countries *Source: Officials of Foreign Employment Associations*	Remittance: More than NRs. **100** Billion (*Source: Kantipur Daily, January 14, 2005)* Remittance is **14.13%** of the GDP Source: *HMGN (2004) Economic Survey HMG/Ministry of Finance, Kathmandu.*	NRs. **1,200** or 37% of the service charge *Source: Managing Director of Recruiting Agent*	No	NRs. **505** is collected from each worker as a premium for the insured amounts of NRs.**100,000** for 2 years.
Pakistan[4]	**3,231,329** (1971-2002) Age: 25-45 years Job Categories mason, car painter, electrician, cook, plumber, waiter, steel fixer, painter, labourer, technician, mechanic, cable jointer, driver, operator, tailor, survear, fitter, denter, computer/programmer and system analyst, designer, gold smith, rigger, sales man, craft man, black smith etc. Major Destination Country UAE, Bahrain, Brunei, Hong Kong, Iran, Iraq, Jordan, Kuwait, Libya, Lebanon, Malaysia, Oman, Qatar, Saudi Arabia, Singapore, U.K, USA, Yemen, Japan, Korea etc.	**17%** of total migrant workers came back to Pakistan permanently.	Not Available	Remittance: **3,871** million US $ (2003-2004) Remittance is **4.46%** of the GNP	**100** Rs for stamping agreement in government treasury, fee of Rs **2,500** for permission from protector of emigrants to proceed. Rs.**1,050** deposited by all persons getting employment abroad as a welfare fund.	No	Rs **650** per MW registered with protector of emigrants for insurance. Compensation: In case of death Rs. **300,000.** Loss of two limbs or two eyes or one limb or one eye Rs. **300,000.** Loss of arm or leg/one eye/ or complete sight of one eye/ Permanent loss of hearing from both ears/ Loss of arm or leg below an ankle Rs.**150,000.** Stoppage of functioning of any part of body due to paralysis or stroke Rs. **30,000** to Rs. **150,000.**

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Budget allocated on health for MW	Insurance for MWs
Philippines	Total deployment in 2004: **933,588** Land based: 704,586 Seafarers: 229,002 M: 88,732, F: 199,426 (New Hires in 2002) Job Categories Clerical Workers: 5,221 Sales Workers: 3,903 Service Workers: 112,856 Agricultural Workers: 665 Production Workers: 60,708[5]	Not Available	**1,512,765** (Dec. 2003) *Source: The Commission on Filipino Overseas 2004*	**10,689,005** (in thousand US $) in 2005[6]	Not Available	No	Not Available
Sri Lanka[7]	Total: **213,450** F: 133,474 & M: 79,979 Major age group 25-29 Job Categories Professional level, Clerical & Related, Skilled, Unskilled, Housemaids. Gulf Countries 95%,Other 5%	Not Available	Not Available	Remittances: Rs.**158,291** million. Remittances as percentage of GNP: ***13%***	Not available	No	Money collected from MWs by insurance companies Rs.**106,726,500** and money paid out to MWs Rs.**101,233,500** (In 2004)
Vietnam[8]	Contract MWs in 2002 Total: **46,200** (including 10,600 female workers) Major Destination Country Malaysia: 19,900 Taiwan, Province of China: 13,200 Laos: 9,100 Japan: 2,200 South Korea: 1,200 Others: 600	Not Available	Not Available	Not Available	Not Available	No	At the moment migrant workers are responsible for paying social insurance in order to enjoy welfare benefits after leaving the destination country.

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Budget allocated on health for MW	Insurance for MWs
Receiving Country							
Hong Kong, SAR of China SAR, China	There are **19,155** foreign professionals, **218,430** foreign domestic helpers (most female) and **11,037** other imported workers at the end of 2004. For foreign domestic helpers, **54.8%** were from the Philippines and **41.2%** from Indonesia. *Source: Hong Kong, SAR of China Yearbook 2004*	Not Available	Not Available	N/A	Taxes of MW and local is same. Vast majority of foreign domestic helpers' income has not reached minimum wage that requires to pay income tax.	No	No
Japan[9]	**192,194** (2004) *Number of registered aliens **1,973,747** (2004) Skilled labor **13,373(7.0%)**	No of deported MW: **33,911**	*Illegal stay over permitted period **219,418**	N/A	Not Available	No	No
Malaysia[10]	Total: **1,812,631** Indonesia 1,209,127; India 134,946; Nepal 192,332; Bangladesh 55,389; Myanmar 88,573; Philippines 21,694; Vietnam 81,194 etc.	Not Available	**1.3** million	N/A	Not Available	No	Not Available
Thailand[11]	**1,284,920** registered for ID card as of Feb 2005 and **838,934** registered for work permit in 2004	Not Available	Estimated number of undocumented MW is more than double of documented MWs	N/A	Not Available		No

HIV and AIDS Indicators, 2005

Country	Adults (15+) with HIV	Women (15+) with HIV	HIV prevalence (%) in most-at-risk groups in capital city	AIDS deaths
Origin Country				
Bangladesh	11 000	1400	Injecting Drug Users – 4.9 Female Sex Workers – 0.2 (2004) Men who have sex with men – 0.4	<500
Cambodia	130 000	59 000	Female Sex Workers – 26.3 (2000)	16 000
India	5600 000	1600 000	Injecting Drug Users – 5.0 (2000) Female Sex Workers – 9.4 (2000)	[270 000 – 680 000] [low estimate-high estimate]
Indonesia	170 000	29 000	Injecting Drug Users – 65.5 (2000) Female Sex Workers – 0.0 (2000)	5500
Nepal	74 000	16 000	Injecting Drug Users – 50.0 (2000) Female Sex Workers – 2.0 Men who have sex with men – 3.9	5100
Pakistan	84 000	14 000	Injecting Drug Users – 22.9	3000
Philippines	12 000	3400	Injecting Drug Users – 1.0	<1000
Sri Lanka	5000	<1000	Female Sex Workers – 0.0 (2000)	<500
Vietnam	250 000	84 000	Injecting Drug Users – 30.6 Female Sex Workers – 10.0 (2000) Men who have sex with men – 6.5	13 000
Destination Country				
Hong Kong, SAR of China SAR **China (No separate info on Hong Kong, SAR of China)	650 000	180 000	Injecting Drug Users – 8.3 Female Sex Workers – 0.5 Men who have sex with men – 1.5	31 000
Japan	17 000	9900	Men who have sex with men – 2.9 (in 2000)	1400
Malaysia	67 000	17 000	Female Sex Workers – 6.9 (2000)	4000
Thailand	560 000	220 000	Injecting Drug Users – 38.0 (2004) Female Sex Workers – 4.3 (2004)	21 000

Source: UNAIDS, 2006. '2006 Report on the Global AIDS Epidemic'.

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2 http://www.tki.or.id/asp/rekapitulasi/rekap_penem_sektor_2005.htm

3 Decree of Ministry of Manpower and Transmigration of the Republic of Indonesia, No: Kep 157/MEN/2003

4 Source: Ministry of Labor and Manpower Overseas Pakistanis, 2004

5 Source: 2004 Annual Report of the Philippine Overseas Employment Administration.

6 Source: http://www.bsp.gov.ph/statistics/sefi/ofw.htm

7 Source: Information Technology Division-SLBFE- 2004.

8 Labour Migration in Asia, IOM

9 Source: Immigration Bureau of Japan, Immigration Control 2004 (2005)

10 Statistics by the Ministry of Home Affairs, Malaysia, 2005. Obtained from the Cambodian Embassy in Kuala Lumpur

11 http://www.rockmekong.org/pubs/Year2005/Migration_Mekong/regional%20overview.pdf

ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	antiretroviral
BAIRA	Bangladesh Association of International Recruiting Agencies
BEOE	Bureau of Emigration and Overseas Employment
BMET	Bureau of Manpower, Employment and Training
CARAM	Coordination of Action Research on AIDS and Mobility
CBO	community based organisation
DGPTMW	Director General of Placement and Training of Migrant Workers
FGD	focus group discussion
FOMEMA	Foreign Workers Medical Examination Monitoring Agency
GAMCA	Gulf Approved Medical Centres Association
GCC	Gulf Cooperation Council
GDP	gross domestic product
HIPKTEK	Association of Medical Clinics for Migrant Workers (Indonesia)
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
IOM	International Organization for Migration
ISC	Integrated Service Centre
MDG	Millennium Development Goal
MoU	Memorandum of Understanding
MSC	Migrant Services Centre
NGO	non-government organisation
OFW	overseas Filipino workers
OPF	Overseas Pakistanis Foundation
PDOS	pre-departure orientation seminar
POE	Protectorates of Emigration
PPIMFC	Placement and Protection of Indonesian Manpower in Foreign Counties
RSCPH	Raden Soekanto Central Police Hospital
SLBFE	Sri Lanka Bureau of Foreign Employment
SoH	State of Health
SP	Solidaritas Perempuan
STD	sexually transmitted disease
STI	sexually transmitted infection
TB	tuberculosis
TV	television
UAE	United Arab Emirates
UN	United Nations
UNAIDS	Joint United Nations Programme of HIV/AIDS
UNDHR	United Nations Declaration on Human Rights
UNGASS	United Nations General Assembly Special Session
US	United States
WHO	World Health Organization
YPI	Yayasan Pelita Ilmu

CARAM Asia's annual State of Health of Migration (SoH) research turns to the migrant community itself to define the current scenario in migrant access to health care and information. Through this report migrant workers played a part in shaping the future by contributing and sharing their experiences as well as suggesting changes to the policies affecting the migration process.

Thirteen countries participated in the research. They are Bangladesh, Cambodia, Hong Kong, India, Indonesia, Japan, Nepal, Pakistan, Philippines, Malaysia, Thailand, Sri Lanka and Vietnam. The key features and strengths of the research is its role in promoting change through organizational learning, and the research process that worked effectively to link participation, social action, and knowledge generation. Drawing from country experiences, the State of Health research shows remarkable outcomes on its path, cutting across all countries and people involved, that holds promise for a better future in the struggle for accessing migrant's health.

CARAM Asia expects that the recommendations in this report will help trigger some significant actions at national as well regional level via the implementation of interventions relevant to migrant workers.

CARAM Asia is a regional non governmental organisation working on migration and health issues. Formed in 1997 it has developed into a network of 12 partner organisations covering 11 countries in Asia and is in research partnership with the Vrije University Medical Center based in The Netherlands. 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.

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