CARAM Asia

MIGRANTS 2007

MANDATORY TESTING

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STATE OF HEALTH OF MIGRANTS 2007

MANDATORY TESTING

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FOREWORD

It is a matter of pleasure and privilege to write a foreword to CARAM Asia's report on the State of the Health of Migrants. Its topic - for this extensive 16-country research - mandatory testing comes at a critical juncture when more barriers are being erected to make it more difficult for migrants, who make up the lower socio-economic classes, to find work and a right to work productively.

This in-depth study will help fill the gap needed for public health practitioners, programme managers and above all the policy makers to realise that any attempts to regulate testing will only drive mobile populations to shun health care systems altogether. This in turn will defeat any public health goals designed to address the HIV epidemic.

Provider Initiated Testing should not be used as a screening mechanism to decide who can work and who cannot. Testing should remain a gateway to access healthcare services, specially treatment and care, aimed at improving the health and well-being of migrant workers. Healthcare institutions should instead be migrant-friendly and be equipped with information to reach at risk groups like migrants who need to be educated on prevention regarding HIV transmission, prevention, and the specific vulnerability of migrant workers; the process of testing, and the meaning of HIV test results.

The report, in reviewing laws and policies in relation to mandatory testing of migrants, makes it evident that States need to take a rights-based approach in dealing with migrants and monitor practices of employers and recruitment agencies who often find gaps between laws and policies to exploit migrants.

UNAIDS will fully support mainstreaming migrant-friendly testing in all countries.

JVR Prasada Rao
Regional Director (Asia Pacific)
UNAIDS

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EXECUTIVE SUMMARY

The Asian network Coordination of Action Research on AIDS and Migration (CARAM Asia) has completed a second round of action research under its State of Health taskforce - this time focused on the issue of Mandatory Testing. The research, completed in sixteen countries spanning across Asia, including both origin and destination countries, compares existing laws and policies on HIV testing in each country with the requirements of mandatory health testing that migrants who wish to work abroad must undergo. This report garners input from not only key stakeholders, but most importantly, from migrant workers themselves. Using participatory research methods, migrants' direct experiences with mandatory health testing were collected from all ends of the migration continuum - prospective migrants at their country of origin, migrants working at destination countries, and returnee migrants including those living with HIV, some of who were deported as a result of testing. The result of the research and analysis by CARAM partner organisations was the development of a "Migrant-Friendly" Testing Framework.

The main finding of the research is that the practices of mandatory testing for HIV and other health conditions as a screening tool for the entry of migrant workers into destination countries is discriminatory, dehumanising and results in the violation of basic rights, especially the right to health. Migrants who fill unskilled or semi-skilled jobs are singled out for mandatory health examinations that include HIV testing. Under these circumstances, migrants are treated differently from the general population, falling outside the protection of prevailing laws and policies on HIV in both origin and destination countries.

At all points in the migration process where medical testing is required, migrants' basic rights are effectively stripped away as laws and ethical standards of practice regarding HIV testing are overlooked. Sending countries willingly submit to destination countries' demands for mandatory health testing, making their own laws on HIV irrelevant. Once they have reached the destination country, migrants must again undergo mandatory health testing that includes HIV. Under conditions of mandatory health testing, it was found that standard components of HIV testing are discarded in both origin and destination countries: there is no explicit consent taken before undergoing testing; migrants do not receive any pre-test or post-test counselling; migrants have no control over the confidentiality of their results, often with results given directly to recruitment agents or employers; and although there are health services available, migrants, prospective migrants and returned migrants are not referred to those services when they are found to have an exclusionary condition, including those who are HIV positive.

Migrants usually come from poor rural areas, where the hope for a better life rests tentatively on the shoulders of a family member going abroad for work. They sell essential assets such as land or take out loans to pay for entry into the recruitment process. Prospective migrants then approach recruitment agents who help fill in necessary paper work and obtain visas. As part of the visa process, migrants

must undergo a health test from a certified clinic. Depending on the destination country, the migrant is required to test for a list of specified conditions and diseases that are exclusionary, including HIV, STIs as well as TB and pregnancy. In most cases, the migrant is referred to a specific clinic that is approved by the receiving country or one that provides a sales commission to agents. In some cases there is no choice: for example, all migrants going to a country in the GCC (Gulf Cooperation Council) must attend clinics authorised by GAMCA (GCC Approved Medical Centres' Association). These clinics, however, are more expensive and are mostly located centrally in capital cities, adding extra costs such as transportation and lodging.

Due to various factors, such as the volume of migrants testing at a clinic at one time, many standard practices which have been established for voluntary HIV testing are discarded. First, there is a lack of real informed consent, as neither the testing procedures nor the list of conditions being tested are elaborated, and no other information is provided as to what the implications or potential impact is of getting a positive result. Most migrants feel obliged to sign whatever documents are provided to go abroad, and health officials assume that there is implicit consent or that consent from the recruiter is acceptable. But it is in this first omission that so many other violations arise. Without information on what is being tested, migrants are left to simply follow directions. No pre-test or post-test counselling is provided, which is especially worrisome for HIV testing, and there is little regard for their dignity, as there are often testing procedures that make migrants feel embarrassed and uncomfortable such as being completely unclothed or having a person of the opposite sex conduct the exam.

There is also complete lack of respect for confidentiality. Results of the health test always go directly to the recruiter, oftentimes before the migrant knows the results, and migrants are lucky if they get to see their report at all. They are usually just informed of whether they can work abroad or not, with those deemed "unfit" commonly not informed of the condition found. Results may be read out loud in front of others or given by the recruiter, obviating any chance for post-test counselling. GAMCA clinics feed the results directly into a database that is supposedly shared with all other GAMCA centres around Asia, disallowing a "permanently unfit" person from ever legally migrating for work to a GCC country. In other words, these health exams are not for the benefit of migrants. Nothing more clearly illustrates this than the fact that there is little or no referral to treatment or support services for those who do have a health condition or disease found, including those who test positive for HIV.

For those who pass and are allowed to travel for work, they must be tested again upon arrival and throughout their stay in the destination country. Once again, all standard practices for voluntary HIV testing are disregarded. This time, not only is the volume of migrants testing an issue, but there are also language and cultural barriers which negate any potential for meaningful consent or for pre-test and post-test counselling, if any attempts are even made. Although there are a few countries that do not require mandatory testing, there are loopholes used by employers to impose testing. When a result is found, especially HIV, most every destination country will immediately deport the migrant worker without explanation. There is little compensation, and no consideration for the migrant's rights or dignity. Even worse is the fact that the migrant is deported without being provided treatment or referral in either the destination country or once back in the country of origin, usually without even knowing what health condition was found. The person is simply left to return to their family bewildered, devastated and hopeless. For those with HIV, this raises serious implications regarding spousal transmission.

In today's world, migration has become a part of the economic functioning of many countries – both sending and receiving countries. There is greater reliance on migrant workers, yet these people are not perceived as individuals with rights, but as expendable economic units. Without migrant workers, poorer and less developed countries would suffer considerable financial set-backs, as remittances contribute significant amounts of income to their country's GNP. For example, in 2006, USD 5.5 Billion was sent in remittances to Bangladesh; Indonesia received USD 4.4 Billion and the Philippines received USD 12.8 Billion; while remittances comprised 12% of Sri Lanka's GNP and 15% of Nepal's GNP. At the same time, due to shifts in demographics, such as increasingly aging societies with low replacement rates, developed and industrialised countries must rely on migrant workers to fill less attractive jobs that are essential to the functioning of their economies. These jobs include factory and construction work, domestic labour, seafood processing, agriculture and other food related industries, as well as the service industry including entertainment. The numbers are considerable: Hong Kong, SAR of China has over 225,000 foreign domestic workers registered; South Korea has over 468,000 registered migrant workers mostly in factories; Dubai and the United Arab Emirates respectively have 304,900 and 500,000 migrant workers in construction; while Malaysia has 1.8 million migrant workers registered and Thailand estimates that only around 600,000 of the two million migrants present are currently registered. Yet, migrant workers are treated as criminals for something that should be a basic human right – health.

Mandatory testing for HIV flies in the face of international conventions and guidelines; has no proven effective role as a means for preventing the spread of HIV; and contributes to the stigmatising of migrants and people living with HIV. For these reasons, CARAM Asia and partner organisations call on the cessation of the practice of mandatory testing and related deportation, or at a minimum, for governments and parties involved in recruitment and testing practices to observe and integrate the "Migrant-friendly" Testing Framework into current practices by: following established standards of informed consent, ensuring provision of pre-test and post-test counselling, protecting confidentiality, and providing proper referral to those who need support or treatment. Medical testing should not be used as a screening mechanism to determine which migrants are allowed to work; it should be used to improve migrants' health by acting as a gateway to access health services and treatment.

CHAPTER ONE

MIGRANT WORKERS, HEALTH AND HUMAN RIGHTS

Migrants waiting to
be tested in Mahachai,
Samut Sakorn Province,
Thailand

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MIGRANT WORKERS, HEALTH AND HUMAN RIGHTS

A number of papers have documented an association between human mobility and increased risk of HIV infection. In France, while migrants make up 6% of the population, 14% of the reported cases of AIDS occur in migrants.[1] In 2004, approximately 70% of the 4,253 persons who were newly diagnosed with HIV in the UK were born outside the country.[2]

In low HIV prevalence countries like Pakistan, Bangladesh and the Philippines, migrant returnees are showing higher incidences of HIV than the local population. About 35% of documented HIV cases in the Philippines are among overseas workers, and 42% of new HIV cases recorded in 2006 were among this vulnerable group, according to health department data.[3] Pakistan produces an even more shocking number: of the known HIV cases, 80% were people deported from Gulf States for having the disease, according to a joint study conducted by UNAIDS and Karachi's Aga Khan University.[4]

Part of the reason for this is the fact that migrant workers represent a socially marginalised group that are not being reached by prevention, treatment and care programmes.[5]

Being a migrant in and of itself is not a risk factor; the risk factors are the stresses and vulnerabilities associated with the migration process. A new and different environment may lead to increased personal risk as people become separated from family, from a regular sex partner, and reside in single-sex housing. It must be understood that the desire to have sexual relations with others is entirely normal, especially given feelings of loneliness and a sense of isolation in a new country, and that the desire for companionship and intimacy is a basic human drive. It is unreasonable to expect that migrants should relinquish these basic human desires once they cross borders. However, they can be properly prepared to diminish any associated risks.

Unfortunately, coming from impoverished areas, they may also have inadequate awareness or understanding about HIV before they migrate, leaving them unfamiliar with their personal risks of HIV infection and ways to protect against the disease, especially in a new setting.

Migrants also occupy a relatively vulnerable position in terms of access to health in the receiving society due to general factors such as language barriers, location of services, different concepts of health and disease, and bias among service providers and the general society. Undocumented migrants, in particular, are especially vulnerable as they are also exposed to unsafe working conditions and unsanitary accommodation, may be exploited for meagre wages and have limited mobility due to their lack of legal status.

GOVERNMENT RESPONSES

In response to the AIDS crisis, many governments have invested their energies in erecting migration policies characterised by controls set up to serve narrowly defined national goals. Approximately 60 governments around the world have established health screening procedures.[6] These take place in the country of origin – during the work permit application procedure – upon arrival at the border or airport, or after the migrant has been in the country for a while and needs to renew his/her work permit. Migrants are being screened for up to 22 diseases and conditions, including TB, HIV and pregnancy. In many cases, migrants who are found with a positive result on any of these tests are deported or refused entrance or a work permit.

Governments use various arguments to justify mandatory health screening policies: most are based on either economic reasoning or public health/security concerns. However, underlying reasons for their policies are often actually political or moralistic in nature. Governments may state that their policies are motivated by public health objectives, while in fact the main driver is political gain.

One of the main arguments for justifying mandatory testing is the fear that migrants could potentially infect the host population by introducing certain contagious diseases. This is the public health/security argument. The public health argument states that governments have the duty to protect the health of their citizens from virulent diseases. National security is traditionally defined as the protection of a state's territory, population and interests against external threats. The security argument thus follows that it is the duty of states to protect their populations against the importation of disease, meaning the entrance of foreigners who pose a potential health threat. This strategy uses a zero-sum rationale, which means that, in this case, public health can be viewed as a simplified equation that is the sum of the number of individuals in good health. Thus, by giving each individual, in this case migrants, a value of 'healthy' or 'threat', these governments can declare that they are maintaining public health, and have a scorecard to show for it, i.e. the number of unhealthy people disallowed from entering the country.

In some cases the use of mandatory testing, notification and containment are considered to be effective strategies in preventing the spread of highly communicable diseases such as the recent Severe Acute Respiratory Syndrome (SARS) epidemic in Asia; however such strategies are not considered applicable for containing the spread of HIV. Another problem with this line of reasoning is that once allowed entry into the country, migrants' health is given minimal attention. National laws and policies do not consider migrants' well-being and generally do not take any responsibility for maintaining and protecting migrant workers' health and welfare in the destination country. Essentially, they are considered expendable. This is exemplified by the fact that the most common solution to dealing with a migrant worker who is found to have a communicable disease is to simply deport them.

This security argument is closely related to political motivations. Unskilled migrants and people living with HIV are both groups that have historically suffered and continue to suffer from stigma and discrimination. In Asia, HIV continues to be associated with marginalised groups such as sex workers, men who have sex with men, drug users and migrant workers. Migrants are often perceived as abusers of the social welfare system, as criminals and as carriers of disease; they are used as easy scapegoats as they have no political clout to rebut such accusations.

As Somerville and Wilson argue[7]:

> "Migrants are the perfect target group for politicians who wish to be seen as strong and effective leaders to be doing something and not afraid to take tough measures…. Politicians are safe in excluding non-nationals, on the basis of HIV status as they do not enjoy the right to vote and therefore cannot retaliate."

By ensuring that migrants who fail their medical test are barred from entering the country or are deported if found unfit, governments are seen by their citizens as protecting the country from the threat of disease, even though there is limited chance of migrants intermingling with the greater society in any case, while nationals of that country may already be infected with HIV and be the real cause of the diseases spread.

Another argument often used is the economic argument. Destination countries are concerned that the entry of individuals with serious medical conditions will strain the health care system and be a major burden on the economy of the country. Rather than contributing to society, the host country anticipates that these immigrants will eat up precious health and economic resources. This is especially the case with HIV, which is commonly understood as an expensive condition to treat. With the advent of treatment with antiretrovirals (ARVs) and subsequent advances in their effectiveness, policymakers in many countries fear that the lure of ARV therapies could attract an increasing number of HIV-infected immigrants and consequently lead to an unsustainable burden on public health programmes and budgets.[8] As we will see later, this fear was unjustified.

COUNTRIES WITH RESTRICTIONS

An ongoing survey by the German AIDS Federation showed that 102 out of the 169 countries they reviewed in 2005 had some form of entry or residency restrictions applicable to migrants living with HIV.[9] In Asia, the list of destination countries that conduct health screening which includes HIV tests is long; it includes Brunei, China, South Korea, Malaysia, Singapore , as well as the Middle Eastern states of Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates. For instance, in Malaysia, foreign nationals applying for permission to work as unskilled labourers – including domestic workers and builders – are required to undergo HIV testing. If they turn out to be HIV positive, permission to enter the country is denied or expulsion follows. In Oman, there is no HIV testing at the border; instead, applicants for a work or residence permit must present a recent certificate proving that they tested negative for HIV, and any non-national who is discovered as HIV positive will be immediately expelled.

It has to be noted that imposing restricted entrance to migrants living with HIV based on the results of mandatory testing is not limited to Asian and countries in the Middle East only. The United States and New Zealand, for example, require negative HIV tests from non-nationals who wish to apply for residence or a work permit. In fact, the US Immigration and Naturalisation Service conducts the largest mandatory HIV testing programme in the world.[10]

DOES IT WORK?

Opponents to mandatory testing counter the rationale used by destination countries with arguments that either show the problematic side of mandatory testing or undermine the false rationalisations used. First, critics argue that from a public health point of view, the rationale for carrying out mandatory testing and restricting the liberty of movement or choice of residence on the basis of test results as a way of preventing disease is flawed. In a similar vein, critics hold that the economic argument that migrants will create a drain on the economy is hypocritical, considering how much they contribute to destination countries' economies in the first place. Lastly, the other arguments cite the obvious ethical issues and human rights violations inherent to mandatory testing.

Public health arguments

Although HIV is a communicable disease that if untreated can lead to AIDS, which is fatal, it is not a contagious disease in the sense that it is transmitted through direct contact via specific behaviours, i.e. sexual intercourse or sharing of intravenous needles. It is not transmitted through casual or indirect contact. Moreover, its spread can be prevented relatively easily through the taking of certain measures, such as regular condom use. People living with HIV can live healthy lives for many years, without falling sick, and given appropriate access to health information and services, including access to ARVs and the treatment of opportunistic infections, they can keep on working productively without their infection posing a threat to their co-workers. Thus, there is no public health or security reason to deny migrants living with HIV access to a country based on their positive status, nor expel them once their condition is known.

Mandatory HIV testing is ineffective as a public health measure given the 'window period' of detecting HIV, which is the time between HIV exposure and the time when tests can detect HIV antibodies. Hence, a mandatory test upon application for a work permit or at the border can never guarantee that the person entering the country is HIV negative.

By only insisting that migrants be tested, they will also be over-represented in epidemiological data, leading to further stigmatisation and discrimination of migrants as carriers of disease. Moreover, mandatory testing policies focus on preventing the entry of individuals with HIV rather than modifying behaviours, leaving nationals of the receiving country vulnerable to a false sense of security that HIV is a foreign problem or an external threat that can be dealt with by using border controls.

Ironically, the imposed determination of whether a migrant is HIV positive (or as unfit if positive for any other proscribed condition) and using that status to exclude the individual from entry or continued stay in the receiving country, may have the perverse effect of creating incentives for those migrants to avoid legal routes of entry and encourage illegal entry or falsification of supporting documents.[11]

Furthermore, restrictions on migration may lead people who fear testing to enter a country clandestinely, and because of their clandestine status they will have less access to health services. Following that, although based on anecdotal evidence, it appears that HIV-positive migrants and those with other exclusionary conditions identified through screening are more likely to go underground, if they are not

arrested and expelled immediately. The introduction of compulsory measures may therefore mean that those people will delay seeking health care, potentially (and ironically) increasing the possible spread of certain communicable diseases, such as TB.

Considering these negative, unintended consequences, the public health 'pro testing' argument can easily be turned around:

> "When non-nationals are deprived of opportunities to be healthy, this not only endangers their own health, but also promotes denial and discrimination. It jeopardises public health efforts, in particular prevention efforts, thereby threatening the public's health." [12]

Economic arguments

The fear mentioned above, that the availability of antiretroviral treatment would attract an increasing number of HIV-infected immigrants and consequently lead to an unsustainable burden on public health programmes and budgets, has proven to be unjustified. In fact, it is economic opportunity that remains the driving force of migration, not the search for therapies. Moreover, migrants are a significant contribution to countries' economies; they fill major gaps in the service and unskilled labour sectors of many developed countries' economies, doing everything from picking fruit and shelling shrimps, to construction in the hottest climates, to cleaning individuals' houses. Without these migrant workers, the economies of many countries would simply collapse due to ageing and increased economic mobility that has resulted in an outflow of nationals from working in those basic but undesirable jobs that keep economies going. Thus, when the total net financial contribution made by migrant workers to the economy of receiving countries is compared to the costs they will impose on its health care system, the latter is minimal.

Furthermore, the overall demand for health services in developed countries and the financial burden it imposes on a country's GDP is driven by larger and more powerful forces, such as the ageing of a population, increased obesity, expensive medical interventions, and pervasive social behaviours that have a significant impact on health, such as smoking. Any attempt to reduce healthcare costs should be addressed at macro-level issues and should not focus on concerns about the demands that a single group, such as migrants, might impose on a health care system.

ETHICAL AND HUMAN RIGHTS ARGUMENTS

Ethical principles

Compulsory HIV testing and related restrictions on travel and residence raise important ethical and moral questions, which governments that impose these policies conveniently disregard in the face of internationally established principles.

Compulsory testing

One of the most compelling arguments against compulsory testing is that the ethical principles of testing, what are commonly referred to as the 3Cs (Confidentiality, Counselling and informed Consent) are not

followed. Unfortunately, in the process of mandatory testing we find that these basic universal principles of dignity are repeatedly abused or overlooked. In Malaysia, for example, the Foreign Workers Medical Examination Monitoring Agency (FOMENA), a privatised consortium, 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 test, migrant workers are required to sign a consent form, but they are rarely informed about what they are being tested for. They are not provided with pre- or post- test counselling, and often they are not aware of why they have been deported.[13]

Logically, informed consent is problematic in the case of mandatory testing, as the (prospective) migrants do not really have the choice to refuse the test; they will either lose their job or be denied the opportunity to work abroad. Informed consent is also problematic in that it is predicated on the fact that the counsellor needs to be able to communicate effectively with the migrant being tested, which may be difficult when the migrant does not speak the language of the host country. Considering these factors it is important to establish a definition of informed consent.

Obtaining informed consent involves:

- disclosing advantages and disadvantages of testing for HIV;
- listening, answering questions and seeking permission to proceed through each step of counselling and testing;
- verifying that the person can be deemed competent, understands the purposes, risks, harms and benefits of being tested; and
- communicating in a mutually understandable language or having adequate translation provided, including translation of any documents that are signed.

The International Labour Organisation states that HIV testing should not be required at the time of recruitment or as a condition of continued employment. Any routine medical testing should also not include mandatory testing. It should not be carried out at the workplace as is it unnecessary and imperils the human rights and dignity of workers: test results may be revealed and misused, and the informed consent of workers may not always be fully free or based on an appreciation of all the facts and implications of testing.[14]

UNAIDS and WHO also do not support mandatory testing of individuals on public health grounds. However, recognising that many countries require HIV testing for immigration purposes on a mandatory basis, they recommend that such testing be conducted only when accompanied by counselling for both HIV-positive and HIV-negative individuals and referral to medical and psychosocial services are provided for those who receive a positive test result.[15]

At a joint WHO/UNICEF/UNAIDS Technical Consultation on scaling up HIV testing and counselling in Asia and the Pacific in June 2007, these organisations stated that:

> "mandatory and other coercive forms of HIV testing do not serve a legitimate public health goal, jeopardises access to health services, reduces health seeking behaviours and enhances stigma and discrimination." [16]

At the same Consultation, participants recommended that in order to scale up voluntary HIV counselling and testing,

> "countries need to review and revise national policies and laws to prohibit mandatory HIV testing for migrant workers and ensure access to HIV prevention, treatment, care support and referral services in both home and host countries, and advocate for the same through regional and intergovernmental mechanisms."

Exclusion

Health activists argue that mandatory HIV testing and automatic exclusion and deportation are not justified, whether passed on public health grounds or on the basis of excessive costs to public services.

> "There should be a presumption that all visitors to a country should have a right of entry, unless the state can show justification for excluding them; that while the state may exclude immigrants, including on medical grounds, such exclusion should comply with principles of human rights and justice; and that refugees should never be excluded on the grounds of medical inadmissibility." [17]

UNAIDS and OHCHR (the Office of the United Nations High Commissioner for Human Rights)[18] argue the principle of non-discrimination requires, as a minimum, that when States prohibit people living with HIV from residency due to economic concerns, HIV should not be singled out from comparable conditions. When entry applications are considered, humanitarian concerns should outweigh economic costs.

Human rights principles

According to the consolidated International Guidelines on HIV/AIDS and Human Rights, drafted in 2006 by UNAIDS and the OHCHR,

> "there is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to current international health regulations, the only disease which requires a certificate for international travel is yellow fever.Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns."[19]

Further, the guidelines state that:

> "public health, criminal and anti-discrimination legislation should prohibit mandatory HIV-testing of targeted groups, including vulnerable groups."

Despite these internationally accepted guidelines and specific recommendations, very few countries in Asia have repealed existing restrictive measures and legislation. And even when testing is not legally required, requirement for testing might come from agents other than the State, as is evident in the example of Hong Kong, SAR of China. Despite the fact that Hong Kong, SAR of China does not require mandatory health testing, surveys found that 97% of the interviewed Indonesian foreign domestic workers and 67% of the interviewed Filipina foreign domestic workers were submitted to health testing in Hong Kong, SAR of China.[20] This

high percentage of testing comes from the requirement of either the employers or the recruitment agencies; there is no policy or law requiring it.

Compulsory testing

Mandatory HIV testing creates situations where a range of human rights violations can arise. The rights under threat include the right to non-discrimination, equal protection and equality before the law; the right to bodily integrity; the right to privacy; and the right to the highest attainable standard of physical and mental health (the 'right to health'). This is particularly true for many women, who already find their human rights may be threatened or violated on a daily basis because of their sex.

For instance, mandatory HIV testing violates the right to health because it limits the quality of life and puts a burden on those who are already among the most vulnerable (i.e. people living with HIV), especially if it is used as a restrictive measure.[21] It also violates the right to information and education as it is highly likely that people will not search out information if they fear a punitive or discriminatory response because of their HIV status. Mandatory HIV testing also violates the right to privacy. As health is a private matter, every single person should have the right to control information about his or her HIV status. This means that all information garnered about an individual's health, from counselling to the disclosure of test results, should be maintained in a confidential manner; this information should not be disclosed to third parties, including the authorities.

Compulsory testing not only violates the human rights principles mentioned above, but also fuels discriminatory behaviour against vulnerable people, very often by establishing or reinforcing the discriminatory notion of "high risk" groups.

Exclusion

Restrictions that discriminate against people with HIV and AIDS, or people from countries with high rates of reported AIDS cases, violate a number of provisions of international law (and also national laws) that prohibit such discrimination. The International Guidelines on HIV/AIDS and Human Rights state

> "…although there is no right of aliens to enter a foreign country or to be granted asylum in any particular country, discrimination on the grounds of HIV status in the context of travel regulations, entry requirements, immigration and asylum procedures would violate the right to equality before the law."[22]

Any exclusion of a prospective migrant with HIV on public health grounds is discriminatory and inconsistent with current, commonly accepted public health practices.

CONCLUSION

There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. Mandatory testing does little to halt the spread of HIV. Instead, testing reinforces the stigmatisation, discrimination and segregation of infected individuals and migrants. To counteract this, it is necessary to emphasise human rights in the development of laws and policies that cover the health of migrant workers. Furthermore it must be recognised that HIV-positive migrant workers can remain productive for many years and contribute to the social, economic and cultural fabric of both destination and origin countries. In this way, HIV-positive migrants have an important role to play in raising public awareness about HIV and curtailing related stigmatisation that leads to the development of discriminatory laws and policies.

Mandatory health testing policies fail to account for the myriad of factors that can erode migrant workers' health and well-being once they reside within a country's borders. Current border protocols are derived from a fear-based position, and tend to operate from a paradigm of xenophobia. Not enough emphasis has been placed on protecting global public health, which includes migrants' welfare. Moreover, research findings that challenge the adoption of mandatory health testing policies have been ignored for political gain.

Ignorance of one's HIV status can have serious consequences, such as delayed treatment resulting in poor health and related expenses, and the potential of unknowingly infecting others. Research reveals two common reasons why people do not attend HIV counselling: limited HIV testing services, and social stigma and discrimination associated with HIV infection.[23] Both these factors play a prominent role in the lack of HIV awareness among people in developing countries and have resulted in the continued spread of the disease. Often, it is only through health testing to work abroad that people find out their HIV status.

Those living in remote areas remain ignorant of their HIV status because testing services are not available locally, and because they cannot afford the time or cost involved to travel to far-off facilities. Other concerns, such as lack of confidentiality and stigma and discrimination, are also powerful dissuasions for those who may suspect they are infected; in other words, stigma and discrimination continue to be the main barrier to voluntary HIV testing.[24] Ironically, mandatory testing contributes to and feeds this social stigmatisation of people with HIV as needing to be isolated and segregated. Thus, mandatory testing can be seen as a form of institutionalised discrimination that results in the further stigmatisation of those who most need help.[25]

HIV testing and counselling services are a gateway to HIV prevention, care and treatment under the right circumstances. The benefits of the knowledge of HIV status can be seen at the individual, community and population levels. They include the following:

- For the individual: enhanced ability to reduce the risk of acquiring or transmitting HIV; access to HIV care, treatment and support; protection of unborn infants.
- For the community: a wider knowledge of HIV status and greater linkages to related intervention; a reduction in denial, stigma and discrimination; collective responsibility and action.
- At the population level: knowledge of HIV epidemiological trends; positive influence on the policy environment; normalisation of approaches and attitudes to HIV and to AIDS; reduction of stigma and discrimination.[26]

As access to ARV treatment is being scaled up in low and middle income countries, testing rates are still low. Currently, HIV testing services in developing countries are only available to about 15% of those who need them.[27] The cornerstones of HIV testing and counselling scale-up must include improved protection from stigma and discrimination as well as assured access to integrated prevention, treatment and care services. The conditions under which people undergo HIV testing must be anchored in a human rights approach which protects their basic rights and pays due respect to ethical principles of confidentiality, counselling and informed consent.

UNAIDS/WHO RECOMMENDATIONS FOR TESTING PRACTICES

Ensure an ethical process for conducting the testing, including defining the purpose of the test and benefits to the individuals being tested: and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information

- Address the implications of a positive test result, including non-discrimination and access to sustainable treatment and care for people with HIV
- Reduce stigma and discrimination especially within health care settings
- Ensure a supportive legal and policy framework which response is scaled up, including safeguarding the human rights of people seeking services
- Ensure that the healthcare infrastructure is adequate to address the above issues and that there are sufficient trained staff in the face of increased demand for testing, treatment and related services.

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C

METHODOLOGY

A health worker giving a migrant a medical check up in Mahachai, Samut Sakorn Province, Thailand

CHAPTER TWO:

METHODOLOGY

This preface to the country reports details the research processes and methods undertaken by the CARAM Asia partners that participated in the State of Health of Migrants (SoH) Report representing 16 countries across Asia.

CARAM and its partners believe in the value of participatory research as a way of obtaining valuable information that directly reflects the realities of migrant workers, as well as a way of developing the skills and awareness of research participants as part of the movement towards promoting migrant workers' health rights. This participatory value is reflected in the State of Health (SoH) research by the active involvement of partners from the various countries represented in each stage of the research: from the development of concepts and frameworks through to the implementation of the actual research work and the shaping of the report.

To ensure clarity and uniformity in the research, at the outset a framework was established that shaped research strategies for partners to embark on their research at the country level. This was done at a workshop held in Bangkok, Thailand in November 2006. The purpose of the workshop was to give partners a deeper understanding of the issues surrounding mandatory and compulsory HIV testing, and orient them with a rights-based understanding of the issues. Objectives for the research were developed together, as was a concept of 'migrant-friendly testing', which became the basis of the framework for the research.

Working from this rights-based approach, a list of topics was developed relating to testing policies and practices in different origin and destination countries with a special emphasis on migrants' experiences. Other parts of the workshop included assessing current trends and concepts in HIV testing, identifying research gaps in the region, setting indicators, identifying research participants within migrants' communities as well as relevant stakeholders, and developing research guidelines and questions for each group. Participatory research methods and tools and other data collection techniques were identified, and skills in using these methods were strengthened by drawing on the experiences of the SoH 2005 research 'Access to Health.' Throughout the entire process in the workshop, the participating members contributed and often facilitated from their respective fields of expertise and experience, which included the professional research community, migrant workers' representatives, migrant support groups and activists.

This research was divided into three sets of indicators: a) structural indicators, b) impact indicators and c) process indicators. *Structural indicators* reviewed national laws, policies and programmes to ascertain whether they reflected the letter and the spirit of relevant ratified international instruments, and generally

assessed whether governments recognised migrant workers' challenges with regard to health testing. They looked at whether governments made efforts in laws, policies, programmes and budget allocations towards assisting migrants to asses how the interests of migrants in testing procedures are considered. The *impact indicators* reviewed the demographic, labour migration and related health/testing indices available to provide an overview of the migration situation and the forces driving migration in each country. The *process indicators*, of primary importance to the SoH report, link the structural and impact indicators to the reality played out on the ground by focusing on how national laws, policies and programmes related to testing are actually implemented. This was done by gathering the viewpoints and experiences of relevant stakeholders, and was checked against the experiences and insights of migrant workers in each participating country to assess the real impact these practices have on migrants' lives, health and well-being.

The majority of research was then carried out in the following months. In November 2006, as an outcome of the first workshop, a five-member SoH work team was initiated and was charged with the responsibility of coordinating and facilitating the process and progress of the research among the different partners and to provide necessary technical support as needed. Three members of the taskforce visited partners in their countries to further oversee and support partners' field research and data analyses. An extensive exchange, sharing of experiences and question-answer sessions through e-mail provided instant facilitation to the entire research process and provided transparency.

DATA COLLECTION

The SoH research allowed a wide range of female and male migrant workers in participating countries to give accounts of their direct experiences with mandatory testing through direct interviews and group discussions. Groups of migrants that participated in the research represented all ends of the migration stream: prospective migrants, including those who were deemed temporarily and permanently unfit (at origin countries), migrants working at destination countries, and returnee migrants, including those living with HIV, some of whom had been deported as a result of testing. The occupations held by migrant workers were diverse and highly representative of the gamut of jobs that migrants take in most destination countries: domestic work, construction and factory work, sales, hotel and restaurants, chauffeuring, seafaring, seafood processing, and the entertainment industry. Collectively, they identified issues and obstacles regarding testing that have a real impact on migrants' lives, and as a result, recommendations and possible alternatives emerged filling in the concept of 'migrant-friendly testing'.

The perspectives of relevant stakeholders were also actively garnered, including interviews with government policy makers, ministry officials from health and migration sectors, officials from National AIDS Councils, testing authorities from both government facilities and the private sector, immigration authorities, recruitment agencies, migrant training centres, workers in health care facilities, HIV positive care and support groups/networks and NGOs working on migrant issues.

The field research adopted fundamental participatory principles, and used various standard methods and tools. Focus group discussions (FGDs) and in-depth interviews (IDIs) were the key methods utilised in most countries. FGDs were used with groups of migrant workers, on average ranging in size from 6 to 12 participants. IDIs were commonly used for stakeholders as well as with migrant workers. Besides the more

conventional qualitative techniques, participatory learning and action (PLA) methods were used, in which the emphasis was on allowing people to freely explore their emotions, insights and perceptions. The PLA methods commonly applied were the balloon opinion exercise, the bubble method, mapping, and priority ranking. These participatory and visual methods enabled migrant workers to express themselves more freely in regards to how testing impacted them. Interviews and focus group discussions used semi-structured guidelines, rather than closed-ended questions, to allow a freedom of expression and thought by participants. Participating migrant workers and stakeholders could question and comment on the research process, and some collaborated in modifying this process. In Hong Kong, SAR of China, the qualitative research was complemented by a quantitative survey, where a questionnaire with closed questions was given to 108 Filipinos and 97 Indonesians domestic workers.

To ensure accuracy of information and to clarify the understanding of some issues, information was usually triangulated, meaning that information that came from migrants was posed to stakeholders for verification and visa-versa. Direct observation of health testing sites for migrants was done in all countries so that researchers could have a chance to see the actual conditions of testing facilities. Some partners were even bold enough to actually undergo the actual testing process by posing as prospective migrant workers in the Philippines, Pakistan and Sri Lanka. CARAM-Asia holds these people in great esteem for their commitment to the work, and commends them.

Table: Key methods in SoH Research
FGDs and IDIs conducted among Migrant workers and Stakeholders in Partner Countries

Country	Number of IDIs with migrant workers	Number of IDIs with stakeholders	Number of FGDs with migrant workers
Bangladesh	5	13	6
Bahrain	9	9	4
Cambodia	18	13	10
Dubai	26	6	10
Hong Kong, SAR of China		25	8
India	40	23	14
Indonesia	5	10	6
Japan	5	4	
Korea	3	3	4
Malaysia	3	7	4
Nepal	9	11	3
Pakistan	12	17	8
Philippines		9	6
Sri Lanka	18	17	10
Thailand		4	5
Vietnam	2	11	4
total	**155**	**182**	**102**

DATA ANALYSIS

All data that was collected through participatory activities was transcribed, translated, and then coded. This ensured that all quotes used could be referred back to the proper source. It was a tedious and time consuming process, but ensured reliability of information and accountability to the sources, especially when quoted in reports.

A second workshop was then held in Kuala Lumpur, Malaysia in March 2007. This workshop brought together the researchers from each of the 16 partner organisations to promote consistency of results. The workshop focused on improving partners' skills in qualitative data analysis and report writing. To streamline the analysis of the amount of qualitative and quantitative information gathered, guidelines for analysis at country and regional level were developed and agreed upon by all research partners. Presentations were given on initial results, giving the work team an opportunity to provide feedback and assess potential weaknesses in the reporting.

Research partners sent their first reports to the SoH taskforce, who made necessary comments and feedback. Once the individual country analysis and report writing had been completed, validation activities were conducted in some countries to confirm that the partners' analyses reflected the reality of the migrant workers. This was done by revisiting research participants or representatives of similar migrant communities to share their findings and confirm the analysis results, while allowing feedback. Some sent copies of the country report to migrant workers' networks and concerned stakeholders for their comments, while others held formal consultation meetings with key stakeholders from migrant forums, testing centres, recruiting agencies, NGOs and government sectors for validation. Proposed changes were incorporated to make sure that the final report is acceptable to all concerned: migrant workers as well as stakeholders. These country reports will be used as the basis of country level advocacy efforts. To fit in the regional report, each country then pared down their country report to a standard length.

Finally, using the regional analysis framework, information from all the country reports was analysed and drawn on to develop the Regional SoH report, which looked at the issue of mandatory testing in both origin and destination countries. In May 2007, a final analysis meeting took place in Malaysia to shape the regional analysis and finalise recommendations with the participation of work team members and representatives of SoH partner organisations. Lastly, recommendations intended to bring 'migrant-friendly testing' to fruition were drawn up targeting stakeholders, policy makers and enforcers (mainly governments), based on the experiences and needs voiced by migrant workers.

C

ORIGIN COUNTRIES

Blood being drawn in order to fulfill testing requirement to secure employment

Bangladesh

Bangladesh is a major labour sending country, where foreign migration for employment has been a growing phenomenon as a reaction to the widespread unemployment and underemployment that has prevailed in the country for decades. For this developing country, with its small geographic area of 144,000 square kilometers and a projected population of 150 million in 2007, foreign employment is seen by many unskilled or semi-skilled people, mostly from rural communities, as the only way to break free from the vicious cycle of poverty.

In this regard, the Government of Bangladesh (GoB) has been active in trying to maximise the potential of overseas migration and enhance the flow of remittances. The Bangladesh Bureau of Manpower, Employment and Training (BMET) was established in 1976 with the responsibility of monitoring the flow of overseas migration. Then the Ministry of Expatriates' Welfare and Overseas Employment was established on 20 December 2001, to ensure the welfare of expatriate workers and the enhancement of overseas employment. According to BMET sources, the number of documented Bangladeshi migrant workers who went for employment overseas in the year 2006 alone is over 3,500,000. Their remittance exceeded $4.9 billion, contributing about 32% to the national GDP.

The number of documented migrants is estimated to be almost equal or just a little less than the numbers who go abroad undocumented. During recent years, a gradual increase of Bangladeshi migrant workers in Asian countries has been recorded, with Saudi Arabia being the most popular destination. Up till October 2006, the total figure of documented migrant workers who had left the country since 1976 stood at 4,461,562, amongst which the top destinations were Saudi Arabia (2,196,271), UAE (651,516), Kuwait (467,596), Oman (246,327), Bahrain (130,001) and Qatar (100,519). During this period, Malaysia (269,821) was the most sought after destination in the Asian region, followed by Singapore (140,487) and South Korea (17,949)[1].

The Ministry of Expatriates' Welfare and Overseas Employment, GoB, came out with the External Migration Policy in 2006, which addresses some important issues faced by migrant workers. It does not, however, mention health or medical testing at all. One of the main pre-requisites set by receiving countries for employment is being medically fit. Hence mandatory medical testing is a necessity for overseas employment of Bangladeshi migrant workers, and the standards and requirements of medical tests are governed by the receiving countries. The new formalised External Migration Policy or National Policy on Health does not mention any specified rules for mandatory medical testing of migrants. However, the National Policy on HIV/AIDS and STD has directive guidelines on HIV testing, which mentions protecting the rights of all those who have undergone testing or will go through testing in the future. The policy very clearly states that

> "Mandatory testing and other testing without informed consent have no place in an AIDS/STD prevention and control program." [2]

It does not protect any specific population group but it does mention migrants,

> "Screening for HIV infection or other STD will not be mandatory for travellers or migrants into or out of the country…" [3]

The only policy which does mention medical testing for migrants specifically is the recruiting agent's Conduct and License Rules, 2002 which states,

> "Arrange the medical examination properly." [4]

However, there are no specific laws on testing in the country. Although mandatory testing is not supported by the GoB National HIV/AIDS policy, in practice testing is adhered to, responding to the demands of receiving countries, and which are formally stated in existing Memorandum of Understanding (MoU). For example, in the MoU on the recruitment of Bangladeshi workers between the Government of Malaysia and the Government of the People's Republic of Bangladesh Article vi. states *"….comply with Malaysian medical requirements."* C. iii. Pg.10 of the same states that

> "The workers shall bring along a copy of the medical examination report and to be shown upon request at the entry point…..All medical examinations and procedures shall be governed by the terms and conditions determined by the Ministry of Health Malaysia."

Although testing is incongruent with the national policy on HIV and STDs, the government has little or no bargaining power in the matter.

PRE-DEPARTURE

In the process of migration from Bangladesh, the most important stage and the greatest deterrent for a potential migrant worker is undergoing medical testing. This is ingrained in the minds of potential migrant workers from the very first contact with their agent or broker. They are very clearly told that in case of an unfit report, their chance of going abroad is next to impossible.

> "It's a prerequisite for getting a job abroad, for going, we first needed to have the database and then we are told to do the medical test.The agencies say that.That means for gaining passport medical test is to be done." (Returnee male migrant worker from Korea)

The potential migrant workers, mostly uneducated or low-educated, coming from rural areas, are completely dependent on the brokers or recruiting agencies for any information regarding the migration process. This ignorance, along with their desperation to go abroad, makes them blindly follow all the procedures they are told to pursue. The person is informed by their agent or broker as to where and when he has to undergo medical test; there is no choice.

> "When the middleman informed us about medical testing, I asked him where the place was. He told us to go to Fakirapul. One man (staff) took us there because it was an unknown place for us." (Potential male migrant worker)

Most of the time this implies that the migrants have to travel long distances as most of the testing centres are situated in the capital Dhaka, except a few in the two major cities of Chittagong and Sylhet. This travel adds additional financial burden onto poorer migrants, who also have to bear the cost of the medical test.

> "We people come from Chandpur by first trip and get back home the same day after doing the medical test.The agency does not give us any support.Those who come from outside they live in Fakirapul (in Dhaka) and by the roadside, or in the hotel." (Current male migrant worker from Malaysia).

> "It takes 160/170 Taka excluding food and other stuff.The per day cost amounts to nearly 350 Taka to 400 Taka ." [5] (Another current migrant worker)

This is one of the main reasons that test results are received by agents, to avoid making the migrant worker travel again.

Medical testing centres in Bangladesh are either approved by the government under the Directorate General of Health Services (DGHS) office or by bodies set up by receiving countries like GAMCA (Gulf Approved Medical Centres Association). For GCC countries, the GAMCA centres follow the detailed range of tests as guided by the GAMCA Rule book. The non-GAMCA centres follow almost similar tests as well, which might differ on the basis of destination country requirements. There are a total of 34 GAMCA testing centres in the country among which 27 are in Dhaka, 4 in Chittagong and 3 in Sylhet. These are well regulated, controlled by the central GAMCA office, where the migrant workers have to be registered first and distributed equally among the GAMCA centres for testing.

However, there are an unknown number of non-GAMCA testing centres in the country. Some of these incorporate testing within general medical services already provided, but many are established specifically as testing centres, solely targeting migrant workers and competing for clients, as shared by one owner, *"The centres who could do marketing best, they used to get most of the work"*. These centres seem to be working in close association with recruiting agents. This association shifts the focus from quality testing to marketing testing and makes migrant workers a commodity, giving rise to opportunities for exploitation.

Through a direct visit to one such centre, it was found the clinic was staffed with 2 untrained lab technicians and one part time doctor running the entire set-up. The same centre employed 5 brokers to maintain links with recruiting agents, and paid them commissions to ensure a supply of migrant workers to that particular centre, even though the facilities and environment were observed to be very poor. It is found that even the payment for medical testing is made to the recruiting agent, which could be much higher than the actual cost. A migrant from the beginning is kept in total ignorance, is given no choice what so ever on the matter of selecting a centre, and is often exploited severely, as expressed by a potential male migrant worker having completed testing,

> "They are fleecing us. What can we do? We need to go abroad! They never allow us for selecting particular testing centre as per our choice."

Another Saudi returnee male migrant worker said,

> "They took 7 thousand taka from us. We ourselves gave the money to the medical centres. The medical test for Saudi Arabia is 2150 taka."

Although the actual fees may vary from Taka 1000 to 2100 depending on the destination country (GCC and non GCC), through the various steps involving brokers, sub-agents and main-agents, the migrant workers often have to pay a much higher cost and are tricked into a binding relationship with the agent, as explained here by a returnee migrant worker from Malaysia, who has much experience on this matter;

> "…There are three types of agencies: Broker, Sub-agency and main agency. When the sub-agency delivers us to middle agency then they do medical test for 40-50 taka just to have mental satisfaction. Rather I personally believe it is an absolutely bogus thing.We do it instantly to convince the clients that the visa is in process. By sub-agency I mean that the broker is told to collect some people for which he will get a commission. But sub-agency gives to middle agency and middle agency to direct office or someone else. For accepting the comment "I will go abroad", they take 20 thousand taka. Later I saw this test was totally valueless. I know they took five thousand taka for medical test."

Consent by migrants to undergo testing is not an option even in standardised GAMCA testing centres, as found in the research. None of the migrants, prospective or returnee, who had undergone testing in Bangladesh, indicated that they had to give consent for testing or were told about the procedures, as reflected here:

> "No advice or consent was given to us. We just submitted our passport photocopy only." (Potential migrant worker having completed testing)

As for the staff at medical centres, the very fact that a migrant has come to a centre and has an appointment seems to imply that they have agreed to be tested.

> "We could not test unless one has a medical appointment.When a patient makes an appointment then we take it as consent." (Medical officer, non-GAMCA medical centre)

Further to this, no information is given about the tests either, as shared by the Office Executive of a GAMCA Centre:

> "No, we don't give any information on testing to the passenger because if we give them information then they will try to influence us".

It is evident that a prospective migrant is not informed about the tests they have to undergo either by the agent or test centres. Most pleaded ignorance to the tests performed except that they gave blood and urine, did an X-ray and body-check, but had no idea what was being tested. This included not knowing if HIV testing was done or not.

> "I do not know what happened after taking blood, urine or X-ray." (Potential male migrant worker)

None of the testing centres visited during the study offer any pre or post test counselling, a fact which is also confirmed by the migrant workers.

> "No, as far as I know in this country this kind of counselling is not done." (Returnee male migrant worker from Malaysia)

The physical examination is perceived by most research participants as a very degrading and humiliating process, involving as it does a complete undressed body-check.

> "In our country it is excessively done. In Bangladesh everything is seen, we undress." (Returnee male migrant worker from Malaysia)

Others present at the focus group discussion nodded in agreement. Although it is widely practiced, it is in fact not a formal requirement, as shared by the Office Executive of a GAMCA Centre:

> "Yes, to do physical test, people has to be completely naked. No, this is not a GAMCA instruction, we do it ourselves.This is to check mainly the skin diseases.There is lady doctor for women.The number of female patients is very few, only 8 to 10 woman in a month.We give a certain time to gather all the female passengers and then do the physical test (by a lady doctor)."

This situation could be much worse for some prospective female migrants, as observed in a non-GAMCA centre, where there is no female doctor and so a male doctor performs the body-check with the assistance of a female attendant. However, the prospective migrants feel helpless, never question the procedures and abide by the instructions of testing, all because of the hope of going abroad.

> "... my urine and others were taken for tests. After taking all these they opened my underwear. He (doctor) pulled my penis to see if I had any problem. Then I didn't have the courage to bargain with him. But I still remember that fear. I had to go abroad and had to comply with it. I have a lot more to say but it will take time to explain. In the medical centre I was shunted and was asked why I talked too much. Then without quarrelling with them I came back arranging my clothes. It was my bitter experience." (Returnee male migrant worker from Malaysia)

Although the attitude of medical centre staff in most cases was said to be friendly and helpful by the migrant workers, the competence of medical staff remains questionable in some non-GAMCA medical centres that were visited. Some of the lab staff were found to have no formal training. A potential male migrant complained:

> "I suffered this problem when I went a centre and two young staffs were taking blood they repeatedly couldn't find the vein.".

The non-GAMCA clinics, especially the smaller ones catering solely to the testing of migrant workers, were clearly operating purely for profit. They were lacking in hygiene, their toilets were dirty, there was a lack of separate facilities for females, and often they did not have all the testing facilities available. They were also dependent on external medical centres where they sent samples for testing. At least one such centre claimed to do confirmatory tests of HIV positive results, even though they only perform the Elisa test, and seemed to have no clear concept about this.

On the other hand, some non-GAMCA but large establishments like Modern Diagnostic Centre Ltd are ISO (International Standard Quality) certified medical centres. Here there is compliance with the high quality standards of testing: equipments are sophisticated and modern, and confirmatory tests are provided for all, including HIV. GAMCA centres too were observed to be maintaining good standards of operation,

with proper seating and clean, separate toilet facilities for females and males. They send the HIV cases to ICDDR,B for confirmation, similarly for hepatitis B and C, and do the confirmatory tests themselves. However, none of the GAMCA or non-GAMCA facilities make any provision to inform migrant workers regarding testing procedures, policies or instructions for unfit, or temporarily unfit clients.

In most cases the time taken for delivering the report is 2 days although it can take up to a week. The results are almost never given to the migrants themselves; their brokers or recruiting agency collect them, or they are given directly to the authorities in the GAMCA office. The confidentiality of test results therefore seems to be of no importance in the context of migrant worker's medical testing. Besides, this ambiguity with test results just adds to the anxiety the prospective migrants go through, making them more vulnerable to the schemes and designs of the agents to manipulate and extract more money from them.

> "The report is not given to the patient.There remains a gap. Sometimes the owner of the travel agencies tells us that we are unfit to earn some money." (Current male migrant worker from Malaysia)

Moreover, unfit people are not informed on their actual result, let alone given counselling, treatment or referral; only an unfit result is given, by both GAMCA and non-GAMCA testing centres.

> "If a passenger is fit, then we give the entire test result and Fit Certificate. If unfit, then we give an unfit certificate where we write the reason for unfit. No, we don't give the entire test result reports to an unfit person." (Office Executive , GAMCA Centre)

This is a clear violation of the National Policy on HIV/AIDS and STD policy that states,

> "Neither physicians nor anybody else are free to notify any other person other than the person tested of the test results, unless on the request of the person." [6]

Further it states:

> "The person requesting the testing has the right to know the result." [7]

Referrals are almost non-existent; some centres simply stated they made no provision in this regard. One non-GAMCA centre proprietor did express the need for something when he said:

> "There are 900-1000 migrant workers coming in Dhaka city everyday.Among them 12% are unfit due to HBsAg.We should pay them attention."

However, two centres reported that they give a prescription to the temporary unfit people and ask them to return for a re-test after the treatment is taken. This seems to depend solely on the attitude of the testing centre, based on which the fate of a prospective migrant could be decided and great financial loss faced, as explained below:

> "The people who fail test here, for SGPT, Serum Bilorubine, skin diseases like chaud (exima), daud etc… we give them prescription. GCC countries told us if someone has skin problem, then send him to skin specialist. If he gets well then give him fit certificate later. Arabians are scared of skin diseases. Many testing centres make people unfit because of skin diseases. This is not right. Many passengers become very afraid, thinking, "What happened to me?" But it is nothing serious. People should not

> be made unfit only because of skin diseases. Another thing is calcification, which is a spot in the lungs. People do not suffer for this. But centres are making people unfit for this. It is not right. Many medical centres make people unfit for pressure or diabetes. But it can be brought under control.We give them prescription and ask to come again later for testing. We don't make such cases unfit at first time, for example this sugar thing.We try to bring it under control.We re-test second or even third time until the condition is normal. Such diseases which can be controlled, people should not be made unfit.They have to be advised to bring it under control and reappear for testing. People invest lots of money to go to foreign country. They give about 200,000 taka for this to the agency. But if they become unfit, they don't get the refund like this.Agency gives in broken amounts 10 or 20 thousand taka at a time. It takes a long time to recover the money, it is a great loss and very painful for them." (Office Executive, GAMCA Centre)

The lack of referrals and treatment facilities is evident. This has also given rise to the practice of a 'pre-medical', to anticipate such unwanted detection and being declared permanently unfit. Here, some prospective migrants are instructed to take these 'pre-medical' tests prior to the final medical test, thus adding to the cost, time and efforts invested. As explained by the Manager of a non-GAMCA Centre:

> "We do the pre-medical, don't do the final medical. Pre-medical is the passenger check himself, they test to be on the safe side. After doing test at my place, they will test again at GAMCA testing centre. They will submit their name and particulars at GAMCA office, take slip and go to the specific centre that GAMCA will send them. They do testing themselves before going to GAMCA, because say for example he knows he has a medical problem or suspects that he might have a problem. If they go first to GAMCA, pay 1,800 taka to do medical test and found unfit then there will be a seal marked on his passport. He won't be able to go again. If he tests here first and know the disease then can take treatment and get cured before going to GAMCA finally. Or don't go and waste the money in GAMCA at all. If someone goes to GAMCA first, then he doesn't have any chance to take medicine and can get unfit permanently. If they are unfit in pre-medical, then they apply medicine. May be he has got chest infection. He goes to chest specialist, take medicine for 15 days or 1 month. After getting cured by taking medicine, then retest again and if found fit, only then goes to GAMCA."

This however could have been avoided if the necessary treatment or referral services were a part of the migrant workers' medical testing, which unfortunately is not the case in Bangladesh.

Unlike non-GAMCA centres, which do not follow any reporting system, the GAMCA testing centres have to submit regular reports to GCC countries, but the GoB does not have any involvement or information in such reporting, and thus, any opportunity for formal referral to treatment, care and support is thereby missed.

> "Yes, we make quarterly compiled reports of all the fit and unfit test results done. I send by e-mail and also the hard copy by DHL to the GCC office in Riyadh. No, the Bangladesh government doesn't know anything about it. No, can't give you the report. But yes, I can tell you in general that among the unfit cases, the highest is for HBsAg, syphilis, HCV and X-ray for TB, implemental lesion and calcification. HIV cases are very few, this year we had only one case." (Office Executive, GAMCA centre)

Even for the confirmed HIV positive cases, no counselling is available within the testing centres, or any other support services, as admitted by GAMCA office and the testing centres visited. However, one GAMCA centre reportedly referred a person to NGO facilities for counselling services, and another non-GAMCA centre shared that they do advise persons to go to one of the listed government centres from a list that was provided by the DGHS office, but both remained doubtful whether the unfit person followed their advice.

> "We do maintain database which send quarterly to GCC ministry. We do not know about the consequence of unfit person because it is settled by the testing centre". (General Manager, Central GAMCA Office, Dhaka)

> "It is not our duty to counsel HIV positive cases. But we informed JAGORI of ICDDR,B about the HIV positive person. Don't know if they did anything to help him." (Office Executive, GAMCA Centre)

> "If we get HIV positive confirmed case, then first we send the sample to PG. Give the report to manager.We have list of organisations by DG health where we refer them for support." (Lab In-charge, non-GAMCA Centre).

> "No, we don't counsel the HIV positive persons.We refer them to certain places.We were given a list by DG Health of certain NGOs who gets help from abroad to serve AIDS patients and were asked to send the positive cases to those organisations. We were given the list in 2005 when we attended a seminar organised by DG Health. Since then we are sending AIDS patients to those organisations." (Manager, non-GAMCA testing centre)

In their desperation to seek employment abroad, many such unfit persons try to adopt strategies with the help of recruitment agents, which makes them even more vulnerable to financial loss and exploitation. Upon getting an unfit medical report, the brokers and recruiting agency might offer solutions to the migrants, as was revealed during the research by posing as an unfit prospective migrant and approaching a recruitment agent for help. The agent said:

> "You want to make unfit result fit? Yes, I can help you to solve this problem. Where are you going? Dubai? If you pay 700 taka then I can make fit report. For GAMCA you have to go to Chittagong and it will cost you more, about 8 thousand taka it will take 8 to 10 day's time. How I will do it? That you don't need to know. I have my ways".

Although the GAMCA centres follow strict rules and report the unfit results to the central GAMCA office, but they are not shared between centres in 3 districts. Due to lack of coordination between the testing centres in different cities, manipulation and violation of rules seems to be possible. Moreover, the desperate migrants even take the trouble of changing passports and reappear for tests, as expressed by the GAMCA Office Executive:

> "Unfit persons can't be tested again in a GAMCA centre in Dhaka because all their details, agency name, passport numbers are also on record.To test again, he has to come after changing his passport. He has to spend 8 to 10 thousand taka for this.This is not right.This is violation of human rights.The agencies just make people suffer to earn money. If one unfit person is made fit, he will be caught finally anyway after arriving in the foreign country".

He further added:

> "Unfit people are shocked usually to learn the result, one person even became senseless. If a person becomes unfit, then they try hard to make it fit. Many a time people come to us to make contract. They come and say,"I have this problem, can you give fitness certificate?" We don't do such thing here at our centre.They ask the recruitment agent to help. Unfits can be made fit in many places, it is what we have heard. But they will get caught afterwards in foreign country. All the GAMCA testing centres in Dhaka, Chittagong and Sylhet should be brought under one system so that forgery can be stopped. Passengers should be made aware of the dangers of making unfit results fit by doing forgery, that they will face financial loss and sent back home finally from foreign country. Passengers create pressure to make unfit result fit. Recruitment agency also help them and try to create pressure even though they know that these passengers will become unfit in foreign country and return back home. This should be stopped."

It seems that the brokers and agents have their own nexus with the testing centres; it is all about fleecing the migrant for as much money as possible at the end. They are earning handsomely from each migrant in the name of helping them to pass the medical fitness, hence they encourage the migrants to take on illegal paths.

> "Before that one person from Banani told me that you have this disease - is it? "Give me money and I will send you abroad.This was not any problem". He was a broker. He sent people. He wanted 200,000 taka from me." (Deported migrant worker from UAE)

Monitoring of testing policies, procedures and test centres

The DGHS, Ministry of Health, GoB is responsible for issuing license to testing centres, pathological labs as well as maintaining monitoring standards. But the Office of DGHS does not specify testing labs for the purpose of migration. There are no standardisations or guidelines available for testing centres from the government. The Director, Hospital and Clinic Office of DGHS shared:

> "Ministry of Health does not have any policy. We work under Health Ordinance of 1982. But we do work for the help of other ministry like MOEWO (Ministry of Expatriate Welfare & Overseas). Regarding this matter, we do not have anything to do. We do not have any involvement. We know a good number of people have been medically unfit."

In fact, monitoring of testing centres largely depends on their affiliations. The small migrant worker based testing centres seems to be operating to their own rules, neither subject to any form of regular monitoring or supervision, nor having to make regular reports to anyone. However, they do mention receiving visits by Ministry of Health officials when licenses are issued and renewed every year. This so-called monitoring seems to have no impact on the issue of the quality of the services, since in most of the observed centres bad infrastructure, lack of trained medical staff, poor hygiene, and lack of necessary equipments were very common. On the other hand, larger non-GAMCA medical centres maintained good standards and reported having mobile team visits from DGHS office, but they also do not need to provide regular reports regarding the testing of migrant workers.

In the case of GAMCA centres, the monitoring is rather strict and the quality has to be maintained, as set out in the guidelines provided in the GAMCA Rulebook, since there is a high penalty for defaulters. In the first place, the selection of the GAMCA centres goes through strict procedures as shared by the General Manager, GAMCA Office:

> "Personnel from GCC Health Ministry come to our country and visit different testing centres in Bangladesh for enlisting new members.We have nothing to do with selection of new members. GCC Health Ministry selects the test Centres as per their selection criteria."

As for monitoring, a surprise visit each year is made by a specialist pathology team from GCC countries that visit centres and punish the defaulters. Again, following the General Manager:

> "There is general procedure followed for punishment. We measure on the number of fault cases then make decisions according to the degree of cases with punishment criteria: For 200 fault cases: License cancellation + Financial compensation, For 150 fault cases: Short term cancellation + Financial compensation, For 100 fault cases, Financial compensation."

The same was confirmed by the GAMCA centre's Office Executive:

> "Everything here is done as per GAMCA instructions.We are very careful about our testing standard. If people fail test after going to GCC country, then there is penalty system. If there is 1 to 3 such fault cases in a year, then there is penalty of 1 thousand up to 9 thousand dollar. A centre can be held-up or cancelled also. A GAMCA team from GCC country visits us once a year.They bring the reports of such failed test cases with them. Some centres have 54 or 55 cases, even 100 or 200 cases were also brought. They have even got HIV. But they haven't cancelled the facility. So the medical centres think that if we earn 100 percent and give 1 percent fine then that's all right! But this is not good".

While this remark reflects that the sole focus of GAMCA monitoring is on the accuracy of test results, it misses the human aspect of a migrant's testing that concerns their satisfaction, access to information, consent, counselling, treatment and referrals. Also, this remark seems to touch upon the business motive of testing centres, and questions the effectiveness of such tests. As the manager further continues:

> "We do the medical and give the date's seal.The validity of medical card is 3 months. If a person can't go within 3 months of his medical test done, then he has to undergo testing again. People can get diseases within this time also. So it is my suggestion to GCC countries to make it clear that up to how many months after going to their country, if people are tested unfit then we will be responsible for that"?

The observation clearly shows the ineffectiveness of such testing, since a person with a fit certificate might very well get the infection after the tests done within the home country or upon arrival in destination.

ON-SITE

In most countries a migrant worker has to go through a medical test at the time of arrival and subsequently for any renewal of their visa. This generates a great deal of fear and anxiety, mostly because an unfit result results in strict deportation.

> "During medical, doctor asks do you have any problem? We say, "No". Already we are in fear what will happen if we become unfit. So much fear, our heart becomes cold! Allah, what will happen? Allah knows best what will happen." (Returnee male migrant worker from Malaysia)

The frequency of tests depends upon the destination country as well as the kind of occupation one gets employed in: for example, in the food industry the test is done each year, whereas construction workers have to test every 3 years (in Dubai) or only once on their arrival (in Bahrain). Some migrants feel that once they are on foreign land, the testing procedure is much more dignified than in Bangladesh itself, mainly because a naked body-check is not required in most destination countries.

The cost of tests are usually borne by the large companies, but often many migrant workers in disadvantaged positions find themselves bearing the costs on their own. The research shows that there is no formal information available on testing policies, procedures or even test results for migrant workers in the destination countries either, and there is therefore little preparation for the shock that awaits a positive result.

> "You have to do medical test in Malaysia. Even if you do medical in Bangladesh, you have to do medical again in Malaysia. We are doing it each year in Malaysia. I am working for 13 years in Malaysia. I have medical test 13 times in 13 years.There it takes 180 ringgit for medical.The big private companies give the medical cost themselves. Small companies, who have 5-6 workers, they don't pay, workers have to pay themselves for medical.There first 3-4 years they used to check body by taking off all the clothes. After that, no more. Before they used to test blood by pricking in the finger and taking only small blood on a glass plate. Now no more. Next they used to take one syringe full of blood. Now they take two syringe full of blood. After going to Malaysia, I have given 2 kg blood! No, nobody tell us anything about the test.They take blood, urine, X ray, height, weight. Report goes to the employer. I don't know anything about the report." (Current migrant worker in Malaysia)

> "They told me to get out of the car. I was taken to the hospital (for testing).They did not say anything else. Our office told that they will take the medical test the next day." (Returnee female migrant worker from UAE)

Not much was reported on the subject of confirmatory tests or any system of referral. Only in Saudi Arabia was confirmatory testing mentioned, otherwise most reported that on being tested unfit they were simply asked to leave. In most cases they were not even given the reason for being unfit, and without notice or compensation were asked to leave the country, making them go through great psychological and social trauma.

> "I did not know anything about the disease before. One Bangladeshi boy told me that I was HIV positive and I should have back to the country. There the counselling is not done. The Bangladeshi doctor secretly told us.Along with me there was one woman who came back to the country as well." (Deported HIV + migrant worker from UAE)

> "If someone is unfit, then he will be sent back home.They have sent back many people. From my own factory, they have sent 20, 25 people.They don't send back for general diseases.They send back home for TB, AIDS, Jaundice, for these disease.We have seen it like this, say he is working. He doesn't know anything beforehand. He has become unfit. Employer will make the ticket and then will call him from work. If he is informed beforehand, he will run away or will have anxiety, "I have come by spending so much money, and now I have to go back!". So he is not told anything before. He will be told to pack his clothes and then he will be taken to the airport. That is why everybody is afraid of medical. Who knows what will happen if we do medical. I am there for many years, still if I become unfit they will send me back home. No, they don't give any medicine.They say go to Bangladesh and see a good doctor. Have treatment.They give the due payments. Company gives the ticket. Nothing extra is given. If any big kind of injury or loss happens in this country, then there is compensation. For example, if you cut your finger, or loose your eye, then they give insurance money. But if you are unfit in medical, they don't give anything.They are just sent back home then and then." (Returnee male migrant worker from Malaysia)

REINTEGRATION

Going for overseas employment is the only resort for many people in attempting to attain a better future for their families. They invest all their life earnings, and even borrow at a high interest rate to go and work in foreign lands. Thus being found unfit, whether in the home country or abroad, shatters all aspirations and dreams of not only the person, but the entire family, leaving them vulnerable not only mentally, but also financially and socially. The case is even worse for a HIV positive migrant worker, especially those who have been deported back. Social acceptance of persons with HIV is negligible in Bangladesh. This, coupled

with lost hopes and ruined investments, leaves a person very isolated and helpless. In the absence of any information or formal referral systems to care and support groups for persons with HIV in the country, many suffer alone and are left to survive on their own. Although there are calls for compensation and rehabilitation for deported migrant workers, much remains to be done.

> "While doing Akama in Saudi Arab I was found HIV+. I was sent back to the country within two days…My wife hates me very much. She attempted suicide with 40 litres octane. My children do not come to me. My wife does not let them come near me. I feel very bad. I have been very sad for the last 30 months." (Deported male migrant worker from Saudi Arab).

> "The government does have some provisions for rehabilitating deportee migrants but this is usually not accessible to people easily, neither are the migrants aware of such provisions. We try to compensate some portion of the loss though the compensation is not enough.The Government of Bangladesh has a fund in this regard but migrants have not received any compensation from this fund. When these sorts of cases come we refer them to BMET." (Personnel from recruiting agency)

> "There are support groups, NGOs for HIV positive who work on rehabilitating the infected persons. While doing Akama in Saudi Arab I was found HIV+. I was sent back to the country within two days. After coming back to Dhaka I did the Akama test in Farmgate Green Super Market. Then I went to Jagarani. They did my counselling. They did it free of cost. At first I did tension a lot. By the by the tension is overcome." (Deportee male migrant worker on being tested HIV+)

> "If I have become unfit and sent back home, then I will become the loser. I should be given compensation. I have worked for so many years in the company. If I am given 1 lakh or 2 lakh taka, then this could be my capital.With this money I can do business and earn a living. Or, the medical unfit people return empty-handed, losing all their money and job". (Current male migrant worker from Malaysia).

Cambodia

The Cambodian economy is predominantly agrarian, with agriculture employing 73% of its population Chronic poverty, landlessness, viable livelihood options and natural disasters such as droughts and floods are compelling many rural Cambodians to migrate to other rural areas, to Phnom Penh and also to neighbouring countries in order to seek work. The pull factors are the prospect of paid employment and a better life, the existence of an established network of recruiters and intermediaries that help facilitate migration, kinship ties in destination countries that results in chain migration, and the ease of travel within the country and to neighbouring countries.

Recruitment for work abroad is done through the local media, with advertisements placed in newspapers or announced on radio and television. There are recruitment agencies that set up branches in the provinces where they deploy brokers to recruit people from the communities. According to the migrant workers who were interviewed for this study, information regarding the medical testing requirements is included in the information provided by recruitment agencies. Some migrants said that neighbours and family members informed them about the health tests. Most migrants were aware of the fact that they again would be tested upon arrival in the destination countries.

PRE-DEPARTURE

Testing Procedures

As part of their application process, Cambodian migrants are either sent by the recruitment agents to hospitals or private clinics for their medical testing, or a doctor or medical personnel is invited by the recruitment agents to perform the tests in the training centres. The latter procedure is done primarily with the Cambodian domestic workers who stay in training centres before their departure.

Migrants coming from the provinces may be required by the local counterpart of the recruitment agencies in the cities to undergo an initial medical examination upon filling out their application. Those who pass this medical examination are then sent to Phnom Penh to proceed with their application process. There, they will be subjected to another medical examination.

The following conditions are tested for, conducted in accordance with the requirements of the destination countries: HIV, sexually transmitted infections, diabetes mellitus, tuberculosis, bronchial, asthma, peptic ulcer, malaria, heart disease, kidney disease, leprosy, hypertension, cancer, epilepsy, hearing problem, hepatitis, and psychiatric illness. Women migrants are also tested for pregnancy. Domestic workers staying in the pre-departure training centres are tested for pregnancy every month until they are deployed.

> "Firstly, blood testing, lung x-ray to check tuberculosis, second HIV testing, the third hepatitis and malaria; we have done lots to follow the requirement of receiving country." (Russian Hospital health staff, Phnom Penh).

> "Generally, all workers male and female as housemaid or factory workers, they need to be tested on three important tests, firstly STIs, second HIV and third hepatitis, we can accept them after they pass these tests shown the result after three days or one week. We sent them to Thom hospital for medical check up like lung x-ray and hepatitis.We monthly need to check urine up during they stayed in training centre for getting pregnant, it is our guideline to do with domestic worker in Malaysia and they need to be tested again before employer take them to work." (Recruiting agency staff, Phillimore, Phnom Penh).

Cost of Medical Testing

The cost of the medical tests is often not clear to the migrants because the recruitment agencies combine all the application costs prior to departure into one fee. The migrants then pay the recruitment agencies through salary deduction. According to the recruitment agents the costs of the tests vary depending on the clinic or hospital. According to them, the cost for HIV and Hepatitis testing is more expensive at the Department of Occupation and Health: 45 to 50 USD compared to 20 to 30 USD if conducted by the hospitals working with the recruitment agencies. However, destination countries, like Malaysia, require the tests to be conducted by the Department of Occupation and Health for the reason that, being a government hospital, it is considered to be more reliable.

Migrants have to pay extra indirect costs when they undergo medical testing because they have to travel to Phnom Penh City where the recruitment agencies and medical clinics are usually located.

However, there are medical clinics that are aware of the difficulties faced by migrant workers applying for work abroad, so they try to keep their medical testing costs low.

> "I think that we cannot charge higher fees because the garment factory and agriculture workers, they cannot afford and they must dream of looking for another medical treatment place that close to their house. So we cut down the cost from $40-50 to $4-10, I don't have income like the others. If they have income of $10, I have $7-8.We decrease cost to give a chance to garment factory workers." (Director of Chantrea Clinic, Phnom Penh)

Informed Consent, Counselling and Disclosure of Test Results

Because migrant workers are required by the destination countries to undergo a medical test, informed consent seems to be a meaningless notion. Yet the Department of Occupation and Health holds a slightly different opinion on the definition of informed consent:

> "100% are voluntary because they want to work abroad and it is the need of them, they never refuse and they know clearly on testing." (Government official, Occupational and Health Department, Phnom Penh).

Again, it is the recruiters who inform the Cambodian migrant workers about the medical tests that will be required by the employers and destination countries. This is the case among migrants bound for Malaysia, Thailand, and South Korea. The positive thing about this is that migrants are not totally unaware about what tests they need to undergo.

> "I knew and already prepare myself. The broker told that we have to do blood testing on HIV/AIDS, Hepatitis.The employer will pay for us…" (Migrant returnee from Malaysia).

> "In general our company provides information as they want to go to Thailand or Malaysia, they need to make a contract, they are told about their salary and how much we need to cut down and we told them first they need to pass the medical exam and which is paid by our company, for [..].We explain about taking blood, and that it will not affect their health they only give a few cc of blood." (Recruiting agency staff, Phillimore, Phnom Penh).

According to the Cambodian Law, any person who is tested for HIV should have pre-test and post-test counselling. The provision in the Law states specifically:

> **Article 24:** All testing centres shall provide pre-test and post-test counselling services for those who request HIV/AIDS testing. The counsellors shall be sufficiently competent in conformity with a determined standards set by the Ministry of Health.

The data gathered from migrants and from the government and hospital personnel regarding counselling show contradictory testimony. Migrants stated:

> "They told that only one minute we can get the result on HIV/AIDS testing, but the doctor didn't provide any counselling. So I wait for about 3 hours to get the result." (Prospective migrant bound for Thailand).

> "Nothing to explain, when we arrived they started taking blood." (Female returnee from Malaysia).

At the same time, government officials and hospital personnel state that counselling is provided to migrants before their blood is taken. The same stakeholders also claim that when the results come out and a migrant worker is found to be positive for HIV, they are given post-test counselling.

> "The counsellor, they take their role and responsibility, before we do the testing we sent them to meet counsellors, after we know the positive result… Some have skin rash and we need to send them for treatment and give them good advice to go to other places to get ARV, and some who have cough we send them for treatment, so we need to explain them how to access health care clinic." (Government official, STI Health Centre, Phnom Penh).

However, the stakeholders interviewed in this research admitted that the pre-test and post-test counselling is rarely performed by doctors or medical personnel. In order to save on costs, the recruitment agencies hire non-professional counsellors to conduct the pre-test counselling before the migrants are sent to the Department of Occupation and Health for the medical tests.

When the results of the medical tests come out, they are communicated directly to the recruitment agencies. The migrants are then informed by a staff of the agency, either in person if the migrant has been asked to return to the agency for the test results or via telephone call. If the migrant has returned to the province, the agency's broker who operates in the community is tasked to inform the migrant of their medical test results. This is contrary to the Law on the Prevention and Control of HIV/AIDS:

Article 33: The confidentiality of all persons who have HIV/AIDS shall be maintained. All health professional, workers, employers, recruitment agencies, insurance companies, data encoders, custodians of medical records related to HIV/AIDS, and those who have the relevant duties shall be instructed to pay attention to the maintenance of confidentiality in handling medical information, especially the identity and personal status of persons with HIV/AIDS.

Article 34: The medical confidentiality shall be breached in the following cases:

a) When complying with the requirement of HIV/AIDS monitoring program, as provided in Article 30 of this law.
b) When informing health workers directly or indirectly involved in the treatment or care to the persons with HIV/AIDS.
c) When responding to an order issued by the court related to the main problems concerning the HIV/AIDS status of individuals. The confidential medical records shall be properly sealed by the custodian, after being thoroughly checked by the responsible person, hand delivered, and opened officially and confidentially by the judge in front of the legal proceeding.

Article 35: All HIV/AIDS testing results shall be released to the following persons:

a) The person who voluntarily requests HIV/AIDS testing;
b) A legal guardian of a minor, who has been tested for HIV/AIDS;
c) A person authorised to receive such testing results in conjunction with HIV/AIDS monitoring program as provided in the article 30 of this law; and
d) The requirement of the court, as provided as point (c) in article 34 of this law.

"[It took]Two days, I heard it from the broker." (Prospective male migrant to Thailand)

"The doctor told the teacher[9] and the teacher acknowledged the students (If they were) with hepatitis infection, they were separated and not allowed to stay and eat (same for) HIV/AIDS infection could not join eating." (Female returnee from Malaysia).

"The result was told to the teacher who did the registration at our village." (Female returnee from Malaysia,)

Monitoring of Testing Centres

In spite of the availability of excellent rapid tests, the reliability of the test results depends on their correct use; misdiagnosis may have severe consequences for individuals and for communities as well. Quality monitoring and evaluation of testing is thus very important. Systematic and continuous quality monitoring and evaluation of the testing procedures includes: Quality Assurance (QA), Quality Control (QC) and Quality Assessment (QC), according to the 2004 Guidance for Establishing Voluntary Confidential Counselling and HIV Testing (VCCT) Centres, National Centre for HIV/AIDS, Dermatology and STD (NCHADS). This guideline has been enforced by HIV testing centres in Phnom Penh due to a consultation meeting with individual key stakeholders from the hospital and HIV testing centres facilitated by CARAM Cambodia. The

majority of them cited that the staff working in these areas were provided training in order to enhance effectiveness, and that internal monitoring was also done.

> "For mechanism the effectiveness is we have trained all staff and after that we do follow- up and we fill in the gaps.We train more if they used impolite word etc…" (Government official, Keit Tomealear Hospital, Phnom Penh).

> "According to our standard we need to have internal control as quarterly meeting and evaluate by NCHADS every two years." (NGO clinic staff, MEC, Phnom Penh).

Even the recruitment agencies have to ensure the quality of their tests and the accuracy of results coming from the medical clinics where they refer the migrants, because the migrants are again tested in the destination countries upon arrival. If a migrant who had passed their pre-departure medical testing is found to be positive for HIV when tested in the destination country, the recruitment agencies would waste money for transportation, medical check-up and time for sending the migrants back to their communities.

Impact of Results

Cambodian migrants who tested positive for HIV and hepatitis before going abroad found that they were discriminated against by their neighbours. While still at the training centres, for example, they had to eat separately from the group. They were isolated from the other migrants. They also experienced deep regret because they were no longer allowed to work abroad and can no longer support their families.

> "I heard that If found HIV/AIDS, tuberculosis and hepatitis, we would not be allowed to go." (Returnee female migrant, Kompong Thom).

> "I felt frustration and hopelessness because I felt I won't be able to support my family and the neighbours would mock me." (Returnee female migrant, from Malaysia).

Fortunately, under the Law on Prevention and Control of HIV/AIDS, all persons infected with HIV shall receive primary health care services free of charge in all public health networks. The Law also encourages the participation of the private sector in HIV prevention.

India

India is one of the major labour sending countries in Asia. Although the movement of people across national boundaries is long standing, labour migration from India has taken two distinct shapes since independence. The first is where people with technical skill and professional expertise migrate to countries such as the USA, Canada, UK and Australia as permanent migrants, which has been going on since the early 1950s. The second is where unskilled and semi-skilled workers migrate to oil exporting countries of the Middle East on temporary contracts, especially following the oil price increases of 1970s. Other countries such as Malaysia and Singapore have also emerged as key destinations for Indian workers. In 2004, the number of workers who were given emigration clearance for contractual employment was just under 500,000, with almost 90% going to the Gulf States. By 2005, the number of such workers had risen to 559,000[10]. Altogether the number of Indians working in the various countries of the Gulf as of 2005 is estimated at 3.7 million[11]. Other migration issues of importance in India are irregular migration and trafficking, and given the size of the country, internal inter-state migration.

Despite their contribution to the economies both in origin and destination countries, the imposition of mandatory testing following the requirement of receiving countries, which generally includes HIV testing, increases the vulnerability of migrants instead of ensuring their health and rights. Mandatory testing reinforces either refusal of entry into a country for employment, or deportation. It renders the migrants open to retrenchment, stigmatisation and discrimination.

However, in India, there is no particular policy or legislation on 'mandatory testing' of the migrant workers. The National AIDS Policy 2002 clearly denied any public rationale for mandatory testing of its citizens, in particular for employment and/or for treatment during employment. On the grounds of fighting against AIDS, the National AIDS Policy has emphasised and encouraged voluntary HIV testing, to be accompanied by proper pre-test and post-test counselling, treatment and support. To this end, the government of India established the National AIDS Control Organisation (NACO), which has been supporting the establishment of VCT centres in all states. In June 2004, the number of VCT centres stood at 709[12]. These are located in medical colleges, district hospitals, civil hospitals, PHC, CHC and village hospitals. Apart from those, different non-government organisations and charitable care centres provide voluntary HIV testing. A good number of government accredited or non-accredited private hospitals and clinics are also engaged with HIV testing across the country.

Mandatory testing of migrant workers, in general, takes place in destination-country-approved testing centres. The Gulf Approved Medical Testing Centre Association (GAMCA) is the sole authority for overseeing all medical testing of the prospective migrant workers heading for the GCC countries. Though information is scarce, it is indicated that there are around 200 GAMCA medical testing centres across India. In Delhi, the number of GAMCA approved medical testing centres numbers just 5. Tamil Nadu, one of the major areas of outflow migration, has only 8 approved testing centres for GCC countries, most of them based in Chennai. Further, in Kerala, GAMCA approved testing centres are located in only 4 districts out of a possible 14. Accurate numbers of panel testing centres for Malaysia, Singapore or South Korea are unavailable, but may be very few.

Health status serves as one of the most tangible indicators of a migrant's well-being, and the mandatory testing includes an HIV test. But the prevailing practices of testing procedures and the monopoly business of testing centres are of major concern and contentious. The Rule Books of destination countries for medical testing of migrants puts the emphasis on the quality of tests in order to halt the spread of the infectious diseases in the host countries, but do not take into account the rights and well-being of the migrant workers.

PRE-DEPARTURE

Testing procedures differ from country to country, depending on the employment and the country the migrant worker is heading for. The GCC countries follow their own testing procedures, apart from international standards which govern the HIV test. The more ideal provisions related to testing set out by the National AIDS Policy are rarely seen in practice. Though Article 9 (4) of the GAMCA Rule Book mentions

> '….medical examinations will be carried out only upon request',

in practice, the migrants are tested without proper consent. Some testing centres maintain a sort of formality by providing a 'consent paper', but with no information. Most of the time, this paper is written in a foreign language that the migrants are unable to read. Moreover the terminology of the diseases is too difficult to understand for the migrants who are, in most cases, uneducated or of lower education. Few, if any, testing centres give any consideration to the importance of consent. One of the doctors in a GAMCA approved medical centre in Delhi said,

> "We take their signature not consent. They are asked by the embassy to come to here. So they have already given their consent."

Accessibility of the medical testing centres is a grave concern for most of the prospective migrant workers. The panel system of doctors and clinics restricts migrants to the more easily accessed and affordable testing centres. When the government testing centres subsidised fees for various tests, migrants are forced to pay an exorbitant amount to the private clinics since it is routed through agents. In addition the migrants have to bear extra financial burdens for travel, accommodation and food to reach the particular testing centres, which are very often located in faraway cities. The nexus among the middlemen, recruiting agents and the medical testing centres, also increases costs of testing either by the way they select testing centres or by doing false tests. A s related by a prospective male migrant in Delhi:

> "My agent has given me the address. I have come here from Punjab. I have come with my brother and had to spend Rs. 4000 extra excluding testing fees."

Pre-test and post-test counselling are meant to be provided to all before and after the test. This follows the ratification of different international instruments, including the International Covenant on Economic Social and Cultural Rights (ICESCR), which obliges the government of India to promote policies and legislation against discrimination in the receiving of health information, treatment and care. Through the formulation of policy guidelines channelled through the National AIDS Control Organisation, the government has in theory tried to ensure counselling services do exist, through infrastructural establishment of counselling

centres manned by trained and professional counsellors. But in reality, the benefit to migrants is questionable. Statements from the migrant workers show that they are not provided counselling either before or after their medical tests, meaning that the numerous tests are performed on them without any information or support. Moreover migrants have little or no access to such Government testing centres since they are under the control of agents, whose main eye is on financial gain. None of the panel medical testing centres, including those approved by GAMCA, provides counselling services; they give it very little, if any, importance and may even exhibit a wrong idea of what the role of counselling might mean to migrants. As a panel doctor in one of the GAMCA medical centres said:

> "Those who are fit they do not require any counselling. It is the only unfit people need counselling."

Article 5.8.2 of the prevailing National AIDS Policy protects the rights of confidentiality of the HIV status of a person. Clauses in the rules meant to be followed by medical centres approved by the GCC also affirm the need to maintain proper confidentiality during the disclosure of test results:

> "Confidentiality and privacy should be protected as related to the results of the test…" [13]

However, the experience of the migrant workers show that there is no mechanism for the disclosure of the test results. The migrants themselves or anybody on their behalf can collect the results on the submission of the token given when they are tested. Some testing centres do not give the results to the client at all, but only to the agents. Apart from that, the results of unfit migrants are directly sent to GAMCA headquarters, and sometimes to the appropriate embassy, without even disclosing the results to the migrants.

> "When I went to medical centre for my result, one lady in the reception counter announced in front of many people 'You have defect in blood. Have you met bad girls?' I replied 'I haven't done this, I have my wife.' When I met her after second time tests, she told me 'You have bad diseases, you must have met with bad girls." (Prospective male migrant in Delhi)

The migrant workers also disclosed that they are made to strip for a physical check-up. Sometimes they are checked in a group and therefore have to be naked in front of many people. Sometimes doctors from the opposite sex conduct these physical check-ups. This situation clearly can be highly uncomfortable for both male and female migrant workers. Many migrant workers expressed how humiliating and shameful they found such an experience.

> "After routine tests, a male doctor asked me lie down on the bed. Then he pulled down my salwar (trousers) till my lower abdomen. He pressed and checked my abdomen, and asked me the date of my last menstruation. I became very much ashamed". (Female migrant worker in Tamil Nadu)

Language is a further barrier for many potential migrants in India. Many times the prospective migrant workers have to go to other states for their medical test, depending on the agent's decision or the availability of approved testing centres. The language barrier was pointed out by a female worker in Kerala:

> "I did not know the language. My brother did all the talking in his broken English. I kept silent all the time".

Referral services for medically unfit migrant workers hardly feature in the pre-departure stage. For those temporarily unfit cases, with conditions that will respond to treatment, the doctors in the testing centres prescribe medicine prior to a re-test. But in case of permanently unfit workers, particularly those infected with HIV, referral services are very limited: in very few cases do the testing centres provide addresses of care and support centres, and there is little in the way of proper information or follow-up activities. In any case, most of the prospective migrants have already returned to their homes after the test and so will come to know their results only through the recruiting agents, who certainly do not provide any referral service.

Monitoring of testing policies and procedures

India has a number of laws at national or state level designed to safeguard the health of the general population. These include the Consumer Protection Act, the Indian Medical Council Act, the Human Organ Transplant Act, and the Medical Termination of Pregnancy. Together with other criminal and civil legislation, these laws lay down the basic code of conduct for medical and clinical practices, as well as the various determinants of negligence and grounds for consumer complaints. However, none of these laws specifically govern the medical testing of migrant workers, which is then done by reference to mechanisms of the panel system set by the destination countries.

Further, even where existing laws arguably cover the interests of migrant workers as clients of a healthcare facility, their impact may be limited. Regrettably, many service providers are little aware of the various provisions in the laws, and neither are the migrant workers. This is true of the general population, meaning people using the health sector have become more and more vulnerable. It is then even more important that the role of the government and professional agencies, in instituting processes and mechanisms to ensure the provision of safe and appropriate services in this sector, is optimally fulfilled.

In terms of the voluntary HIV test, VTC centres are obliged by law to follow the code of conduct, including providing pre-test and post-test counselling, consent taking and maintaining confidentiality in the disclosure of the result. Experience shows that confidentiality is respected, but the rules relating to counselling and consent taking may not be followed so well, in the absence of any close monitoring mechanism.

This is in contrast to the rules and regulations of GCC countries, which are strictly enforced through a strict monitoring mechanism. However, these focus more on the areas of specialists and technicians, and on technical aspects such as the quality of equipments, the cleanliness and the spaciousness of the facility. Of course these help ensure the proper screening of diseases, but concerns and rules about the rights and well-being of the migrants are absent. Incidentally, one GCC rule states that there will be a penalty (up to 3 months suspension along with a fine of 6,000 USD) if a centre exceeds a set limit of unfit cases. Surprisingly, the government has no part in the monitoring of panel medical centres approved by GAMCA, nor do the latter have any obligation to provide any report to the government. Regrettably, some government officials consider the medical testing of migrant workers the responsibility of the labour receiving countries.

ON-SITE

In the destination countries, the migrant workers have to undergo the same medical testing again. They are screened either to confirm the testing results done in the country of origin, or before the renewal of work permits. The timing and content of any medical testing for the renewal of a work permit depends on the policies of particular destination countries. For example, in the Gulf Cooperation Council States, migrants have to repeat medical testing annually; in Malaysia, which has recently updated its mandatory medical testing policy, migrants face medical tests once post arrival, and then for the renewal of work permits in the first and second consecutive year; and for other countries, migrants may have to test every six months. Annual or twice-yearly medical testing is particularly likely for migrant workers who work in factories, construction, or garments sectors.

In the Cooperative Council States and in Malaysia, the medical testing is done by the panel clinics approved by GCC and FOMEMA (Foreign Workers Medical Examination Monitoring Agency) respectively. The research found that the medical testing in destination countries takes place with no accompanying information. Migrant workers are rarely informed about what they are being tested for, nor are they provided with pre-test or post-test counselling. The consequences are aptly described by the following:

> "Baba (employer) had all the papers.We have to give thumb impression on a paper. It was written in Arabic.They asked me to put my thumb on it and I did it." (Returnee migrant worker from GCC)

> "The nurse took me to a lady doctor. It was a beautiful room. The doctor asked me to lie down and pressed my stomach. She said something in English to the nurse that I could not understand. Then, I was asked to wait in the waiting room. After 10 minutes, the nurse took me to another lady doctor who took my blood. I got scared during that moment. I came out and worried about the result. After blood test while I was waiting, the nurse called me again and gave a bottle.Though I did not understand what she said, I assumed what I had to do. I gave her back the bottle with my urine.Then I was taken to the x-ray room.A male doctor asked me to go to the changing room to wear a gown. I was hesitant but changed my dress as there was no option. After x-ray, nearly 15 minutes waiting they called my name. A male doctor said okay. I didn't know whether he mentioned my test result. Then I was returned back to the agent's house in the same vehicle. I was so worried about the result after each test. I was tensed how would I pay back Rs. 35,000 that I took as loan to come here if I was sent back to India……I was not told anything about result and I don't even know the details about who got the reports from the hospital." (Female returnee migrant worker, back from Singapore)

If language is a barrier within India for prospective migrant workers, it is potentially even bigger once migrants have arrived in their destination country. They may well be sent for a post-arrival test on the very first day of this arrival, and certainly within the first month. The chances of migrant workers being able to communicate to the local doctors or employers are remote, even if there was encouragement for them to do so. Many migrant workers shared that they were not treated well at these tests; many recounted how they had been treated rudely.

> "No one spoke to me. Even if they had spoken, I would not have understood. I could not understand what the doctors spoke." (Returnee female migrant worker from Singapore)

> "Yes, we are treated differently.We are treated very harshly. For example we were pushed into a room forcefully to remove clothes. While injecting we are treated like animals. They speak in their own mother tongue (Arabic).We feel discomfort." (Returnee male migrant worker from GCC)

Any human being deserves a dignified exit even during deportation. Migrant workers are denied this basic human right in the Gulf Countries. When a migrant worker undergoes a medical test in the receiving country, they do not get an opportunity to understand their health status. As soon as the health practitioners get the results in their hands, they move into action, without informing the migrant worker what the problem is. HIV positive migrants are usually taken straight to a confinement, which the migrant workers term as jail in many of the GCC countries. The test results are kept between the company and the medical testing centres.

For most of the unfit cases, the employers keep the results secret until the deportation has taken place. Some employers inform the migrants only at the eleventh hour, with the intention of not paying them any remaining dues. In other words, migrant workers are sent back to their home country without any proper information or referral for treatment. The government officials retain all official documents, including passports, until the deportation procedures are completed. These documents are then returned to the migrant worker only when they are about to board the plane, or even after entering the flight.

Mandatory HIV testing not only denies a migrant the right to work, but it strips self respect and self esteem in the process. Confidentiality is completely breached, as there are many people involved in such health-based deportations.

> "I got my test results at 11am and by 5pm the company settled my accounts and by 7pm I was put into a flight. I was under the observation of Oman police during my flight from Salalah to Muscat. None of my documents including my passport were given to me until I boarded the flight from Muscat. It is only after an hour's flight that the attendant handed over the documents to me." (Deported migrant from Oman)

> "I don't know what my problem is? Nobody told me…… neither my Boss nor the Doctor. I have come only one year back and I don't know the language….so I could not able to deal with my Boss." (Deported migrant worker from Malaysia)

The immediate confinement following an unfit result also creates fear and violates the human rights of migrant workers, as expressed by a returnee in Kerala:

> "As soon as I finished my retest, there were 2 policemen to arrest me. I was immediately taken to a jail, which is within the clinic premises. I had no clue what was happening."

REINTEGRATION

Impact of results

Once back home, there is no support system for migrant workers to help reintegrate them back into society. The absence of a referrals mechanism in the country of origin makes migrants more vulnerable. Sometimes the trauma results in depression and can bring suicidal thoughts, since it becomes impossible for them to cope with the loss of their job and their livelihood as well as come to terms with an unknown infection like HIV.

On top of the personal issues, a migrant is likely to face a severely negative reaction from society. Most families see an HIV infected member as a shame to the prestige of the family as well as a hindrance to the possibility of good marriage alliances for other members in the family. Most of the families prefer to hush up the HIV status of their family member for fear of getting ostracised. As a result, many deported migrants never disclose their HIV status either to their family or their social circle.

Some of the deported migrants confided that their test results were disclosed without their consent. The nurses or doctors who had their results with them disclose results to their family and neighbourhood. This disclosure can cause serious discrimination and stigmatisation. A deported migrant worker in Kerala described how

> "within a few days, an evening newspaper in my hometown had a spicy headline saying 'A gulf migrant deported and returned after having tested as HIV positive'. It mentioned my village name as well. All the fingers started pointing at me, as I was the only migrant who had returned from Gulf at that time.'

Another migrant worker deported from Saudi Arabia reflected on his situation:

> "I became a drunkard, a full-blown drunkard. I just wanted to die. I was totally lost. After sitting idle for sometime, I started doing light jobs like I'd some plumbing, painting houses etc. After that I got TB and my family took me to a hospital and there they got to know that I have HIV. They were very disappointed and didn't want to acknowledge me in their family anymore. They ostracised me, particularly my brother-in-law. I was so depressed that I didn't take any medicines for TB. I was adamant to die somehow. Slowly,TB affected my head and I started getting fits. I used to get convulsions almost 5-6 times a day. One side of my body got paralysed. My family just wanted to avoid me and was only ashamed of me.The only reason why they put me in Trichur Care centre was just to shun me from the family. After throwing me into that institution, they never looked back till today. It was at Trichur care centre that I recovered. I was inspired to pray to God. I prayed from my heart and you won't believe it, but I recovered from my paralysis. Then for 9 months I devoted my services for that centre. After that I got shifted to this institute that takes care of HIV positive people."

Most of the migrant workers pay their migration costs by either selling their belongings or taking a loan at a high interest rate. This means any premature deportation, in the absence of compensation, brings untold miseries for the migrant workers.

> "I need more examinations to confirm my result. I think TB is not dangerous disease. I want treatment here (Malaysia) not going back home. I have spent a lot of money to come here… Now I feel very upset...I don't know what will happen in future." (Deported migrant worker from Malaysia)

Unfortunately, health-based deportations are not treated as any cause for concern in India. Although there are special government departments working for the welfare of the migrants, they will not be informed or aware of deportations based on health status. As there are no referrals given by the receiving countries, migrants are left in the dark, as they do not know how to get treatment for their diseases, especially if they are infected by HIV. Such situations are exploited by quacks who claim that they can cure AIDS; they have successfully exploited many migrants from the Gulf. The Gulf countries even had advertisements of one such quack in one of the confinement cells where HIV patients were kept. In the home country, there is no system or organisation that takes care of the health rights of migrants. Many deported migrants testified that it was by accident or coincidence that they managed to become associated with a care and support organisation.

> "When I reached the cell, it was the posters stuck on the walls that helped me understand the reason why I was jailed. It talked about HIV and deportation. I was heartbroken as it meant a loss of job and a goodbye to Dubai.The cell even had the advertisement of a notorious quack in Kerala who used to claim that he could cure AIDS." (Deported migrant worker from Dubai)

Accessibility to treatment, care and support for migrants

In India, adequate policies on migration and related to migrant workers have yet to be developed. For example, as we have seen, there is no legislation or even mechanism in place to respond to those migrant workers who are deported from destination countries due to infectious diseases. It is something of an irony that while India is a significant competitor in the arena of medical tourism, having among the best qualified professionals in each and every field and offering world class medical facilities at competitive charges, migrant workers have very limited access to treatment, care and/or support. There are two main factors about which to be concerned: the lack of policy, and the steady privatisation of healthcare, which has increased the cost of such care, with such increase being even more pronounced for the poorest Indians, such as migrant workers. These of course include those who have just deported from working abroad.

In a close-knit society like India, where people's identity is tied to their family or social identity as much as to their individual identity, social stigma is a major threat to the access to treatment and care. Many deported migrants in Kerala testified that they have not disclosed their HIV status to their families for fear of ostracism. Although government hospitals do have provisions to give free treatment to HIV patients, the fear of society stands as a primary barrier that prevents such patients from taking treatment. Migrants face such exclusions all the more because once a person returns to their native country, they lose the precious status of being a non-resident Indian. This is valued because of its perceived financial power. In such a scenario, any association with HIV related clinics or groups automatically create a suspicion in the neighbourhood. Those who have told their families have in many cases been excluded from their families and societies, so that the latter might retain what they see as their family prestige. Many non-charitable institutions that give shelter to HIV patients similarly do not disclose the fact to the public, for fear of exclusion. Deported migrant workers in a rehabilitation centre in Kerala shared,

> "I was ashamed of myself. Even if someone looks at me unintentionally, I feel that they're judging me. It continues even today.That is the reason why I left my family as well. My family has a respectful status in the society.When I stay with them, I feel that the future of my nieces and nephews who are growing up will be affected badly. Be it a marriage alliance, if someone comes to know that their uncle is a HIV positive, no one will bring any alliances for them. I thought I shouldn't be burden on anyone. My brother still comes to visit me in this rehabilitation centre."

> "I went to almost all the good hospitals in the Indian metro cities including Bombay, Delhi, Madras, Bangalore, Pune to double check the results. I was so terrified that my identity will be revealed that I always registered my medical files under different names and religion."

Another barrier to treatment and care is the physical distance to healthcare centres. Government subsidised treatment is only available in medical colleges. These are few and far between, and located only in certain districts. As many migrants have no money to travel long distances, they do not access treatment.

Generally speaking, there have been positive initiatives. The National Health Policy 2002 endorsed HIV and AIDS as one of the serious threats to public health and economic development. The central government has formulated a national policy on AIDS, and has launched a national AIDS control program, in different phases. Along with the 709 VCT centres across the country, the NACO has been providing ART and regular follow-up services through 91 centres throughout the country. Under the initiative, about 85,000 people were expected to take up the offer of free anti-retrovirals at the government health centres. Besides that giant public sector organisations such as the Railways provide free treatment to nearly 10,000 HIV infected people[14]. In addition, a good number of non-government organisations, homecare services, self-help support groups, HIV positive networks have been providing treatment, care and support services to the people living with HIV across the country. But despite all this, and very unfortunately, the HIV infected deported migrant worker can hardly access available treatment facilities, because there is no proper mechanism to facilitate the process of integration between them and the support service centres or organisations that can help them.

Indonesia

Indonesia is a major sending country of migrant workers, with key destinations being the Middle East countries and also neighbouring countries like Malaysia, Hong Kong, SAR of China, and Taiwan, Province of China. In 2006 alone, a total of 680,000 Indonesian migrant workers were deployed by the government, among which 502,432 (73.9%) worked in the non-formal sector including domestic work, and 177,568 (26.1%) worked in the formal sector. Female migrant workers make up a large majority of these workers, numbering 541,708 (80%) compared to 138,292 (20%) males[15]. The government projection for 2007 is for 1 million Indonesians to be working abroad[16]. It should be noted that a significant number of Indonesian undocumented migrant workers are thought also to be employed abroad: in 2007, this figure is as high as 40,000 in Saudi Arabia alone[17]. The Government has hoped to reach 5 billion USD in remittances, with the actual amount achieved in 2006 standing at 4.4 billion USD[18]. Between 2006 and 2009, the Government estimates to deploy 6 million Indonesian migrant workers to 25 countries.

All migrant workers from Indonesia are required to undergo a range of medical tests, including an HIV test, as mandatory before employment. These tests should be conducted in clinics appointed by the Government. Based on the latest data from the Association of Medical Test Clinic for Indonesian Migrant Workers (HIPTEK), as of 2006, a total of 119 clinics are approved by the government as 'Medical Check Centres for Prospective Indonesian Migrant Workers', based on the Decree of Minister of Health No. 1586/MENKES/SK/XI/2005[19]. These centres are distributed in 16 provinces: North Sumatra (5), West Sumatra (2), Riau (5), Islands of Riau (2), South Sumatra (1), Lampung (2), Jakarta (43), West Java (18), Central Java (20), Jogjakarta (6), East Java (15), West Kalimantan (1), South Celebes (1), North Celebes (1), West Nusa Tenggara (6), East Nusa Tenggara (1).[20] However, only 85 clinics among these are official members of HIPTEK. These member clinics are found in eight provinces; Jakarta (43), Central Java (10), Jogjakarta (2), East Java (13), West Nusa Tenggara (7), West Java (3), Islands of Riau (6), North Sumatra (1).[21] Among these centres, 26 are accredited by the Gulf Approved Medical Centres Association (GAMCA) to test migrants going to the Gulf countries. As members of GAMCA, they are guided by their own rules, regulations and monitoring system, but they also need to follow HIPTEK standards. Meanwhile, around 70% of HIPTEK members are approved to test migrants bound for Malaysia. Only 10 HIPTEK members are appointed to test migrants going to Taiwan, Province of China.

There are some policies related to the medical testing for migrant workers that have been issued by the Ministry of Manpower and Transmigration and the Ministry of Health. These policies cover all aspects of medical testing for migrants, ranging from their obligatory medical tests, the procedures of medical testing, accreditation of medical testing institutions, and the monitoring of medical testing facilities, The policies also lay down the minimum standards for medical testing facilities. To be specific, Act No. 39/2004 on the Placement and Protection for Indonesian Migrant Workers in Foreign Countries (PPIMW) obligates a medical check for prospective migrant workers. Besides physical and psychological tests (Article 49), female migrant workers have to undergo a pregnancy test, since a prospective migrant worker should not be pregnant (Article 35). Specifically on HIV testing, the policy prohibits the use of HIV test results as part of the recruitment process or determination of working status. The Decree of Minister

of Manpower and Transmigration on HIV/AIDS Prevention and Control in the Workplace (No. KEP. 68/ Men/IV/2004) in Article 5 states:

> (1) Employers or officials are prohibited to perform HIV/AIDS tests as part of recruitment requirements or working status of workers/labourers or as a compulsory regular medical check-up.
> (2) HIV tests can only be performed on the basis of a written agreement from workers/labourers concerned, with a condition that the result will not be used as mentioned in article (1).

Article 6 states:

> "Any information obtained from counseling activities, HIV/AIDS tests, medical treatment, medical care and other related activities must be kept confidential just like any medical records."

However, this policy does not seem to have any bearing on migrant workers since most receiving countries require mandatory HIV testing, to which the Indonesian government and migrant workers must comply. This is ensured by the Decree of Minister of Health No. 138/Menkes/SK/II/1996 on Medical Check for IMWs:

- Every prospective IMWs that are going to work abroad should have a statement letter of health (Article 1);
- Medical check for prospective IMWs which is coordinated by IMWs recruitment agency is the responsibility of IMWs recruitment agency (Article 2);
- Medical check as stated in Article 1 and 2 also in effect for prospective foreign migrant workers that are going to work in Indonesia and IMWs that are returning to Indonesia (Article 3);
- Types of medical check that is mentioned in Article 1, 2 and 3 at least are in line with types of test that are requested by the relevant country (Article 4).

PRE-DEPARTURE

In Indonesia, medical testing for migrants is the responsibility of the recruitment agency. Medical tests are conducted after the prospective migrants have registered and passed the written exam in the agency. Most prospective migrants do not have clear information about test procedures and the purpose of the tests.

> "They just gave us briefing, for instance, "You enter the room then follow the instructions." (Female returnee from Saudi Arabia)

Most migrants were only told that they should have a medical test, and that if they suffer from any disease they will not be allowed to go abroad. When they are in the clinic, the migrants only follow what is instructed or arranged by staff from the clinic.

> "Yes they did (giving information), but just like,"you're going to get a medical check-up tomorrow, you have to sleep well, maintain your health, and don't forget" they said, what they meant is, when it is believed that we have some health condition, we have to drink our medications first.And that we have to dress properly.Things like that.Yea, about an hour before the medical they told us to drink milk and soda." (Female returnee from Saudi Arabia)

> "The one who told me was the nurse, 'you change your clothes there, in that room', after urinated, later I was told,'you go to that room." (Male returnee from Malaysia)

Clearly, lack of information on testing is evident among the migrant workers in Indonesia.

According to the Guidance of Minimum Requirements Physical Health on Medical Facilities for Indonesian Migrant workers issued in 2002, the procedures for medical test are: an interview with migrants about their history of medical conditions and treatment they have had in the past; a mental and physical examination; a laboratory examination; and a radiology examination. Women migrant workers are tested for pregnancy prior to departure. According to the migrant workers, the requirements to pass these tests can be severe, and unrelated to a work performance issue.

> "A burnt scar, you wouldn't even notice it, but they said it's not allowed scars like that (and made unfit)." (Female returnee from Saudi Arabia)

Moreover, the research findings show that none of the prospective migrants have experienced any form of pre-test or post-test counselling.

> "Pregnancy pre-test is a barometer for us before answering claim from the agency. If there's a repatriation or deportation because of that, we'll check their date of the first medical test, date of pregnancy retest and the date of departure. If she happened not to have the pregnancy retest, then it's the agency's fault.We don't want to take liability on this". (Chairman of HIPTEK)

> "Not really (counselling). They were busy, can't expect anything at times like that. The least they did was telling us, 'you're having a low blood pressure; you have to pay for the medicine prescribed'." (Female returnee from Saudi Arabia)

The testing centres are relatively accessible because the agencies provide for the transportation of the migrants to the medical clinic. The agency's staff also accompanies the migrants. What is costly for the migrants is reaching the recruitment agencies, especially for those who come from the provinces. However, in case of the GCC countries, Malaysia and Taiwan, Province of China, since only a limited number of centres are authorised to perform testing, this might cause additional travel and costs. Usually the testing process takes half a day to one day maximum, as shared by the migrant workers, depending on the number of prospective migrant workers assembled for testing on a given day.

> "A day maximum. Because the only reliable medical check-up equipments were at this hospital, one hospital, that was the one they trusted, so people from everywhere went there." (Female returnee from Saudi Arabia)

> "Sometimes when there was just one of us they (recruiting agency) wouldn't take us yet, we have to wait for the others, so that we can do it all at once." (Female returnee from Saudi Arabia)

> "Because there was plenty of us. So we'd have this long queue. Sometimes it's not like that though, we have to go home, and come back again the next day, one shift could include a lot of people." (Female returnee from Taiwan, Province of China)

Usually, the cost of tests is initially covered by the agencies and later deducted from the salary of the migrants. However, the sponsors may also advance the cost of the tests, which are paid for by the migrants eventually, or the migrants pay for the cost of testing by giving money to their sponsors before

they are brought to the testing centre. The cost of the medical test is around USD 21 without an HIV test: if that is included, the cost is around 28 USD. Since the cost of the test is lumped together with other recruitment fees, the migrants involved in this research revealed that they were unaware of the actual cost of the tests. Given this situation, it may open possibilities for the sponsors and the agencies to exploit the migrants by asking for amounts larger than the actual fees.

> "The medical money has to be cash, 300, but if we don't make it, we won't get our money back." (Female returnee from Jordan)

> "If we turn out to be unfit, then we lost the money.Well yea, the company asked for 300, but sometimes we give the sponsors 500-600." (Female returnee from Saudi Arabia)

When having medical tests, most of them expect comfort and sympathy from the personnel of the testing centres. But some of them are disappointed with the attitude of medical personnel. Some expressed that the clinic staff are not friendly, are harsh and often snap at the prospective migrants. Nurses in the clinics tend to be sharp-tongued and fussy while some doctors always seem to be angry when they examine the migrants. A prospective female migrant worker going to Saudi Arabia said,

> "When we were told to be naked (only wearing knickers), the staff was rude.We did a simple mistake, we were snapped at…".

The workers are often treated impolitely, with rude words used against them. However, the general environment was said to be clean and satisfactory:

> "Alhamdulillah it's clean. The nurses are grumpy, but yeah, it's comfortably clean." (Female returnee from Saudi Arabia)

According to the migrant workers, the clinic staff do not discriminate against them based on their origin, culture or ethnicity. When undergoing the medical testing process, migrant workers are usually told to undress in a gender segregated group, just leaving the underwear on. Although not comfortable with these practices, migrant workers do not object and follow the instructions by the medical staff. Another reported issue is even though most of the medical staff are female, those who are on duty in radiology or x-ray are usually men. This sometimes leads to harassment of female migrant workers.

> "They'd tell us to breathe in, but when you're pretty they'd do your x-ray for long, that's a male.'Hold on,' they said. They'd be very long. But when you're ugly you'd have a quick x-ray." (Female returnee from Saudi Arabia)

> "Yes. "Don't get surprised, they'll tell you to take off your clothes", like that… Yes, they'd touch us all over, probably afraid if we have some kind of skin diseases, fungus, or something. But the doctor could be a man or a woman…we have a lot of female doctors these days, but back then we had male doctors." (Female returnee from Taiwan, Province of China)

Even though the Indonesian language has been taught since first grade elementary school, there are those who cannot speak the national language fluently. Several prospective migrants who are used to speaking in their local dialects experience difficulty in communicating with medical personnel. No formal translators are provided by clinics to overcome this obstacle.

The migrants receive their test results within one to three days, sometimes a week. The test results are delivered by the recruitment agency. The migrants are only informed whether they are fit or unfit. Only migrants who receive an unfit result are told about the details of their tests. The clinic usually suggests that the recruitment agency brings the unfit migrant to the clinic again, to be given information on details of test results. According to the HIPTEK's Chairman, migrants who test positive for HIV are called directly. However, they still inform the agency which prospective migrant tested positive for HIV. Once an unfit migrant worker returns to the clinic, he or she is referred to a doctor and a counsellor. They are also informed about the hospitals where they can access health services.

According to the Guidance of Minimum Requirements Physical Health on Medical Facilities for Indonesian Migrant Workers issued by the Department of Health in 2002, test results should be treated confidentially and should be delivered in writing to the prospective migrant worker or to PJTKI, with the written permission from the prospective migrant worker. But in reality, confidentiality on the medical status of migrant workers is not respected, since the results, including any HIV test results, are received first by agencies. Also, in practice, counselling or referrals are often not made available, if at all.

> "They called and said that I wouldn't be deployed because I was unfit.To have further information, the agency told me to go there. And, after I arrived there, my test result was already opened; and in the form, there were several columns, like HIV/AIDS, Hepatitis,Tuberculosis, Malaria, etc, and on the right columns, there was a statement, ' yes and no'. Thus, on my medical check result, on HIV/AIDS, it was ticked in "yes", the rests were "no." Under it, it was informed that my test result was unfit because there was an indication of having STI." (Prospective female migrant worker to Hong Kong, SAR of China)

> "To the people from the company (Test result delivered). Yes, the company would then tell it to us. For instance, A or B, one of them is fit.While the other is unfit, she has to go home or get a pending status." (Female returnee from Saudi Arabia)

> "If you passed, they'll take you to the education centre, or straight to the shelter. If you failed, they'll take you to the shelter first, wait for the result there. Because sometimes we didn't get the result right away. Sometimes we have to wait for 3 or 4 days." (Female returnee migrant, Saudi Arabia)

> "No, we don't have a counsel. How can we have a counsel since those who are unfit used our money, while those who are unfit suffer diseases that take a long time to be healed, like hepatitis, or bronchitis?" (Director, Recruiting Agency)

The medical results may also be 'pending' if the migrant worker has a treatable condition. If this is the case, the clinic suggests that the migrant undergoes the necessary treatment and then undergoes medical testing again. One agency provided treatment for unfit migrants by having a doctor check them up, although they are charged 80,000 IDR (10 USD) per month for the service. However, most of the agencies do not provide this kind of treatment. If the second test result passes the migrant worker as fit, then they will be deployed for work abroad. There is at least one clinic which sells prescriptions for treatment for migrant workers who are 'pending'. Usually after buying a prescription from that clinic, migrant workers will be declared fit on the next test. However, research findings show that some unfit prospective migrants were sent back home without any treatment or even advice.

> "There's a clinic that's trying to sell prescriptions. So, a person is stated pending, then we should buy prescription and medicine there; the day after, he/she's fit. Actually, we should give medication for quiet a time to the person who's pending, then we do the medical check on the next day. It's not like this; buy this medicine, this is the prescription, tomorrow takes him/her back, and the next day

> it's stated fit. Such a clinic would make all prospective migrant workers be stated pending, although they're actually fit, in order to make them buy medicines prescription there; you know, such a trick." (Director, Recruiting Agency)
>
> "When you have a pending status, you have to get a treatment from a doctor, drink your medication for several days, and then get another check-up." (Female returnee from Saudi Arabia)
>
> "Well, having a re-test is another thing. If you did a medical, and it turns out that you have to re-do it, the first fee we paid won't comeback to us. And we still have to pay for the next one." (Female returnee migrant from Jordan)
>
> "Never the doctor, home straight ahead." (Permanent unfit female prospective migrant)

In the current medical testing procedure, confirmatory tests are not standard practice. Usually, the initiative to request a confirmatory test comes from the sponsor and the recruitment agency. They do a re-test in another clinic or hospital in Jakarta, as well as somewhere near their village or area. Sometimes, the two test results are found to be contradictory. Particularly when a migrant worker tests positive for HIV or hepatitis, a confirmatory test from another hospital is requested. However, the migrant workers pay the cost of any confirmatory test themselves.

Several institutions in Indonesia have been established to provide services for people living with HIV. However, there is no standardised referral system in providing care, support and treatment to migrant workers stated unfit or who are found to be HIV positive during their medical test. Usually the unfit migrants are referred to the Ciptomangunkusumo Hospital or to NGOs providing services for people living with HIV.

> "So afterward if they're HIV positive we will refer them to NGOs or to Ciptomangunkusumo Hospital to assure that they're indeed positive HIV. If they're proved to be fit, then it all return to the company whether to continue or not. At the mean time, we are discussing about handling them in the villages." (Chairman, HIPTEK)

Monitoring of Testing Centres

The monitoring of testing centres is conducted by a team which consists of persons from the Department of Health, Department of Manpower and Transmigration, health officials at province and regency level, HIPTEK, the Association of Indonesian Health Laboratories (ILKI) and the Association of Indonesian Radiology (IRI). If possible, the team also involves representatives of embassies and Immigration officials from the countries receiving Indonesian migrant workers. The monitoring is conducted at least every six months, with or without notice. The Directorate General of Medical Service Department of Health manages the monitoring of medical testing for migrants. In 2007, they will involve the Sub Directorate of Labour and Health. The Department of Health and HIPTEK have a yearly auditing system for the testing centres that is referred to as Internal Quality Establishment. The audit process is done by checking the service quality, facilities, and the equipment, based on established standards.

Sanctions, including the withdrawal of operating licences, are imposed if it is found that the clinic has violated the standards set by the health officials at the province level. In reality, however, this rarely happens.

> "There are several issues in which have many problems. For instance, they weren't checked according to, e.g., should be checked for this, this, but only examined at minimum, then got the certificate; thus, when they were re-examined in destination countries, there was a problem with their health, so they were sent home.Well, that's the most problem happens." (Doctor, Department of Health)

ON-SITE

All the migrants who participated in this research had to undergo a medical test upon their arrival in destination countries. Most of them already knew that the test had to be undertaken again in the host country, but knew little else, for example about the test procedures, requirements, the diseases being tested for, or the results. Unfit migrant workers are deported back home, especially for HIV, TB and pregnancy for females. The duration between the arrival and the medical check varies. Mostly it is done within one day to one week after arrival. There will then be regular recurring medical tests, every year, or every 2 or 3 years, depending on the host country and the type of employment. These tests are compulsory since the result determines the continuation of their work permit. All costs for these tests are covered by the employers or the recruitment agencies.

Comparing the pre-departure with the on-site testing experiences, many of the migrant workers expressed that testing is conducted more carefully in the destination countries. Migrants also testified that the clinics in the destination countries meet a higher level of sanitation. However, consent and pre-test or post-test counselling are also not experienced in host countries. All migrants involved in this research stated that there was no discrimination when they had their medical tests on-site, but language is still a problem for many of them. Since they do not really understand the language, they simply did what was instructed to them without understanding the rationale undergoing the medical test.

> "Cleaner there. Here, it's dirty, smelled bad.There, it smelled good, big as well." (Female returnee from Taiwan, Province of China)

> "Practically, the examination there was careful." (Male returnee from Brunei)

> "My first time to Arab, I didn't know where they were taking me, just like a goat being taken to a slaughterhouse. But when you get used to it, you'll feel more relaxed.You'll know what they'll do next on the procedure." (Female returnee from Saudi Arabia)

Although female migrant workers are tested for pregnancy in Indonesia, and, if testing fit, are taken to shelter homes to avoid physical contact with their husband, some might manage to visit home before they leave. If they get pregnant before departure and test positive for pregnancy in the host country, they will be deported back home. Sometimes deportation takes place immediately, but it might also take a few months, depending on the wishes of the employer. This might give rise to social problems, including problems of acceptance of pregnancy by the husband or family.

> "We have to do the last urine check here (Indonesia) too. Cause most of the times, people got delayed too long at the company, haven't been medical checked again for 2 months, and they got pregnant. But sometimes the husband won't admit the pregnancy as to his, while of course she wouldn't find out until then...that's why now they have the medical check-up sooner, back then women labours are not as much as these days, we have to wait and wait for the others, but our concern is when she got pregnant, they'd have a negative image upon her, while she didn't get it elsewhere but from home.That's why when we have had a medical check-up, they'd still have to do another check-up on us afterwards,

> and they didn't. When we got to Arab, they'd check us up again, there they found out that she had a 2 months pregnancy. A husband once took his wife home. That's why now the procedure's become a lot tighter, before we go we must have another urine check. Because there are a lot of cases where they thought the woman got pregnant in Arab, while it was actually with her husband or boyfriend. Her husband asked her to go home (from shelter or centre).They'd send her back (from destination country), she got there, but her employer would claim for a refund because she just got there and they already have to send her back.That's why it didn't take long for the employer to do so, 2-3 days; they sent her home, immediately. But some employers delayed and delayed to do it, what they don't realise is the husbands here would suspect that it happened there." (Female returnee from Saudi Arabia)

In 2007, the Indonesian and Malaysian governments negotiated an MoU on medical testing for Indonesian migrant workers. This MoU will govern the conduct of medical testing among Indonesian migrants in Malaysia; included are standards for testing centres in both countries. However according to the Department of Health, it is Malaysia who dictates these standards.

REINTEGRATION

Migrants who are declared unfit in the destination countries are usually sent home directly, without any treatment or referral, and sometimes without even knowing the reason why they are unfit. There are some who were allowed to undergo treatment and have continued to work. This happens only if the employer is willing to take care of them and pay for their treatment. As a male returnee from Saudi Arabia reflected:

> "For instance, in Saudi Arabia, if the employer cares about his/her domestic worker's disease, he/she may be treated; that's OK since it's merely this kind of disease. But, if the employer doesn't care, he/she will say, 'how could Indonesian doctor let sick people to be sent'. At the end, it would be a problem. Instead of our people earning money, he/she is filed for a case in the representative in Arab, I can't accept why a sick person was stated fit.That's what would happen to those that are unfit, not waiting for them to do wrong."

There are many cases in which migrant workers were declared fit in Indonesia, but were found unfit in the destination country. The guidance of minimum requirements of physical examination for migrant workers stated that if there is a difference between the medical test result in Indonesia and the medical test result in the foreign country, the clinic in Indonesia who conducted the initial test is required to perform a re-examination. The results will then be reported to the Health Officials, Department of Health and the embassy of the relevant country. However, there are still clinics that fail to carry out their functions in a responsible fashion:

> "Once we had an experience with irresponsible clinic. There were six people that were returned, but only one was compensated; therefore, my commitment was useless. Now, therefore, we have an agreement. If they do not do the medical check up seriously or if there is any problem, they are the one who will suffer consequences." (Owner, recruitment agency)

To prevent this, recruitment agencies draw up an agreement with the medical clinics that, if a migrant they declare fit is sent and then declared unfit on-site and is repatriated, the clinic responsible will compensate the agency to an amount of 1,000 USD, and provide free examination for 20 migrant applicants. Repatriation of migrants declared unfit should be done by the employer, in coordination with a representative of the recruitment agency in the foreign country. However, there are employers who just send their workers directly to the airport without the agency's knowledge.

> "After I returned from the hospital, I was told to pack my clothes right away. I didn't think that I would be sent home because my employer often went to go to Syria, often had a vacation there. I thought he/she was going to take me there. In fact, I was taken to the airport." (Deported migrant worker from Saudi Arabia)

Accessibility to treatment, care and support for migrants

Article 75 Act No. 39 Year 2004 on the Placement and Protection of Indonesian Migrant Workers in a Foreign Country states that the recruitment agency is responsible for the reintegration of migrant workers, including providing a health service for those who are sick during the repatriation process. Unfortunately, this policy does not cover undocumented migrants or victims of trafficking. Moreover, recruitment agencies just return the migrants to their villages without providing for treatment or even proper referrals services available within the country.

Presently, only the Medical Service Centre (*Pusat Pelayanan Medis or PPM*) provides medical services for distressed migrant workers, particularly trafficking victims. This is part of the Integrated Service Centre (*Pusat Pelayanan Terpadu*) of Raden Soekanto Hospital in Jakarta. The PPM cooperates with the International Organisation on Migration (IOM) in taking care of, and giving treatment to, migrants, as well as returning them to their villages after they get better.[22] Usually, migrants are treated for two weeks, some for more than a month. If they need further treatment after returning to their villages, they are referred to the Society Medical Centre (*Puskesma*s) or a District Public Hospital (*Rumah Sakit Umum Daerah*) near their village, in coordination with the nearest NGO.

When an HIV test is needed, the informed consent of the migrant is solicited and counselling is provided prior to the test. Results are also kept confidential. There is also a mechanism for accessing free ARV from the government. These services are free of charge. As the Migration Health Physician of IOM Indonesia said:

> "In all of our works, there must be counselling, informed consent, and we do not expose someone's confidentiality deliberately."

Several other institutions in Indonesia that provide care, support and treatment services for persons with HIV can be accessed by migrant workers. These include *Yayasan Layak*, *Pokdisus RSCM*, *Yayasan Pelita Ilmu* and *RSPI Soeryanti Saroso*, Jakarta. For instance, *Yayasan Layak* has provided service for around 15 migrant workers since 2003. In their work, they also often cooperate with IOM Indonesia. However, without the existence of proper and systematic referral services, treatment and support to the migrant workers are often denied. In this context, a coordinated effort between government, recruitment agencies, testing centres and care and support groups is a must to safeguard the health and rights of the migrant workers.

Nepal

Foreign employment has been an alternate livelihood option for many younger people in Nepal. In 2006 alone, a total of 177,506 Nepali migrant workers left the country through formal channels, either individually or through an organisation. The vast majority of them were male, with only a small fraction of women (1,535). The top destination countries were Malaysia, Qatar, Saudi Arabia, U.A.E, Kuwait, South Korea and Bahrain[23].

According to the Foreign Employment Act of Nepal, submission of a health certificate recognised by the Government of Nepal (GoN) is one of the preconditions to be fulfilled by a national applying for foreign employment. Although there is no provision of mandatory HIV testing, in practice, a migrant worker has to undergo mandatory medical tests, including HIV, as per the requirements of the receiving country. The proposed HIV and AIDS (Prevention, Control and Care) Bill of 2005 is in the draft stage, so there are no legally binding documents on HIV Testing and Care. Instead, there is the National Guidelines for Voluntary HIV/AIDS Counselling and Testing (VCT), and Anti Retroviral Therapy (ARV Therapy), which was produced by the National Center for AIDS and STI Control (NCASC). To date, the guidelines are used as ground rules for HIV testing and ARV Therapy. According to the guidelines, HIV testing is not mandatory in Nepal; however, compulsory testing can be done in the case when it is required to receive a specific benefit, such as in the case for employment placement abroad[24].

For the purpose of the medical tests for foreign employment, the Government of Nepal (GoN) Ministry of Health has given approval to 51 medical testing centres, a decision taken on August 25, 2006. It has, however, yet to accredit them. In addition to that, there are 5 GAMCA (Gulf Approved Medical Center Association) affiliated medical centres. The prospective migrant workers wanting to go to Gulf countries have to do their tests only in centres approved by GAMCA. All medical testing centres approved by the GoN and GAMCA are situated in Kathmandu, the capital city.

PRE-DEPARTURE

Testing procedures

The medical tests are done at the time of visa processing or even before applying for foreign employment. The migrants are generally informed by the recruiting agents about the test. The testing procedure involves an exhaustive list of series of tests, which vary slightly from country to country, but are generally applicable to all prospective migrants at pre-departure stage.

For Non-GAMCA Testing Centers, the tests performed are:

I. General Examination (psychiatric disorder, neurological disorder, allergy, hernia, varicose vein, extremities, deformities, venereal diseases, height, ear, eye, blood pressure, abdomen, lungs, skin);
II. Laboratory Examination (urine, stool), and
III. Biochemistry (sugar, cretinine, bilirubin, SCOT, urea, VDRL, TPHA, HIV, HBsAg, Hev).

For the GAMCA Testing Centers, the tests performed are:

I. Infectious Disease (HIV reactive, hepatitis B Surface antigen Positive and anti HCV, Microfilaria Positive & malaria blood film positive, known leprosy, tuberculosis, chest x-ray, fibrosis, calcification, pleural thickening, tuberculosis pleural effusion, tuberculosis lymphadenitis, VDRL, TPHA);
II. Non-Infectious diseases (chronic renal failure, chronic hepatic failure, congestive heart failure, uncontrolled hypertension, uncontrolled diabetes mellitus, known case cancer, psychiatric disease, neurological disorders, physical disabilities, colour blindness, deafness) and
III. Other (pregnancy test done for all female applicants).

The national VCT guidelines state that all those who undergo compulsory HIV testing should be informed that they are being tested for HIV. Unfortunately, this is not the case in practice. The research findings show that consent is not taken for general medical testing, much less for HIV testing. Accordingly, most of the prospective migrant workers never knew that they were being tested for HIV, as there is no pre-test or post-test counselling either. There is no formal provision of information about testing procedures given to migrants, and no informative posters were observed on the walls of testing centres. Migrant workers interviewed only remember that they gave blood and urine samples, had a chest X-ray and a physical examination, and female migrant workers had a pregnancy test.

> "You have to do medical check up from here, only then you can go" said the Manpower staff, and so I did medical. They checked up blood, x-ray, eye, weight, they checked all." (Returnee deported male migrant worker from Malaysia, on the tests he had done in Nepal before departure)

> "They called us up and made us photo copy of our passport. After submitting the photo copy they told us to perform the medical test. I came down with the medical test slip and got X-rayed, gave my blood and I was told to go for the physical examination." (Fit prospective male groups going to Saudi Arabia)

> "Nothing regarding doing this or that is mentioned so we don't know that.We don't know. I think they perform the pregnancy test while checking the urine. I don't know regarding the blood test. Some married women are tested positive for pregnancy while checking their urine. No, even if you didn't take the documents, they send us to different sections showing directions for different tests. So later on we felt needless to ask such questions." (Fit female migrant workers going to Israel)

Migrant workers consider medical testing as compulsory to get a visa, and some consider the medical report equal to testimony of legal status and would go to any lengths to fulfill the requirements.

> "It is very important to have a doctor's report because there are a lot who go illegally. And there are fake agencies. But if we have doctor's report than we can go ahead on legal basis. So I was aware about all this, that's why I felt I should have my medical checkup done." (Fit female prospective migrant worker going to Israel)

> "Manpower told us. We can also be confident to go for foreign employment. Medical is done for ourselves.When it is confirmed about going abroad they tell us to undergo the medical test. It is only after having passed the medical test that other process starts. If one fails the medical test then every thing is doomed!" (Fit male prospective migrant worker going to Saudi Arabia)

In Nepal, in spite of the existence of VCT guidelines, most medical testing centres do not practice any pre-test or post-test counselling. Some medical testing centres claim to provide post-test counselling, but in fact, it was found that post-test counselling is only done if a person makes further enquires about their disease. If there is no counsellor available, the migrant is referred to another service provider for post-test

counselling. This is reflected in the comment made by staff of a GAMCA Testing Center,

> "We don't provide counselling even in case of permanent failure. If it is HIV positive then we refer them to Teku Hospital for confirmative test.We don't explain them anything about HIV or Hepatitis".

The VCT guidelines says,

> "Any disclosure of confidential information, no matter how inconsequential it may seem, whether it occurs in public settings, over the telephone, on an answering machine, by mail, fax, or email requires the client's consent".

However, the test results are generally given directly to the recruitment agents. It has been found that the migrants do not have any idea about the things inscribed in their report, neither do they ask nor do the centres show them their reports. Migrants seem to only be concerned about whether they are fit or unfit and do not seem to care to go through the details of their reports, as reflected in this fit prospective migrant's comments:

> "I don't know about this because I and my friends did not go to get the report. It was the staff of the Manpower that brought our reports.All we needed to know was the result, so we did not care about the report; it was the staff who took our result."

In Nepal, the issue of gender sensitivity is not given due attention, as it is not compulsory that a person should be examined by a doctor of the same sex. In some medical centres it was found that female migrants were examined by a female doctor, but this was not the case in other centres; whereas there were also cases where males were examined by female doctors.

> "Yes, she checks the migrants (male) making naked during physical exam. Till now there are no complaints from the client." (Doctor, non-GAMCA testing centre)

> "We were tested by a male, they behaved well." (Fit female prospective migrants going to Israel)

The cost of testing varies from country to country and from one centre to another. For going to Malaysia, it costs 1,500 Nepalese Rupees (NR)[25], while for Iraq it is NRs 9,000. For Israel, it is also high as they have to perform the tests twice: the pre-test cost is NRs 2,000 and the post test cost is NRs 3,100. In addition to this, the migrant workers claim that they also have to pay commission to the manpower agency. Most migrants felt the testing cost is expensive and some expressed that the price they have to pay is unreasonable.

> "I don't think it is reasonable; it is costly. I don't know if it is right or wrong. It is expensive. After all, it is for same urine test, blood test and X-Ray. Migrant workers are always made to pay in everything and everywhere. Doctors outside charge just NRs. 200 for the urine and blood test but we migrant workers are always being harassed in terms of money. It's always the distressed are being agonised. Manpower takes the commission for Rs 400-500 which is very maximum. I think paying that amount is maximum, but normally I feel it does not cost as much as they make us pay because Rs 3100 is a huge amount for us. I did feel the charge was maximum." (Fit Female migrant worker going to Israel)

As all the testing centres are located in Kathmandu, the migrants living in the rural areas of Nepal have to travel to the capital for the medical tests. Proximity to medical centres was expressed as one of the greatest needs of migrant workers, since those who have to come to Kathmandu face problems accessing

these centres, including having to bear the extra expenses involved. They often have to be accompanied by a friend or agent, again adding extra costs of travel, food and stay in the capital. It was found that the funds are mainly provided by parents, the father-in-law or by borrowing money at a very high interest rate of 36%. The situation for female migrant workers is even more difficult, since in Nepal, they do not have fixed properties in their own name. They have to sell their personal property like jewelry and livestock, whereas a male person can mortgage the property and manage money more easily.

> "There were lots of problems since I needed to come from my village, and it takes lots of bus fare as well as one night to come here." (Deported male migrant worker from Malaysia)

> "…by selling land as well as giving land as collateral for loan [On arranging money]." (Deported male migrant worker from Malaysia)

> "We girls don't have anything – not any kind of treasure nor do we own any share in our parent's property. We even don't own any kind of fixed property. All we have is our jewelry that we usually wear i.e. earrings, necklace and so on. But these are not enough. Either we have to borrow money from banks or the other option is to sell our livestock." (Fit prospective female migrant workers going to Israel)

Although referral services exist in Nepal, they are weak in practice. Reports are usually delivered within a day after the test, but rural migrants go back to the village right after the tests and the agent will inform them of their test results. In such circumstances, if they fail the health exam, the migrant workers will not have access to referral services. Those persons who wait and collect their report themselves might get access to referral services. However, experience shows that the testing centres do not even give proper referral to those who are found unfit, and they usually just told to return home without receiving any treatment or referral to treatment or care centres.

> "Three of our friends have failed the medical test and they were told that they should never try going for foreign employment. My friends asked me which medicine I should take for being cured. When I asked at the medical, they told me that it was not so necessary to under go medication. There was some problem with his blood." (Group of prospective male migrant workers)

Different strategies are applied by the agents to make the migrants medically fit for departure. Drinking milk and curd are found to be common strategies adopted by the migrants, which they are taught by the agents. Stories were shared that they have heard about the different strategies adopted by the prospective migrants to help pass the medical test.

> "From somewhere I heard that prior to X-Ray, if we eat curd it will bring positive result, that's why I ate a lot, it is said that there would be no spots and scratches visible after drinking one pound milk." (Fit migrant worker)

There are confirmatory procedures done by some testing centres, but these result in extra expenses, which are prohibitive for poorer migrants. Additionally, migrants have little information on accessing further testing or treatment. Migrants who are located in Kathmandu can try to access treatment on their own, with some having an x-ray in another centre to confirm the results. The government of Nepal does not have any specific schemes for those who have failed health exams, and there is no mechanism to inform those who are HIV+ to go for further treatment or care.

Monitoring of testing policies and procedures

Monitoring of GoN approved medical testing centres is done once or twice a year by a monitoring committee from the Ministry of Health (MoH), following guidelines prepared by the GoN. Not all the centres are monitored, and various factors like the political situation have also affected the monitoring process. The monitoring committee is comprised of persons from a multi-ministerial team including the Ministry of Health and Ministry of Immigration, which does the task in the presence of one physician and one radiographer. The group sends a notice prior to visiting the centres, and the monitoring is done based on the guidelines mentioned.

The GAMCA associated medical centres, on the other hand, are monitored by a team that comes from the GCC every year, comprising 1 or 2 doctors and GAMCA officials.

> "Groups of 6-7 persons go there and check the guidelines. If the requirements are satisfactory then we publish a notice certifying ok. On the other hand, those whose guidelines have not been found to be satisfactory are also informed along with all the reasons why they have not been certified." (Ministry of Health official)

> "They come to visit every place from which people are going to their country. So, they come for the inspection. Yes, after approving, they certify. Main thing is equipment - is there equipment available or not for the lab tests? What are the procedures for X-rays etc.? X-rays are of different qualities and they look and certify. When they come there should be a waiting room, physical check up room, lab and x-ray etc…" (Staff, GAMCA associated medical centre)

While monitoring focuses mainly on the technical aspects of testing, the issues of access to information, counselling, referrals and client satisfaction seem to play no role at all. On one hand, the staff of the medical centres claim the facility to be good, but on the other hand, the migrant workers have a different perspective and often express their dissatisfaction with the quality of services.

> "Places for sitting and toilets are not good. The waiting place is also not fine. Since there is a huge crowd out here a good management for waiting has to be performed. Many friends are standing the whole time while they are waiting. When the clinic was established it should have been advertised. It took a lot of time to locate the place. There is not even an advertising board attached anywhere. After a long struggle to find the place, we guessed and entered finally. We even don't know whether it has been recognised by the government." (Fit prospective male migrant workers going to Saudi Arabia)

ON-SITE

As a rule, according to the requirement of the destination country, all migrant workers are obliged to go for medical examination again upon arrival. The testing is done at the time of entry in some countries, and in others within one to three months. No medical testing is required once the migrant workers reach Israel, and migrant workers will not be deported on the grounds of medical fitness or illness upon arrival in Israel. Nepalese workers in Malaysia are tested over an initial three year period, but do not need to be tested again after that. In some destination countries, when migrants are told to undergo medical tests by their employer, they are not allowed to be examined in any health clinic other than where they were referred to by their employers.

> "I don't know much about re-testing and confirmation. It took at least three hours to reach the place were they tested us.They took us from the work place in the morning and bring us back in the evening. They did not let us go to other place." (A returnee migrant worker from Malaysia)

Many migrant workers do not know that they have to be tested upon arrival in the destination country. They undergo various tests, but have no information on the tests performed, and most could only recall that there was a blood test. The tests are done following the employer's requirement and they differ from country to country. The results are given to the company or employer, and not directly to the migrant workers.

> "It may be done accordingly with the company's requirement… In fact the medical test I had to undergo was just the blood test. They took my blood from between the nail and flesh. That is all for the medical test done in Saudi Arabia." (Male returnee migrant worker from Saudi Arabia).

> "Everywhere we have to do medical but not in beginning. When I went to Qatar, they checked up blood and x-ray after about fifty days." (Male returnee migrant worker from Qatar)

> "No, I did not get any information. Boss got the report and said you are failed so you have to go back to your country." (Deported male migrant worker from Malaysia)

The findings show that pre-test and post-test counselling is not available to migrant workers in destination countries. In case of an unfit test result, they are just told that they are sick and have to go back home. The migrant workers do not receive any treatment, care or counselling in the destination country; they are simply deported, as indicated by these deported Nepalese migrant workers:

> "He did not do Samjaune bujaunaa (which means counselling). They told (the employer) that you will get back your money and (the employer) is not allowed to keep the sick person. They told (the employer) that if they will keep me, their work will be seized and I will also be sent to jail. Then (the employer) told that it would be better if I return back." (Male deported migrant worker from Malaysia)

> "They told me to do medical test there. 6-7 days after medical test, boss told me that there is scar in your chest. I asked boss that if the scar can be cured by taking medicine. He told me that he has to look at report. Then I worked for 14-15 days and after that, he told me that I have TB and I have to take medicine for six months to one year.They bought ticket and sent me home." (Male deported migrant worker from Malaysia)

Though medical testing could be used as a mechanism to assess the health status of migrant workers and ensure treatment and care, in practice it is used as a tool to screen out and deport migrant workers who may have health conditions. Unfortunately, there are cases where migrant workers have reportedly been sent back even in cases of minor illness that are treatable. Moreover, there does not seem to be a general provision of confirmatory testing; and even where it is available, it does not seem to be available for migrant workers.

Testimony of a Deported Male Migrant Worker from Malaysia
First time I stayed 3 years in Johor, Malaysia, then went back to Nepal. When I arrived in Malaysia again I got common cold and had problem in throat and nose. I was unable to walk and do the work and they did a medical check up. After 15 days I got report and the boss said that my medical report is unfit. They said you go back and I said there is problem to go back. They said it is government rules, so I must follow and then I came back. I don't use any drug like hashish or anything. I use only tobacco and nut.When I asked boss, he said you use drug? Then I replied no. I was really in terrible situation, problem was on throat, chest pain, coughing. I am using that medicine and I have a good health now.They deported me due to drug but when I did check up twice here, there is no problem. I said to Boss I ate De-cold medicine (medicine taken in Nepal for fever), which was given by my friend, but Boss said you must use drug. I said them please do my medicine check up again but they said it is done only one time and then deported me.

REINTEGRATION

Impact of results

Once deported, the plight of the migrant workers takes a new shape when they return to their own country. They cannot easily tell their family, and seeking support while keeping their situation secret is difficult. Financially, it is a real burden on the part of the deported person as well as their family, as the migrant worker has returned home empty handed after investing all the family savings and even borrowing money with a high interest rate to go abroad for employment. Not only are they affected socially and economically, but the migrant also goes through tremendous psychological pressure. Often it becomes impossible for the deported migrant workers to disclose the reason for returning, so they try to hide their health condition thinking that they are safeguarding the family from distress. But in reality, the returned migrant must bear the burden of their shattered dreams, as well as the guilt of the fact that the family is potentially faced with economic ruin, as they will find it difficult to impossible to pay back the loans.

> "Family members think that the son, husband, brother, whatever the relation is who has gone for foreign employment will earn money and come back and their family status will improve. But in contrast, when the person returns back empty handed, the family perspective towards the person changes and the trust level decreases. Due to this he feels difficult to face family members. He starts thinking that he has wasted lots of money and how can he get all the money back. This thing runs in his head and affects him psychologically. Due to this he again tries to go to another country as soon as possible. He thinks that he will succeed next time so he takes a risk. This is also one of the direct mental effects." (Male Trade Union staff)

There are many cases where migrants have returned back due to diseases which are considered minor in Nepal, and many return very soon after their departure, within just a few months.

> "Someone could be all right this moment and then could be infected with pneumonia, bronchitis, chest infection etc….We cannot give guarantee for that." (Male Doctor in GAMCA centre)

> "Some of the labourers go there after being told that they are fit here and then are found unfit there, sometimes found seriously ill and sometimes they just have simple diseases. Though these types of disease are taken as simple in our country, they are taken as serious disease in foreign country." (Male Trade Union staff)

In such cases of deportation due to illness, the only option a migrant is left with is to treat the disease on his own and then seek some other livelihood to pay back the amount taken on loan. The migrant may also still plan to go for foreign employment again in the future, as this is often the only way they can see to recover the lost initial investment made on going abroad for employment. The comments made by this migrant worker who was deported from Malaysia reflect this:

> "If I get my whole money back, including the amount I have paid as interest and if my health is fine, I will go to another country after a few years. I need to go to another country to earn money."

Accessibility to treatment, care and support for migrants

There are no existing policies, guidelines or legislation in Nepal that guarantee access to treatment, care and support for migrants declared unfit or for their families.

> "Since we are a trade union, some of our policies and our working style do not match with those of deported. But we are slowly putting our hands in the field of social sector too. Hence in near future we are planning to do something but we are not able to support them at present." (Trade Union staff)

Treatment and care services for the deported migrant workers are also not found to be a main concern of other organisations, even though referrals could be made. The practical experience of migrant workers in accessing care and support is not very promising currently and the expense of treatment is also borne by the migrant worker or his family.

> "I am from Dhanusa, I spent eighty thousand (to go abroad) and now I am in great trouble. I did x-ray from my side. It's all right. When I came here I bought Rs.2000 medicine. It's all right now." (Male deported migrant worker from Malaysia)

> "Now there are lots of organisations working in this sector, if anyone needs immediate help and needs temporary shelter, they have to fight for their rights, then we send that person to our partner organisation. We try to convince them that people with HIV have equal rights like other people and should be allowed to work with full dignity. It is the responsibility of the government to take care of these people as well as to provide them opportunities to work and make environment for them in the society and family to live their life with full dignity." (Trade Union staff)

However, members of the National Network on HIV revealed that 18 information and counselling service centres exist that provide support services for migrants. These centres are all located in the western development region. This is difficult to access and thus the research team could not ascertain to what degree unfit and deported migrants might use these centres.

Pakistan

In Pakistan, it has been observed that over the past 10 years, people with technical skills have been migrating to Canada, UK and Australia, whilst the majority of semi-skilled and unskilled workers tend to head for the Gulf Countries or to other popular destinations such as Malaysia and South Korea.

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 and protecting international Pakistani migrant workers. Established in 1971, BEOE is a centralised agency of the Federal Government that processes recruitment demands for Pakistani labour through Licensed Overseas Employment Promoters.

Migrant workers from Pakistan going into unskilled labour abroad number approximately 150,000 every year[26]. Pakistan has an unusually young overall population, with 63% of the country's population below the age of 25. Unsurprisingly in the light of this, the government's Bureau of Emigration data shows that the majority of the Pakistani migrants working in the Gulf countries are aged between 20 and 30 years old. Most of them are also illiterate, unskilled and ill-informed about health issues, including HIV.

In Pakistan, there is no law on mandatory HIV testing and no legal obligation or regulation that requires health testing for migrant workers. However, as a sending country, documented Pakistani migrant workers are at the behest of the receiving countries, and, if so required, they must get medically tested from an authorised medical testing centre recommended by the embassy of the receiving country. Sea-based workers are required to get medically tested from a ports' health officer under the Merchant Shipping (Medical Examination) Regulation of 2002.

The Pakistan National HIV and AIDS Policy, which is in its final draft stage, states that:

> "HIV testing and counselling will be voluntary and confidential, and testing will always be accompanied by access to information and counselling. People who test HIV positive will be assisted in accessing on-going counselling, treatment, care and support.Test results will be confidential and systems put in place to ensure the privacy of people who undergo HIV testing. Even in cases where services recommend testing because of perceived risk or as a diagnostic measure in the presence of illness, the specific consent of the person will be obtained before testing".

In the National HIV and AIDS Strategic Framework (2001-2006), migrant workers are considered among the groups of concern with regard to HIV transmission within the country. The main reason for this is that Pakistani migrant workers, especially those in Gulf States who are found to be HIV positive through mandatory testing, are deported back to Pakistan without any referral. In addition to this, significant numbers of migrants who may also have reproductive and sexual health problems return to Pakistan upon completion of their contracts, yet the health system has no effective mechanism in place to track and provide health services for these returnees. Attesting to this, it has been found that a significant number of those who tested positive for HIV in Pakistan were primarily males who had been migrant labourers in the Gulf States but had been deported. Without proper counselling, these returning migrants

pose a significant risk to their spouse and family, with newspapers increasingly reporting cases of HIV among spouses of deportees, and related mother-to-child transmission.

PRE-DEPARTURE

Situation with regard to mandatory testing

In Pakistan, as a criterion for employment abroad, it is obligatory for prospective migrant workers to pass a medical examination for conditions stipulated by receiving countries. Some tests like HIV, TB, hepatitis B & C and STIs are generally required for employment in every country. Some countries ask for additional tests: for example, the Malaysian Health Ministry now includes a drug abuse test and include major psychiatric or neurological disorders in the list of tests required for employment there. Although testing is not a state requirement, migrants and the sending country must comply as expressed by an official at the Sindh AIDS Control Program:

> "We don't have any such laws (mandatory testing). In fact it is taken as human rights violation. Generally the HIV testing is done on voluntary basis. Only migrant workers are required to go through mandatory testing which is because of the requirements of receiving countries".

Generally, medical testing of migrants can be performed in any government approved medical diagnostic centre, but for GCC countries, the tests must be done by centres accredited by Gulf Approved Medical Centres Association (GAMCA), following specific testing criteria. According to a GAMCA testing centre authority, candidates found to have any of the following conditions will be considered unfit for employment abroad, following the instruction received from the relevant diplomatic mission:

1. Detection of AIDS test positive (HIV reactive).
2. Hepatitis B or C positive (HbsAg or HCV reactive).
3. Tuberculosis or cancerous diseases. (pulmonary or extra pulmonary).
4. Constitutional syphilis (VDRL-TPHA positive).
5. Very low standard vision which cannot be corrected with glasses (for drivers).
6. Any degree of squint or colour blindness. (for drivers).
7. Deafness.
8. Pronounced stammering (fitness at employer's discretion).
9. Any chest deformity leading to inability to perform the declared profession.
10. Abnormal curvature of the spine leading to inability to perform the declared profession.
11. Hernia, hydrocele, spernatocele or varicocele.
12. Hemorrhoids, internal or external.
13. Diabetes mellitus uncontrolled (as per company's regulation)
14. Valvuloar or other diseases of heart, and hypertension blood pressure above 150/100 mmHg.
15. Present/ past history of epilepsy, asthma, peptic ulcer, nervous breakdown, kidney stones & chronic renal or hepatic failure.
16. Drug addiction (morphine test positive).
17. Microfilariasis positive & malaria thick blood film positive.
18. Known leprosy patient.
19. Pregnancy test positive (for a woman)
20. For any disease which can be treated in 15 days, the applicant would be considered temporarily unfit.

Until 1998, there were only 2 GAMCA testing centres in Pakistan, of which the one in Karachi used to test 500 to 600 people per day. But this changed following the decision taken by a visiting GCC panel of doctors, who opted for decentralisation of testing. Since then, new centres were recruited to operate under GAMCA in all provinces. There are currently accredited GAMCA centres in Karachi (3), Lahore (5), Islamabad and Rawalpindi (5 to 6), Multan (3), Quetta (1), Gujrawala (1) and Peshawar (5), according to a GAMCA centre official. All GAMCA centres throughout the country are in contact with each other via internet, and test results are shared on a daily basis to make sure that the same prospective migrant does not apply again to another centre, if proved unfit in one of the centres in another province.

The testing centres do not provide any pre-test or post-test counselling, nor do they have the facility to provide counselling, as found during the visits made to various GAMCA and non-GAMCA centres in Karachi and Islamabad. This was also shared by the migrant workers. Testing centre personnel were generally found to be unconcerned with the counselling component in the testing of migrants, since it is not required either the employers or the host country authority. For example:

> "No we don't provide counselling and don't have any policy in this regard." (Administrator, GAMCA office)

> "No, we do not have a lot of time to council them". (Doctor, GAMCA Testing Centre in Karachi) And "Who does this?" (Doctor in Islamabad)

Even in the case of an HIV positive test result, experience shows that no information or counselling was provided, as shared by a returnee HIV positive migrant worker from Saudi Arabia:

> "I lived in Saudi Arabia for 5 years.When I came to Pakistan on leave after 5 years I went for medical test to Urgent Medical Centre, Rawalpindi and was declared as HIV positive. No, when I went Urgent Medical Centre for test they did not give me any information or counselling regarding HIV test.They recommended me 4-5 tests and asked me to go for these to get my status confirmed."

Moreover, it seems that prospective migrants are not even informed about the nature or content of testing, neither in the testing centres nor during the briefing in Protectorate office, as confirmed by the migrant workers and stakeholders. These prospective migrants are largely ignorant of the nature of the health test, and are not aware of the greater meaning or impact of the results beyond the fact that they have to get the fit medical report, as it is required by the employers in receiving countries.

Although there is a pre-departure briefing system for migrant workers, observation of such briefing showed that it does not include any information on mandatory testing, or the HIV test or the consequences of an unfit result. Although an official from Sindh AIDS Control Program observed that

> "The Government Protector of Immigrants briefing officer should be aware of HIV/AIDS",

this seems not to be the case right now. The Executive Director of a PLWH Support Organisation expressed his frustration over the lack of information on testing, especially HIV.

> "You talk about half hour in training of migrant workers about rules, laws (briefing in Protectorate Office). Why don't you talk 10 minutes on HIV and AIDS? The majority of reported HIV cases of Pakistanis were deported Pakistanis from Gulf countries, who were deported for contracting HIV when they were working there".

This total lack of information is clearly reflected among the sharing made by migrant workers and stakeholders alike:

> "Just my promoter told me that tests were necessary before going abroad. Nobody briefed me about it in lab." (Prospective migrant worker going Dubai)

> "No, I was not given any information about testing. No, we were not told anything before or after the testing. We just performed the tests, no information was there. The candidate does not care at that time. He just wants to go out and make money. Only if you face problem, if you are unfit then you ask. First we go to the travel agent and they told us, "You have to do medical". It is their and medical centre's responsibility to give us information about testing.What are these tests, the purpose of tests? They say it is only formalities. But if they said that we will be tested again in Medina, then we will not be so scared there." (Returnee migrant worker, Saudi Arabia)

> "No we don't have to give them any such information because most of them know about why have they come to the laboratory and why is their test being taken." (Doctor, GAMCA Testing Centre)

> "No, because they know that it is required for before getting a visa for abroad." (Doctor, non-GAMCA Testing Centre)

> "There is no pre-test and post-test counselling in labs or testing centres. There should be clear instructions, briefing and policy by the Government of Pakistan on HIV and AIDS regarding migrant workers. Government should also take step on follow-ups, monitoring for the better system." (Overseas employment promoter)

The cost of testing varies depending on the country of employment and the testing centre used. Generally, migrant workers do not have information regarding the comparative costs involved, but rather are guided by their employment promoters: "I paid Pak Rs.2,800" said one prospective migrant going to Dubai, while another going to Saudi Arabia said, "I paid Rs. 4,000 for the test".

The environment, sitting arrangement, hygiene and cleanliness in GAMCA testing facilities were expressed to be good by the migrant workers, which was confirmed through observation during site visits.

> "In Taj Medical (GAMCA centre), they are very good. They are very high quality, has got very good equipment, good testing facility like foreign country and are very strict. They will not pass you if you have illness. They will treat you. After getting well, they will test and give fitness report." (Returnee migrant worker from Saudi Arabia)

However, some of the non-GAMCA testing facilities were clearly lacking in these areas, especially the toilets, which were considered to be in dirty and miserable condition. In one mapping exercise of non-GAMCA testing centres, the prospective migrants explained that they were given strips to put drops of urine on and were directed to an adjacent dirty street corner to perform the task, much to their dissatisfaction. Migrants are not given any privacy during the testing and the bathrooms are also in a bad state. One such frustrated and embarrassed prospective migrant shared:

> "I had a problem because of the small and dirty bathroom. I think it was not a bathroom but a storeroom.We were four people who went together.They did not take care of our privacy."

Many male migrants shared that only male staff conducted the testing, but some said that female as well as male staff did the testing, which could be considered a problem in the socio-cultural context of Pakistan. According to one person,

> "There are majority female staff members who do the testing. Of course I was feeling very uncomfortable while giving the test, even female staff does X-rays and body screening."

The same was confirmed by a GAMCA testing centre doctor who said,

> "Yes we have three female doctors working with us. The lady doctors do the body screening".

On the other hand, it is considered a big problem in some labs where female staff is not available to perform tests of female persons, as shared by the Head of a PLWH Care and Support NGO:

> "Male staff deals with females who feel very uncomfortable due to their questions, language and gestures. There should be female staff in labs and testing centres".

Regarding the delivery of test results, which are usually given the next day, it is possible for the migrant workers to collect the reports themselves from the testing centre, but most usually returned to their villages upon completing the testing, with the recruitment agency collecting the results. Sometimes the reports are sent directly to the companies or the agents and they then verbally inform the migrant of the result, whether they were fit or unfit, without giving any further explanation. Some migrants who are illiterate had to depend on others to read the results, which are written. In such cases, confidentiality was not considered an issue by most:

> "The envelope was sealed, when I told the doctor to read it then I came to know that I am fit."

On the other hand, for those who are determined unfit, receiving the results was not helpful, with a common complaint being that nothing is written to explain why they are not fit to go abroad.

In relation to confirmatory tests, it is claimed that in case of HIV infection there is always a confirmatory test. Other than this, usually a re-test is not done, as explained by a doctor in GAMCA testing centre:

> "No, we don't test them again. The migrants themselves are not interested in having a test again. They just want to know their result".

In case the migrant worker wants to be re-tested, usually they are told to go to another lab to confirm the results:

> "We refer permanently unfit intending migrant workers to other hospitals." (Doctor, GAMCA Testing Centre)

The system of treatment and referral services offered to temporarily unfit cases varies among testing centres; some state they do not offer any treatment; while others give prescriptions for treatment and advice to appear for a re-test after a certain period. Or they might refer the individuals to other hospitals for necessary treatment. This sometimes happens with those who have already been deported from a destination country for a treatable illness and have attempted testing to go abroad again. In case of a HIV positive test result, along with the recruitment agency, the testing centre's administration department is notified as well. Practice shows that during delivery of HIV positive test results, confidentiality is not always ensured. However, HIV positive cases are generally referred to the government AIDS Control Program with a referral letter given to the person, but the centres have no time or interest to follow-up and ensure that the person complies.

"No we don't have a referral system.We usually advise them to go to Aga Khan Hospital because we know that they have good doctors there." (Doctor, GAMCA Testing Centre)

"Those who are temporary unfit are usually got infected from malaria, pneumonia, blood pressure etc. In many cases the patients feels stressed and their Blood Pressure gets shoot up while taking the medical test.We recommend them to take pills and come next day.Those who are unfit on permanent bases are usually diagnosed with Tuberculosis, Hepatitis B and C, HIV positive. In case of pregnancy women can not get foreign employment. We give them counselling and suggest them to have a test from another laboratory. If the person is HIV+ we refer them to the Sindh AIDS Control Program, along with the medical letter.We have received 11 cases in 3 years, the 1st case of HIV was diagnosed in March 2003 and the last was diagnosed in December 2006." (Medical Officer, GAMCA Testing Centre)

"Two patients were diagnosed HIV positive within last two years. But the ratio of Hepatitis B or C is very high as 7or 8 persons are diagnosed with this infection on daily basis.Yes, we do refer them to Civil Hospital, other government and private hospitals including Sindh AIDS Control Program. No we don't have any such policies for HIV positive people but if we have any such case so we refer them to Sindh AIDS Control with a referral letter." (Administrator, GAMCA office)

Monitoring of testing centres

There seems to be no government policy or control over the testing centres or tests of migrant workers, as reflected by an official at the Sindh AIDS Control Program:

"We don't have government policy for accredited testing centres for migrant workers".

The GAMCA testing centres shared that they are not accountable to any of the Pakistan government authorities; however, they do report directly to the GCC countries. The GAMCA centres have to send a compiled report on test results, including unfit cases and the categories, on a quarterly and annual basis, to the Executive Board of the Health Minister's Council for GCC States in Riyadh. In case a certified fit case is found to be unfit through testing upon arrival in a GCC country, the concerned testing centre is penalised. A doctor in a GAMCA testing centre verified this:

"If this kind of problem occurs the responsible laboratory has to pay $3,000 and if it happens from the same lab again, then their license is cancelled."

The GAMCA testing centres are strictly monitored and regulated by a GCC monitoring panel, who come on surprise visit.

"Once in a year the GCC panel send group of doctors to visit the authorised countries and then they verify.They have a very strict vigilance.Assigned countries are Oman, Qatar, UAE, Bahrain, and Kuwait." (Doctor, GAMCA Medical Centre)

However, the monitoring focuses mainly on the efficiency in tests and the physical and clinical aspects of the testing centres, while the issues of consent, counselling and information seem to have no significance at all, as reflected in comments made by the Administrator of a GAMCA Office:

"Every year a team visits the laboratories to check the standards of various labs. Before giving license they visit and observe the laboratories and then they give a license for a year.Yes we do have certain policies such as the laboratory should be certified from ISO, the machinery of the laboratory should

> be of the new technology so that the results can be improved.We see the Lab staff, their qualification, machinery at the lab and its condition, if it is of a good and a modern state, and the environment of the laboratory either it is hygienic or not".

ON-SITE

When prospective migrant workers leave Pakistan, they have no clear idea that medical testing awaits them again in the host country. Most returnee migrant workers shared that they were not prepared in advance to undergo mandatory testing again upon arrival in the destination countries, and this had come as a great surprise to many.

> "We want to know fully what are the tests in Pakistan and what they are testing again in Saudi Arab? We did a medical exam already, then why we are tested again? What are these tests? What are the results? We want to know. But they said it is Saudi law." (Returnee migrant worker from Saudi Arabia)

General migrant workers have to repeat the medical testing every 2 or 3 years during the period of work-permit renewal, depending on their occupation in most countries. However, migrants working in the service industry like hotels and restaurants have to undergo testing at least once a year, and in some cases as frequently as every 3 months. The testing is usually carried out by either a clinic or a local hospital. However, there is a general lack of information, counselling or even access to test results. According to a returnee migrant worker from Saudi Arabia,

> "No, I don't get a copy of the report. It went to Human Resource Department directly."

It was reported by migrants that there are those who were deported despite having taken the medical examination at home, where they were declared fit, but never given any reason, information or explanation in the host country regarding the tests or results.

> "Before leaving Pakistan, I had medical test in Taj Medical Centre in Karachi. After a week of arrival in Medina, I was tested again in Medina National Hospital. They told its a general requirement of Baldia. Its a municipality department, inspection of staff is controlled by it.They just took blood, urine, stool, checked tongue, ear, hands, X-ray. For housekeeping and others, there is only urine, stool and blood test. But I am F&B staff, so I had to do many more tests. The people who work in F&B, they have to test everything after every 3 months. Others are tested every 6 months." (Returnee migrant worker, Saudi Arabia)

> "My annual medical test showed my HIV status but no one informed why exactly I was declared unfit. They simply asked me to leave the country and asked me to go through confirmatory test in my home country." (Deported HIV+ migrant worker from Saudi Arabia)

Many migrant workers were found to be quite satisfied with the personnel at clinics in destination countries, since there were many Pakistani and Bangladeshi people at the reception, with who they were able to communicate with easily in Urdu. On the other hand though, migrants were not informed about testing or the consequences of an unfit result by the testing centre staff, but from fellow colleagues or friends. Stories circulated about deportation for failed test results, especially for AIDS, making mandatory testing associated with great fear and a sense of uncertainty regarding their employment status abroad.

> "He (Doctor) did not say anything. Just ok, give urine, give blood, like this.They didn't tell us what the tests are for. No, not before test, not after test, nothing was said to us. But I heard from the colleagues what is the purpose of medical. They told us they want to see if you have HIV, hepatitis B, C, chicken pox or any big illness, then they will send you back home. If you have HIV then there and then they will send you back home. Say "You go".They will give no treatment. Just send back home." (Returnee migrant worker from Saudi Arabia)

As an unfit result involves a swift and often very humiliating process of deportation without any treatment or support offered, some would attempt to evade such process either by fleeing and staying illegally as long as they can, or by returning home on their own with the hope that upon treatment they could return again. As one such suspected returnee from Dubai said:

> "I lived in Dubai for 7 years where we used to go for medical tests every year. In the 7th year, when the Dubai authorities conducted my HIV test it was positive.The authorities did not tell me the truth. They asked me to give my passport to them to make some corrections. I myself realised there was something wrong, as I was aware of their rules and regulations. One of the doctors was my friend, he told me that I am HIV positive and the police will arrest me and deport me. I did not give my passport to them and came back to Pakistan on my own."

Generally, the process of foreign employment requires long efforts and huge investments, and the impact of an unfit result will simply destroy the entire investment, in terms of time, effort and most importantly money. One returnee migrant worker from Saudi Arabia narrates,

> "We saw an ad in newspaper for vacancy abroad. We apply. After two, three months the delegation comes. They check our documents and then call us for interview. If we qualify, then he calls us again for second interview.Then we are selected to go.And the travel agent asks us for money. 60,000 rupee we arranged in two, three months. We pay 3000 more for medical and again to the protectorates of emigrant's office. We have lots of doubts that the travel agent might cheat us. Finally we are ready to go after a long struggle, leaving mother, father, family behind us. After all these process, then we arrive to Saudi Arab and then we are tested and you are surprised to find that you are a patient of Hepatitis B, C, and you have to go back.That is a very painful time".

The behaviours and attitudes shown to an unfit person were described as being without any human dignity or care, adding to the persons' suffering, mental agony and torture in their isolation. The lack of care and sympathy is clear in this narration from a returnee migrant worker:

> "If something is found during test, they don't tell, never. Immediately within two three days they are sent back home. They don't leave him (unfit person) with his colleagues. They lock him in a room in staff housing and then send back home. My own colleague was sent back. He had chicken pox. Normally 3 persons live in a room. He was left alone. Even the staff supervisor did not go to see him. They called by the intercom. The doctor gave him medicine for one week. For food, the supervisor will ring, unlock the door and leave the food in the table in the lobby and go back. If anyone wants to meet him, supervisor say,"No, sorry". He could only watch TV and do nothing else. He had cell phone. He called me and said,"I am feeling more sick by the behaviour than the illness I have. I am feeling like I am in jail. I want to see you".We also wanted to see him, but couldn't. Once I secretly went to meet him. But by that time he was also very scared and thought he had a very bad illness. He did not want to meet me anymore. He said, "Go away from here. If you meet me, you will have it also. Don't come. Go away". In Pakistan, we also have it. Children have it. And we care for them, we are not afraid! They stay and live in the same room. But there they are very afraid!"

Host countries are particularly strict on migrants who are found with certain communicable diseases such as HIV, TB, hepatitis and STIs.

> "For HIV, no treatment. Send back home. For hepatitis, if you have jaundice, they will send you back on 2nd day, no treatment. If your medical test is unfit, you are sent back home. It is wrong. It is against human rights. It has to be stopped." (Returnee migrant worker from Saudi Arabia)

Similarly in most receiving countries, if one of these diseases is found, the test results are usually not disclosed to the migrants, they are deported immediately and the employer takes no responsibility as they feel they have no obligation towards the worker. In many cases, the company's manager just told migrants that they are suffering from a major illness and they have to go home.

> "Yes there are many people who are sent back. Some of them were sent back because of eyesight problem. Some of them don't tell the reason of deportation. Company didn't give us any appropriate reason of being unfit for the job." (Returnee migrant worker from Dubai)

The attitudes and treatment towards HIV positive migrants is often expressed to be similar to that of a convict; it is therefore not possible for one to ask for a confirmatory test or any form of care or support. A deported HIV+ migrant worker from Saudi Arabia shared this,

> "They kept me in jail for 15 days and did not tell me any reason. Then they simply deported me and informed me that I could not stay over there any more. I was not allowed to contact anybody during my imprisonment. Policemen dropped me at airport from jail in very strict security. No official notice was given to Pakistani government before they deported me. Awareness raising is a simple solution. Their policies should be changed and no one should be deported on the basis of his/her HIV status".

Most deported persons said that they were not even informed of their HIV status and the cause for deportation, let alone any counselling, treatment or referral back home. In fact, in some countries, migrants were put in jail, not permitted to meet anyone and not even allowed to get there belongings until the deportation papers were ready. They passed the custody period in a state of mental shock and disbelief at the inhuman treatment, on top of the loss of their investment to work abroad. They were dropped directly at the airport without being provided any medical reports; some were given a ticket to travel back to Pakistan, whilst others had to manage from their own account.

> "No we were not informed, they just gave us a ticket and sent us back.We travelled back in disgrace." (Deported HIV+ migrant worker from Saudi Arabia)

> "They did not give us money for the ticket. They didn't give us the expenses for travelling purpose. They just dropped us to the airport under the custody of immigration officer. We spent our own money and came back home." (Another deported HIV+ migrant worker from Dubai)

The Executive Director of BRIDGE, a PLHA Support Organisation has long experience of dealing with the deportation cases of HIV positive persons and portrayed the scenario of Pakistani migrant workers' deportation in detail. Again, it points to the lack of care in the host country, and then the return to yet another hostile environment in the home country.

The majority of our positive people clients are migrant workers. Now the trend is changing (towards injecting drug users) but initially if you work with positive people then 99% will say, 'I am a migrant worker'. The usual story is the semi literate migrant worker goes to Gulf country, mostly work as a driver, mostly they are without family. They earn money, they indulge in sex, mostly with female sex workers but sometimes with male sex workers. He doesn't know anything about HIV. But then he is routinely tested for HIV. If found HIV positive, he is isolated, even not allowed to go to his quarters to take his belongings. He is flown back. The time given before deportation - it depends, if it is from testing facility, he is directly flown out. If from factories, they don't want to allow staying anymore in that country. Send in jail or anywhere else on isolation cell.

Once found positive, they just throw back to parent country. He is not even handed over the passport. Passports are directly given to the immigration authority of Pakistan. No treatment, counselling, nothing, not even the information of the infection is given. They are just told, "You have a dangerous disease and that's why you are sent back". Here the Pakistani authority does not even allow them to drink in a glass, because they are not aware.

In the past, they used to inform the AIDS Control Program. When I was Project Director of Sindh AIDS Control Program, I used to get call at 12 at night saying, "We have 6 HIV Mujrim. We want to hand them over to you". What can I do taking them? I just would say to release them. Mujrim means accused, man who has committed crime.This is how positive people are considered here. No medical report is given with them.They just stamp in passport,'Deported'.The deporting authority here tells them that they have HIV, harass them, mistreat them. Sometimes they take money from them and release them from airport. When deported, they have to be informed properly and give counselling. They are in state of denial.They are more depressed because they lost job.They want to go back.

When they come here, usually they tell me,"I am healthy. There was an Indian doctor. Indian doctors don't want us to work there. They tested and gave me an HIV report. But I am healthy. I don't have any illness. It's a trap". But when we test them here again, we find them HIV positive.When deported, the HIV positive migrant workers have to be informed properly and brought under the care support facility for counselling and necessary assistance.

REINTEGRATION

Even though there are government as well and NGO initiatives to offer treatment, care and support to persons with HIV, in the absence of any formal referral systems, deported or returnee HIV positive migrant workers are unaware of these services and thus fail to access them.

> "There is no such system or policy that the receiving country is bound to inform the Government of sending countries before deporting unfit migrant workers.That is why and we are not able track HIV positive migrant workers when they are back to home." (Official, Immigration Bureau, Islamabad)

Moreover, as of yet there is no treatment and care program focusing on the particular needs and access issues of migrant workers.

> "We don't have any particular policy for migrant workers, but any can be treated at our centres. Our services are for everyone. We provide medical treatment for which they are sent to Jinnah Post Graduate Medical Centre and Civil Hospital. Different NGOs provide them financial support according to their needs and we provide them counselling and medicines." (Official, Sindh AIDS Control Program)

On the other hand, since the migrant workers that are deported for HIV infections are not informed properly on their status, they do not have any idea on the treatment or care they may need, as expressed by a group of deported HIV positive migrant workers during a focus group discussion:

> "We didn't know about our disease so how could we get treated?"

All the focus group participants, except one, shared their feelings that they were totally lost and disappointed and waiting for their death, which they then thought could finish them at anytime. This was because neither were they counselled by anyone on how they could spend a healthy and positive life with HIV nor did they know of anyone who could assist them. On the other hand, one returnee HIV positive from Dubai expressed he was very lucky as he was clearly briefed and counselled by his physician and referred to treatment and care facility immediately, so he was not as dispirited as the other participants.

This clearly shows the difference that timely assistance makes in the lives of HIV positive returnees, and in spite of all these challenges, some fortunately do succeed in receiving assistance from NGOs upon their return to Pakistan. Some care and support groups have established direct referrals with some testing centres that test migrants, while others make contact through peers.

> "Yes, we reach/contact through labs, agents, networking and NIH recommend our name to patients. We have developed and distributed information, education and communication (IEC) material including broachers, posters, flyers and we have database of organisations." (Head of New Light AIDS Control Society)

However, there is a need to strengthen and reinforce these referrals, since for many, it takes longer than expected to know about or access the desired services.

> "I came to know about that after five years. One of New Light members contacted me and visited my home and to provide me information." (Deported HIV positive migrant worker from Saudi Arabia)

Moreover, calls for change are being made by migrant workers to move Pakistan towards more migrant-friendly measures within mandatory testing.

> "As human beings, they should not deport positive persons. Then financial package should be announced for HIV positive people for their care, support, treatment so that people living with HIV can live a healthy life and earn bread and butter for their families." (Deported HIV+ migrant worker from Dubai)

> "Behaviour of lab staff and doctors should be improved through extensive training programmes so that they treat us politely and counsel us. Migrant workers should be briefed about deportation process and the rules and regulation of receiving country regarding HIV and AIDS." (Returnee HIV + migrant worker from Dubai)

> "There should be policy for HIV positive workers in receiving countries. Deportation is not a solution. Workers and company should cooperate with people living with HIV." (Head of New Light AIDS Control Society)

Philippines

Overseas employment remains one of the main features of the Philippine Government's poverty alleviation program. This program involves generating one million jobs for Filipinos abroad and in 2006, the Philippine Overseas Employment Administration (POEA) reported the deployment of a total of 1,092,055 overseas Filipino workers (OFWs) to 190 countries worldwide. This represents a 10% growth rate compared to 2005. Of this figure, 831,318 are land-based while 260,737 are sea-based.

With the increasing number of Filipinos taking the labour migration route to find better lives, an increasing number of OFWs are getting infected with HIV. As of March 2007, a total of 2,792 Filipinos who tested positive for HIV have been reported. Thirty-five percent (35%) of these were OFWs. It is important to contextualise these figures to avoid stigmatising the migrant community. This data, although very important in the light of developing effective HIV prevention responses among OFWs, is inherently biased mainly because OFWs are required to undergo HIV screening during the processing of their overseas employment contracts. Medical clinics are required by the Department of Health (DOH) to automatically report HIV positive results which directly feed into the National HIV/AIDS Registry.

The general population is not subjected to such a test. In fact, the Republic Act 8504, otherwise known as the Philippine HIV/AIDS Prevention and Control Act 1998, clearly states that compulsory testing for HIV is prohibited.

> Article III. Sec. 16: Prohibitions on Compulsory HIV Testing – Compulsory HIV testing as a precondition to employment, admission to educational institutions, the exercise of freedom of abode, entry or continued stay in the country, or the right to travel, the provision of medical service or any other kind of service, of the continued enjoyment of said undertakings shall be deemed unlawful.

Currently, the medical tests that OFWs undergo are meant to screen those who are fit to work. When they are found unfit, for example, if they get diagnosed with HIV, they can no longer work abroad since most destination countries require HIV testing. Given this situation, it is still important to determine how OFWs can actually benefit from these medical requirements. Towards this end, this study aimed to generate information regarding the current policies and practices on medical testing among OFWs, and develop recommendations to improve these policies and practices to make them more beneficial to the health of OFWs.

PRE-DEPARTURE

Accreditation of Medical Clinics for OFWs

All medical facilities that perform medical tests for OFWs need accreditation from the DOH. The technical requirements include service capability, physical plant, equipment and instruments, and personnel. The service capability requirement covers the range of clinical services provided by the medical facility,

including in relation to physical examination, dental examination and psychological evaluation, and ancillary services like x-ray facilities, having a secondary clinical laboratory and HIV testing.

The requirement for the physical plant refers to the floor area of the entire facility and the physical set-up of the different examination rooms. Particular attention is given to the floor plan of the facility to ensure safety and sensitivity to the needs of male and female clients. There are also prescribed licensing requirements specifically for the operation of an x-ray facility, clinical laboratory and provision of HIV testing services.

For the personnel requirement, the DOH requires a full time clinical staff: two examining registered physicians (one male and one female), a licensed nurse or midwife, a licensed dentist, a psychologist, a receptionist clerk, a cashier and an optometrist. The facility should also have retainer specialists in the fields of pathology and radiology, as well as in other specialised areas.

As of April 2006, the DOH lists a total of 136 accredited medical clinics and hospitals conducting medical testing for OFWs. One hundred and thirteen (113) of these clinics are located in the National Capital Region (NCR) and 23 are in the provinces, located in areas with a relatively high recruitment activity. All these medical and diagnostic clinics are members of the Association of Medical Clinics for Overseas Workers (AMCOW). Seventeen (17) of them are members of the Gulf Cooperation Council (GCC) Accredited Medical Clinics Association (GAMCA), all based in Metro Manila.

GAMCA was organised in the Philippines in compliance with a letter dated November 11, 1999 from the Executive Board of Health Ministers Council for GCC. It urged the creation of a body that would maintain a central referral office for the medical examinations of Filipino applicants for employment in the GCC states. Since the GCC-accredited clinics are also accredited by the DOH, they have to comply with the requirements of the DOH, as well as the GAMCA.

Monitoring of Testing Policies and Procedures

The Bureau of Health Facilities and Services (BHFS) under the DOH is the regulatory body that exercises accreditation and regulation functions over medical facilities for OFWs. The BHFS has a checklist of documentary and technical requirements that medical facilities should comply with prior to being accredited. The accreditation issued by this office is good for two years. Within this period, the BHFS conducts regular monitoring once over the two-year period, unless complaints are filed against a particular clinic. In this case, the BHFS may conduct monitoring or investigation of that particular clinic, regardless of whether the latter has already undergone regular monitoring for that period.

If there are complaints against an accredited medical facility, the BHFS investigates the complaints. In the past year, Dr. Palong-palong, the Director of the Quality Assurance and Monitoring Division of the BHFS, cited that the complaints they receive are mostly related to mis-diagnosed illnesses. Depending on the outcome of the investigation, corresponding sanctions are meted to erring or violating parties. The penalty for the first offence is P50,000, and for second offence, P100,000. For the third offence, the clinic is given a suspension of the accreditation, i.e. the clinic cannot perform any pre-employment medical examination for OFWs.

A monitoring team usually consists of a doctor, who is knowledgeable about operations; a nurse, who is in charge of looking at the process of physical exam; a medical technologist, who looks into the laboratories; a health physicist, to check on the x-ray facilities; and an engineer or an architect, who looks into the physical structure of the facility.

The BHFS is concerned only in monitoring medical facilities' compliance to its documentary and technical requirements. They do not have control over the volume of migrants that use a clinic for testing, nor do they have control as to the cost of medical tests. They also do not monitor whether a medical facility conducts pre-test and post-test counselling for HIV testing. Although pre-test and post-test counselling is explicitly written in the AIDS Law as a necessary part of HIV testing, the BHFS does not have a concrete policy for its implementation.

Most clinics have other types of accreditation aside from that issued by the DOH. Some would have ISO certificates to prove that they conform to certain international standards. Others are part of the Philippine Council of Accredited Healthcare Organisations (PCAHO). PCAHO certifies medical facilities based on quality systems and they conduct surveillance every nine months. GAMCA clinics are also monitored each year by GAMCA officials from the Middle East.

Medical Testing Procedure

According to the Philippine Overseas Employment Administration (POEA) Primer of June 2002:

> The agency shall refer an applicant for overseas employment for medical test only after the agency and/or its foreign principal or employer has interviewed him and pre-qualified him for an existing overseas position duly covered by an approved job order by the Administration.

However, stories shared by OFWs indicate that they are required by their agencies to undergo medical tests even without the assurance of placement. The validity of a medical test is only 90 days. Thus, if a migrant is not deployed within that period, they have to take another medical examination.

The referral slip given by recruitment or manning agencies to OFWs for the accredited medical clinics lists the examinations that a migrant has to take. Otherwise the pre-employment medical examinations include the following:

- Complete physical examination and history
- Chest x-ray
- Optical check-up
- Complete blood count
- Blood typing
- Routine urinalysis
- Psychometric evaluation
- Routine Fecalysis
- Dental Check up

For women applicants, a pregnancy test is required. The ECG is required for applicants 40 years old and above, or as necessary.

Some applicants are required to undergo additional tests, depending on the job category, the requirements of the employer, or the country of destination. These tests include an HIV test, hepatitis B screening, leprosy test, malarial smear, liver function test, Venereal Disease Research Laboratory (VDRL) test, drug and alcohol tests, and others.

Of the pre-employment medical examination, the physical examination seems to be the most bothersome for migrants. One of the researchers who underwent the medical examination process as part of the data gathering described the physical examination:

> "A sign was posted [inside the examination room] indicating to applicants that we had to remove our clothes… I went in with two other applicants… The three of us stripped except for our underwear… The examination consisted of the doctor examining our eyes, made us roll our eyes. He also asked each of us to stick out our tongue. Then each in our turn, we were asked to lie down on the bed. He then used his fingers to press down near the diaphragm, the kidney areas and our sides. After that, the applicant stood up again and was told to remove his underwear and bend over. Then the doctor requested the other two to turn their backs while he examined our anus and the scrotum one by one."

Among male migrants interviewed for this research, many said that they were tested with other migrants in a group. While this can hasten the process of the physical examination, migrants are subjected to discomfort and shame.

> "I experienced to be tested with others. There were about 10 of us in a room at the same time. Just one doctor… a male doctor. When he says bend, we all bend. Then he will use a flashlight." (Seafarer)

But the medical testing requirements do not end once the OFW passes the medical testing during the application process. There are many countries that require migrant workers to go through another round of medical tests upon arrival before they can start working. These tests are conducted to make sure that the workers are indeed fit to work. The tests conducted may vary depending on the country, or on the type of work. Food and Beverage (F&B) workers, for instance, require more tests because of the nature of work that they will be doing. But most would require a blood test for hepatitis and HIV, a physical examination, and a chest x-ray to check for tuberculosis. Women migrants are screened for pregnancy. Most migrants are not aware that they are being tested for HIV. There are about 60 countries that put migrant labour through HIV screening. But as in the pre-departure stage, most migrants take the tests as part of the routine requirements for employment.

Costs of Medical Testing

The costs of medical examinations differ depending on the package, again as required by the employer or country of destination. They may range from P1,500 to P5,000 (approximately 33 USD to 109 USD) but could go even higher, especially when the migrant fails in one of the tests and has to be treated. When the migrants are found to be temporarily unfit, they bear the additional cost for such things as buying medicines, a new pair of eyeglasses, having new fillings for the teeth, or undergoing additional tests. But migrants related in a focus group discussion that sometimes, these medicines or procedures are not really necessary. They feel that this is a scheme by the medical clinics to extract more money from them. For seafarers, however, the cost of the medical examination is shouldered by their principal. It is only when a seafarer is declared unfit for work that he has to pay for the cost of the medical examinations.

> "What is not fair is that you cannot have (reading) glasses made outside… I told them that my vision is still okay. They told me I have to get it from them. "What do you want? You have to avail of this in order to leave." So I gave in."How much," I asked them."P1,000 (approximately 22 USD) ." Isn't there a cheaper one," I asked."If you buy this outside, it's more expensive." "Can I have a discount? Can I pay only P500 (approximately 11 USD). I can pay you at once," I said."No, it's for P1,000. Anyway, you are going to the US." So I paid." (Seafarer)

Most of the accredited medical testing centres and all the GAMCA-accredited ones are located in the Metro Manila. This means that OFW applicants from the provinces have to come to Metro Manila to process their documents and have their medical tests. This entails additional costs for them because they have to pay for the travel, lodging, food and transportation from their lodging to the clinic. To help out, some NGOs have put up half-way houses that charge OFWs minimal lodging costs.

On site, the cost of the medical testing may be shouldered by the migrant, the employer, the agency or the principal. For Taiwan, Province of China-bound OFWs, the cost of their medical tests upon arrival is included in the placement fee they paid. On the other hand, domestic workers in Hong Kong, SAR of China, who are made to undergo medical testing upon arrival, do not have to shell out expenses because their employers pay for this. And as a general practice, principals shoulder the medical testing expenses of seafarers.

HIV Antibody Testing

The unique situation of OFWs, as far as HIV testing is concerned, is that their principals or their countries of destination require them to be screened for HIV. In fact, Administrative Order No. 1 series of 2003 of the Department of Health states that

> "Test for HIV antibodies or hepatitis B antigen or VDRL as required by country of destination or per principal's request shall be done."

However, even Hong Kong, SAR of China or Japan-bound OFWs are still undergoing HIV screening, even when these countries do not require it.

Those who undergo HIV testing are made to sign a Personal Information Sheet. At the back of this sheet, the OFW is made to sign the form saying that they agree to have an HIV antibody test. There is also basic information about the HIV test at the back of the sheet. But while OFWs are given this form which they have to sign, many do not bother to read its content. Filling up the information and signing the form are simply necessary procedures.

Testing centres, clinics and laboratories are also required to conduct free pre-test and post-test counselling services for persons who avail their HIV testing services. However, in the focus group discussions conducted by the Philippine research team, only one person claimed that he underwent pre-test counselling. Clinics claim that conducting such counselling would take too much of their time and entail additional costs. Some clinics ask the migrants to just read the consent form where basic HIV and AIDS information is available at the back. In most instances, there is not even an attempt to inform the migrants about HIV or AIDS.

> "They did not tell us [about HIV and AIDS] but as far as I know they are strict, so they include the HIV test." (Seafarer)

The AIDS Law safeguards the confidentiality of a person who undergoes HIV testing or is diagnosed to have HIV. But in the case of OFWs, medical test results, including the HIV screening results, are forwarded to the recruitment or placement agencies. This practice is legitimised by the DOH Administrative Order No. 1, Series of 2003 which states:

> Result of the Pre-Employment Medical Examination (PEME) shall be submitted to the referring agency or its principal/shipping company within seventy two hours after completion of required PEME test. In the event that medical findings indicate the need for certain minor ailments to be treated, the clinic shall advise the agency/company of the estimated period/time that said treatment shall be undertaken so that the same may be referred to the agency/company for his acquiescence. (Department of Health, 2003)

HIV positive results are forwarded to the STD/AIDS Central Cooperative Laboratory (SACCL) for confirmation. Whether the person goes to SACCL for confirmatory testing is another matter. In some cases, there are doctors who get in touch with unfit migrants and talk to them personally to explain the test results prior to referring them to SACCL.

> "If the person is [HIV] positive, we have to call the person back. And if confirmed, we talk to them in a confidential manner, with the Medical Director and the HIV proficient med tech. So we have to talk to him. We explain to the person the findings, what it is all about, and we ask his/her possible contacts. If possible, if he/she can bring the person so we can talk to that person and explain. But it's very rare for them to come back here. Usually, if they return, they go to SACCL because that is where we have the trained doctors to counsel them." (Director, GAMCA-accredited Clinic)

If at the country of destination or port, a migrant is found unfit for work, as for example migrants who have tuberculosis or are HIV-positive, the result is immediate deportation. In many destination countries, domestic workers are terminated from their employment if found pregnant. The deportation cost is usually shouldered by the employer or the principal.

The usual practice is for medical clinics onsite to report positive cases of HIV to the Immigration authorities, to the agency or to the employer. Deportation of the OFW who tested positive for HIV is immediate, mostly within 24 hours, giving no time for most deported OFWs to seek assistance from the Philippine Embassy or Consulate. On the other hand, it might not occur to OFWs to seek support from the Embassies due to the perception that they will be discriminated or exposed.

REINTEGRATION

Impact of Testing

Migrant workers always hope for a clean bill of health that will declare them fit to work abroad; they dread being told that they are unfit. When problems arise in the medical tests, the requirements of the destination country determines whether a migrant worker is temporarily or permanently unfit to work. When migrants are found to have conditions that are curable, they are made to undergo treatment. After completing the required treatment, they have to undergo the specific test that they initially failed. This means a delay in their application process and deployment, not to mention additional expenses for their

medication or treatment. Those who come from the provinces are also faced with higher costs because they need to stay longer in Manila while they comply with the recommendations of the testing centre regarding their test results.

The migrants who participated in this research and who have been declared unfit to work abroad permanently have been rendered such due to HIV infection. The impact of a permanently unfit result on a migrant worker runs deep and is very complex, especially if it is due to HIV. This kind of impact does not only fall on the migrant; it also affects their family. For OFWs, the biggest impact of being diagnosed HIV positive is the loss of employment opportunities abroad. Unfortunately, many families of migrants depend solely on the money their loved ones send them from abroad. When this loved one is repatriated or is disqualified from working overseas, the whole family suffers a drastic decline in economic capacity. They find themselves exhausting whatever savings they have accumulated over the years. In some cases, the children have to stop schooling. Furthermore, the economic conditions in the Philippines also hamper the opportunity of these OFWs to find local employment.

> "... One who is tested positive for HIV, like me, loses the opportunity to work. […] No one will hire me anymore, unless I have a degree or I'm a professional. Problem is I don't have a degree.This is the negative side of testing. If this hadn't been found out, I would still be working... Just because I have this condition, I've lost the opportunity, too.That's how it is." (Factory worker in South Korea)

Migrants also have to deal with the psycho-social impact of HIV infection. Some are shocked; others refuse to believe that they have contracted the virus, while others contemplate committing suicide.

> "In Singapore, in the house where I stayed, my room was near the window (laughs). I stayed in my room for about a week already; I stopped working. I wanted to jump from the 10th floor." (Health worker in Singapore)

The personnel of medical clinics have shared their experiences when disclosing an HIV positive result to a client. The reaction of the OFWs ranges from indifference, denial to depression. A doctor who participated in this research said that some even become violent upon receiving the dreaded news. There are OFWs who continue to hope, even resorting to applying for work in countries where HIV testing is not required. Yet, there are also those who would immediately isolate themselves, not even returning to the clinic to get their results or to be referred to relevant service providers. A migrant relates how he felt after it was confirmed that he was positive for HIV.

> "For a week after confirmation, I refused to leave my room.Then I would just go out if there was no one around.When they've all gone to work… I did not want to see them (laughs). And around dawn, that's the only time I ate. And then… our church mate who was a lot older, I confided in him because he was the one who accompanied me to my medical exam. He was a Singaporean who went to our church. He couldn't believe it when I disclosed my condition. He told me that if I told people they might treat me differently. He counselled me. "Look at the situation in the Philippines; they would almost burn you alive, hunt you down… Don't tell anyone." (Health worker in Singapore)

This experience is typical of OFWs who became infected with HIV. Thus there is a need for accessible counselling services where they can seek emotional support. There is also a need to extend such services to the families of OFWs, particularly the spouses of migrants who got infected. As related by a seafarer,

> "Of course, at first, she was hurt. I had to explain it [HIV and AIDS] to her. At first, she cried and she couldn't accept me back. [She was angry] but… But she couldn't possible turn me away and eventually she learned to accept me… Because of our children, perhaps she didn't want us to break up." (Seafarer)

Access to Health Services for OFWs Diagnosed with HIV

OFWs who have been diagnosed in destination countries are rarely able to access health services since the policy of most destination countries is to deport them home. The few who were able to access counselling and medical assistance on site were able to do so from NGOs and religious organisations. But even then, the services were limited and eventually these OFWs had to come home.

In the Philippines, the National AIDS Response rests on the combined efforts of the Government, the NGOs, the communities, international organisations and funding partners. For instance, the Global Fund to Fight AIDS, TB and Malaria (GFATM) funded HIV responses in 11 project sites all over the country. These projects are implemented by NGOs and organisations of people living with HIV, in partnership with Local Government Units. The thrusts of these projects are HIV prevention among the so-called most-at-risk populations and other vulnerable groups like the OFWs; care and support for people living with HIV, including the provision of ARVs; and the improvement of management systems to make service delivery of different stakeholders more efficient, coordinated and sustainable.

Although the efforts of the different players in the HIV response in the country have improved, there is still a long way to go to sustain and scale up these current responses to the health concerns of OFWs, especially in relation to HIV and AIDS.

Sri Lanka

Sri Lanka is a labour exporting country primarily to the Gulf and other Asia Pacific regions. The demand is predominantly for unskilled and domestic labour especially to the Gulf countries. Sri Lanka has been catering to this employment segment for over 20 years now, and has a large female migrant labour population employed in this region alone. Due to high educational attainment, and because most receiving countries in the Gulf are going through a boom in infrastructure development and construction, there is a growing trend towards supplying semi-skilled labour to these countries.

In 1985, the government set up the Sri Lanka Bureau of Foreign Employment (SLBFE) to actively promote overseas employment and undertake the welfare and protection of Sri Lankans employed overseas. The SLBFE, working under the purview of the Ministry for Foreign Employment Promotion and Welfare, is the regulator, developer and protector of the foreign employment industry in Sri Lanka. As a result of enthusiastic state interventions, employment migration increased rapidly from a recorded total of 14,456 in 1986 to 230,973 in 2005. In 2005 alone, an average of 633 persons departed daily for foreign employment.

Of all departures in 2005, over 59% were female. Migration of women overseas has shown a very clear gendered dimension, in that the target labour market is significantly for domestic workers (housemaids). 125,054 or 91% of all women deployed as migrant workers in 2005 were employed as housemaids. The top 5 destination countries for these female workers (FDW) were KSA (50,091), Kuwait (28,563), Lebanon (15,978), UAE (13,646) and Qatar (4,859). The export of labour is one of the highest foreign exchange earners in the country. In 2006 alone, the country earned as much as SLR 24,919 million, with a considerable amount of these funds coming from Sri Lankan migrant workers[28].

The government of Sri Lanka does not enforce mandatory testing of any population group. There is no law either prohibiting or requiring mandatory testing. Testing for HIV is purely a voluntary process and the government observes this practice for all population groups at all times. Although this is a national practice, the state also has to abide by destination or host country policies, rules and regulations. This means that prospective recruits who are interested in working in such countries must undergo mandatory testing. In this regard, the state has very little or no control in matters pertaining to the mandatory medical tests of migrants. While the National Policy on HIV and AIDS is as yet in a draft stage at the Ministry of Health, it must be noted that there is no special mention of migrant workers in this draft document. However, the government seems to be aware that migrant workers are a vulnerable group and they are now identified as a sub-population that requires intervention, treatment, care and support.

Sri Lanka has in place a reasonably well-managed and well-established public and private medical infrastructure facility that includes HIV testing. All government hospitals in the key provinces of the country, and private hospitals in Colombo and Kandy, are equipped to handle comprehensive medical examinations and make diagnosis as required. These hospitals are also equipped with medical professionals, qualified and trained technicians and modern equipment. There are also recognised medical labs and

consultations in most urban cities and towns that cater to local community needs. However, not all of them are equipped to handle a comprehensive medical examination. In such instances health care professionals refer patients to either a government or private hospital in the area. However, there is no state policy on quality standards for medical testing laboratories in the country. Currently there is some discussion within the Ministry of Health about preparing a standards and policy document for all testing centres to abide by.

PRE-DEPARTURE

Testing Procedures

Sri Lankan nationals travelling overseas for employment have to undergo a medical examination as required by most host countries including the Gulf Cooperation Council countries (GCC), non-GCC countries in the Gulf and other popular destination countries such as the Republic of Korea, Malaysia, the Maldives Islands, Singapore and Cyprus. The GCC countries have their own mandatory testing procedures that are carried out by Gulf Cooperation Council Approved Medical Centres Association (GAMCA). This body has recognised 13 testing centres in Sri Lanka, which means that they are approved and affiliated to GAMCA - 10 of these are based in the Colombo District and the other 3 are in the Kurunegala District. However, other districts such as Galle, Ampara, Anuradhapura, Batticaloa and Kandy also send very high numbers of migrant workers, the vast majority of who are female domestic workers. Potential migrants from these areas face severe obstacles of transportation and related expenses since they have to travel to either Colombo or Kurunegala for medical testing. GAMCA could well afford to decentralise their testing operations into other important districts as most of these towns are well supported with the necessary infrastructure. However, it appears that the current membership does not want this to happen as it will thin out the number of migrants across centres and bring down the profitability of individual testing centres.

On average, a medical test costs between Rs.2,500 to Rs.4,500 (Approx. US$ 22.7 to 40.9). In some instances the cost escalates if the employer has requested vaccinations against diseases such as hepatitis and chickenpox. Such medicals could cost anything between Rs.4,500 to Rs.8,000 (Approx. US$ 40.9 to 72.7). In addition the migrant worker must pay a commission or fee of Rs.500 as processing charges to the recruiting agent and an equal amount to the sub agent. This places the migrant worker in further economic difficulty.

Following the GAMCA rules, a comprehensive medical examination is mandatory if one is to qualify to work in any of the Gulf countries and a strict set of tests are carried out for a variety of diagnoses. Once a migrant worker registers their personal details and signs the consent form, the process begins with a mandatory physical unclothed or semi clothed body examination that both men and women have to undergo. A height, weight and sight examination is then carried out; blood, urine and stool samples are taken; and, finally, a chest X-ray is carried out. In the case of women, just before leaving the medical centre, they are administered a Depo-Provera injection, much to their surprise. This is done only if the woman is menstruating at the time. If she is not, the woman must return during menstruation for the injection to be administered. Though nobody informs them that contraception will be administered, nor is any consent taken, it is done as a precautionary measure against pregnancy for prospective female migrants. As a female returnee described:

> "They gave an injection, for what I don't know. Before they gave the injection they asked me if I have my periods, then when I said yes they told me to take some blood from there on to a piece of cotton wool and give it to them, I was very embarrassed. I also had to remove clothes and wait with a male doctor. After they gave me the injection only they told about it that it was to stop getting children and also that they give it to young unmarried girls. Don't know the name of the injection. I became embarrassed".

At present, a routine and mechanical practice of consent for testing is observed in the centres. A consent form is given to migrants by the recruiting agent or the testing centre at the point of testing. This document has to be signed by the migrant. In a focus group discussion in Colombo, female migrant participants stated:

> "Agency is obtaining signatures before referring to tests. If we have knowledge and can read the language, it will be possible for us to read those papers. If not we merely sign and give those to them. Signature is being obtained for the document and the contents of it are not explained.We also do not possess any knowledge to ask for it and read it".

Often the form is printed in English and the migrant is unable to read and comprehend its contents. At times there is a Sinhala translation given. Tamil speaking migrants from the North and East of the country are disadvantaged as not all places offer Tamil translations. Moreover, migrants are not given any time to read the document and are merely asked to sign it to proceed with the testing. The way in which the consent is handled is clearly a violation of the right to informed choice.

Research findings showed that none of the testing centres provided even basic counselling or an explanation of the testing procedures, leaving the migrants to deal with the test results, including the impact of a disqualification or unfit test result, on their own. None of the testing centres in which the study was carried out has any pre-test and post-test counselling facility and the staff there indicated that they do not have trained counsellors to offer the service.

A further concern relates to the confidentiality of test results, which is a clear contravention of accepted ethical practice. The only disclosure that a testing centre gives a migrant is the information that s/he is fit or unfit for travel. However, the medical reports are usually given to the recruiting agent, who then sends it to the host country employer or agent. The migrants are thus put through a period of anxiety in regards to both their health and their employment status. While those who successfully access employment are relieved, those who are rejected have no adequate information about their health status and are put through further anxiety and expenses to determine the reasons for their rejection, and to secure medical assistance for their newly detected medical ailments. Following the experience of female migrant workers, as shared in our discussion:

> "They did not inform that confidentiality is being maintained at the time of the examination. There was no such undertaking. We cannot believe that there is confidentiality. Report was not given to us. It is being sent direct to the Agency.We are told of the outcome of the examination. No explanation whatsoever is being given and we are asked to come for an examination again if we have failed".

The GAMCA medical testing procedure requires that all migrants have to unclothe for a physical body examination. This is both degrading and embarrassing even though there are enclosed rooms or cubicles in these centres to carry out this task and there is a gender-balance between the nurse and doctor present most of the time. It was disclosed in our research that even men felt uncomfortable and embarrassed

to remove their clothes in the presence of a male nurse and doctor. One could only imagine the plight of women when they have to encounter this situation without prior notice or preparation. During an observation session of a GAMCA testing centre, a female prospective migrant was found, clearly shaken, ashamed and hardly could speak of the naked body-check incident, more so because she was asked to come during menstruation by her agent. There were instances where women were examined by a female nurse and the doctor in attendance outside the enclosed area was a male. One of the female migrant workers told us:

> "I am a person who has gone aboard on several occasions. On all those occasions, I was examined by male and female doctors. Sometimes they make us half or fully naked. It was very embarrassing at that time. Doctors do not care much and they are very unkind at times".

Sri Lankan women adhere to cultural norms that ensure respect for bodily integrity and privacy. In this context especially when a female migrant worker is not informed, it is very embarrassing and degrading to have to unclothe for an unexpected body examination. It was observed that the GAMCA rule book does not insist on a naked body test though done in some instances.

The physical body examination is carried out as an extra precaution to ensure there are no external complications relating to either the spread of a disease or post operation scars to ensure the migrant does not complain of any pain during work. However, even when these scars are completely cured and have absolutely no complications and skin ailments are harmless, it is at the discretion of the medical centre whether a migrant will be endorsed as fit to travel. What this means is that the testing centre has the right to either accept or reject a migrant just on external body appearances. This by no means is a migrant-friendly medical testing procedure as the migrant could get rejected for a harmless scar or skin irritant. It is also in total violation of a migrant's right to secure employment.

The entire process of mandatory testing is reflected in a brief testimony by a migrant worker below:

> The agent brought me here at 3.00. At the counter I gave my passport and another picture.They gave me a number and asked me to sit. After about 10 minutes they called my name and I went to a room. There was a doctor. The room was half closed with a curtain and a bed. They first checked my body. The lady doctor was seated and a nurse checked me. She was wearing gloves. The lady doctor was watching and telling the nurse what to do. To feel here, to press here. I felt very shy because they wanted me to remove my clothes. I was very reluctant. Then the nurse said remove your clothes, remove your clothes there are others waiting to be tested, don't waste time. They checked for any marks and scars.They felt my neck and stomach area and below. No, they did not tell me much details. But what to do? I have to do what they say, no? Otherwise they will not pass me. After about 10 minutes the nurse took me to another room and another nurse took blood. Then the nurse and I went downstairs and she told me to go to the toilet and urinate into a plastic bottle. I had to leave the bottle in a counter.Yes, it was very clean. Then she took me to the X-ray room and a male took an X-ray. No, this is the first time. I have not done this before. I think I know I am healthy because I don't have any ailments.We work hard in the village to earn our living.The people were very nice. No, they didn't tell me any details. I did what they told me. Even the agent didn't tell anything. I have heard a lot of sad stories but what to do I am taking a chance and going.We have a lot of debt to pay. I pray to God nothing will happen. (First Time female migrant worker)

During the research we uncovered a few strategies migrants use hoping to qualify following a medical test. These strategies may have an impact on the wellbeing of migrant workers. For instance, a GAMCA Testing Centre Doctor in Colombo shared,

> "We have also come across situations where some women are unable to give a urine sample at that point in time and she discreetly asks another migrant to fill up her bottle. She can be disqualified if that other person is unfit. It is a problem we are facing".

In other instances some non-GAMCA private testing centres provide a fit medical test certificate by taking a bribe. One could imagine that the recruiting agent is also involved in this operation. However, this might very well result in the migrant worker being deported. The other strategy is that prospective migrants desperate for foreign employment could obtain a false passport either due to a previous offence, or deportation due to illness, or because they are underage. In these instances the migrant obtains a new identity by changing their appearance or falsifying information such as name or date of birth.

A migrant who goes through a mandatory test is certified as either fit to travel and be employed or unfit for travel. The unfit category could mean that the migrant is temporarily unfit for any abnormality found in the long list of tests, for which a course of medication is prescribed before s/he is re-tested again and given the approval to travel provided the re-test results are negative. However, this also means that the migrant has to bear all costs pertaining to the re-test or confirmatory tests. It is only natural that the anxiety levels remain high until the whole process is completed and the confirmed test result known: either fit or unfit. The permanently unfit are eliminated altogether and have no further opportunity for overseas employment in any GCC country. In the event of a positive result for HIV from an Elisa test, the testing centres will conduct a re-test, whereby blood from the migrant is drawn again and sent under confidential coding to the national STI clinic for a western blot test. If the result is still found to be positive, the migrant is requested to go to the national centre for registration, counselling, treatment and care. The migrant is then permanently rejected for employment with their status revealed and recorded in the GAMCA operations office, which, in turn, shares this information with all other GAMCA centres and all GCC country embassies to ensure that that migrant will not succeed if they attempt to seek re-employment.

Monitoring of Testing Centres

All GAMCA testing centres have to abide by a code of practice and testing procedure that is ratified by the Executive Board of the Health Ministers Council for GCC states and monitored by the local GAMCA administrative office. The Sri Lanka Government has absolutely no control over this. There is a comprehensive booklet entitled "Rules and Regulations for Medical Examination of Expatriates Recruited for Work in the Arab States of the Gulf Cooperation Council". It is the medical testing policy of GCC countries that all the GAMCA accredited centres must follow. These centres are monitored by a team of GAMCA officials representing the GCC countries, who make surprise visits to these clinics at least once a year.

Due to the rigid policies and strict monitoring, the affiliated centres take great care to ensure the medical examinations are foolproof. In case of violations, there are systems of penalties that range from a warning, a fine, revocation, or suspension for 3 months to the maximum penalty of being eliminated completely from the list of approved centres. However, these penalties involve areas related to either Administrative and Financial Violations, or Technical Violations. Therefore, the ethical and human side of the testing, including issues of consent, information, counselling, human dignity, client satisfaction, and referral, are not given any consideration, and have no mention in the rulebook.

Moreover, the deviations in practice and extreme testing measures unilaterally adopted by the centres also go unnoticed, as rightly pointed out by a doctor in a GAMCA testing centre, showing the GAMCA rulebook:

> "What the GAMCA Rule book says and what tests are done – e.g. naked body check – that is not required but still done. Mandatory injection for contraception (not required but done)".

The latter deviation is to ensure that pregnancy does not occur while the female worker serves her first 3 months, during which time an employment agency may be required to find a replacement worker as stipulated in the contract with the sponsor. The GAMCA testing centres send a compiled quarterly and annual test result report, denoting numbers of testing done and unfit cases in total within specific categories of infection found, to GAMCA authorities in GCC countries. However, the Sri Lanka government does not receive a copy of the report and thus the opportunity of any public health intervention based on such information is missed. It was also found from the GAMCA testing centres (who perform tests for other non-GCC countries as well) that the same GAMCA guidelines are followed in offering the sort of comprehensive range of tests which are preferred by countries like Malaysia and Korea. Again, the Sri Lanka government has no involvement in this matter.

Referral Systems, Accessibility to Treatment Care and Support

Referrals are made if a migrant is found to be either temporarily or permanently unfit. GAMCA approved testing centres do consultations and treatment for temporarily unfit migrants for an additional fee, though with no guarantee that the individual will be fit to go the second time around. However, in the case of permanently unfit migrants, testing centres are known to refer them to government though there is no strict requirement by the State Authorities that such failure should be referred to them as a matter of routine. Testing Centres may also refer failures to private hospitals for further examination and treatment. None of these centres, state or private, offer any form of counselling, especially in the case of persons with HIV. During the research there was no reference made to any support and care facilities by any of the testing centres and they were not aware of such organisations if any. Other insidious feature was lack of counselling on disease prevention even if tested negative.

Lanka + is a self-help organisation of persons with HIV that supports people living with HIV and AIDS. It was formed in 1997 with the objective of caring and supporting HIV positive people. Today it has a membership of 84 people, among whom are migrants living with HIV. It offers support and care facilities very discretely in the face of public stigma and discrimination towards people with HIV. Though Lanka+ is unknown to these testing centres and there is no referral made to them for care and support, State Institutions have close links with extension services of Lanka+.

ON-SITE

Sri Lankan migrant workers are subjected to mandatory testing again, within days to 2 or 3 months before getting their employment visa in the destination countries. This is often much to the surprise of the migrants since they had not been informed of this beforehand and had been assured they were already

cleared in their home country. While general migrant workers have to repeat the medical testing every 2 or 3 years during the period of work-permit renewal in GCC countries, migrants working in the food and beverage (F&B) sector have to undergo testing every 6 or 12 months to ensure they are not carrying any communicable diseases or any form of skin diseases. The testing is usually carried out by either a clinic or a local hospital situated in most city centres or in sites where a large number of migrant workers are employed. The local host-country agent or employer usually accompanies them for testing, at least the first time.

There have been instances where migrants have been deported despite having taken the medical examination at home because of sudden illnesses that are often easily curable through medication in the host country. In some cases, the reason for deportation has been that the host country testing centre authorities were not satisfied with some of the results or the physical body examination and external body appearance. Host countries are particularly severe with communicable diseases such as HIV, TB, hepatitis, STIs and pregnancy in the case of women.

> "Nobody told me before that I have to do testing again once I go to Riyadh. When I was there, they said that I have to do medical test again, I was very much afraid. I did not know that I have to pass medical test here again. I was worried thinking that I have just come passing the medical test in Colombo and why I have to test again? What tests they will do on me? If something goes wrong, what they will do to me? What will happen to me? Nobody told me anything and I was so very afraid." (Male returnee hotel worker)

As revealed by the migrants, depending on the country, the testing process could involve a blood test, X-ray, a simple physical check with clothes on, but also some countries required removing clothes for body examinations.

> "In Sharjah it was a bit different. I didn't go for the medical here. I went there and in three days I had to get ready for the medical. Afterwards they come to collect us. There they check the blood, they only take an x-ray if you are very thin." (Returnee migrant worker)

Just as in Sri Lanka, once again they are not given any information, briefing or counselling and now they also have to deal with foreign language instructions, which most of them are unable to understand. There is no translator and language problems become exacerbated if one has to undergo further repeat testing. Some workers could recollect signing a consent form printed in Arabic or English, which they could not understand and which provided no information on what the test would entail. But, as this research established, in none of the destination countries was the testing process explained, nor was any pre-test or post-test counselling or information provided. Moreover, migrants shared that even if they had a question, they would not dare ask it, fearing they would be repatriated. Some felt discriminated against, especially if they worked as a domestic worker or an unskilled labourer. However, the migrant workers have no choice but to undergo the testing process blindly with the only hope that the test will be over and done with and that they can resume work. The reflections of a returnee male migrant worker from Dubai capture these feelings well:

> "But their (Dubai) treatment was not good. The treatment of doctors and nurses was not good. For example, if they are taking blood, they put needle, remove, put again, and remove… as if we don't feel, as if we are animals. Indian doctors are ok. I am talking about Arab doctors. Egyptians. They all speak Arabic, so I am not sure.They treat by skin.Asian people - they treat bad. If a white skin person come,

> they treat well, polite, friendly, will say "come, come, have a seat". But if you are Asian people and if you ask them anything or want to know anything, they will shout at you.Always shouting, they are inhuman. Yes, true, they just want to hurry you up, say Yalla,Yalla.They don't care, don't respect us."

The findings show that the medical examinations are conducted in a more gender sensitive manner in the host country than in Sri Lanka itself. Although in some cases a female migrant's tests have been carried out by male technicians, but body examinations in most instances have been conducted by female nurses and doctors in attendance. However, one of the crucial issues raised by female migrants is the sexual harassment by male employers. This is true of many serious instances where female domestic workers have been sexually abused and got pregnant. In some of these cases the host employer simply wants to get rid of the woman from their place of employment, which is easy since pregnancy is a cause for failing a medical test and results in forced deportation. There have also been instances where abortions took place, sometimes in less clinical environments resulting in post abortion complications which the female domestic worker had to deal with on her own. In an in-depth interview with a female returnee domestic worker, this plight was described:

> "After I went to Kuwait they took me to do a medical test. There it was a bit different to Sri Lanka because apart from blood and urine they also check the stools. My test results were good. I faced a lot of problems from the babu (Master) and his son.When I go to sleep at night they come to my room. The babu is very kind but I became pregnant with the babu's child. I told this to the babu. I didn't know the language so I told it in body language.Then the babu took me to a very big hospital and got me an abortion. I was 1 ½ months pregnant when this happened. After this happened I told the babu that I cannot remain there that both him and his son give me trouble, so then the babu sent me to a camp and after two weeks gave me a ticket and sent me home. Though we get a family planning injection before we go from here it lasts only for 3 months. That's why this happened to me. I know a lot of people who have faced problems like this. Even some of the people here are people who have been in these camps".

It was found in this study that any form of avoidance tactic during host country medical examinations was not pursued by migrant workers for fear of immediate deportation and efforts to cover up existing illnesses were similarly not possible. If a migrant is found to be HIV positive in a host country, their status and identity is disclosed to all relevant government authorities, including immigration authorities, to arrange deportation and to ensure that s/he will never be able to apply or travel to that country ever again. There is little effort made to deal with the results with dignity or confidentiality. Especially in the case of STIs and HIV, migrants are treated like criminals and are isolated from human contact. In many cases, officials knowingly humiliate the infected migrant and act very swiftly to deport the person, often within two days.

> "After the counselling and with Lanka+ and Dr. Nihal I ask myself why the Koreans behaved like that. Why couldn't they be nice to me and tell me that I should leave the country. Why did they handcuff me? Is this the treatment for HIV people?" (Deported HIV Positive male MW from Korea)

> "They will discriminate them (if a person found with HIV) and give them mental anguish. Migrant workers go abroad and do a service in that country. Therefore it should be the responsibility of that country to treat the migrant well with dignity even if he is not well with any illness (AIDS), even provide monetary support." (President, Lanka +)

In the host countries, as is the case in Sri Lanka, the medical examination results are not disclosed to the migrants. One gets a medical card once s/he is found negative of all tests carried out. If a migrant

is found unfit, s/he is deported immediately and the employer takes no responsibility thereafter as they feel they have no obligation towards the worker. Host countries are particularly severe in dealing with communicable diseases such as HIV, tuberculosis, hepatitis, STIs, and pregnancy. However, the migrant workers have many misconceptions and do not have any clear knowledge or information on the particular causes of deportation, except by now most know that HIV is a main reason. It is generally expressed by the migrants that the medical policies in host countries for migrant workers are such that they cannot be challenged and their rules, regulations and decisions are always final. The treatment meted out to HIV infected migrants is similar to that of a convict. It is therefore not possible for one to ask for a confirmatory test or any other form of support and care. Also, it was found that in some cases the person was not informed of the HIV infection and the cause for deportation, as expressed by a deported HIV positive person:

> "It was in the year 2003 that I developed a prostrate problem and I had to undergo a series of tests. I suspected that it was a cancer. However after the medical tests I was told by the hospital that I had a blood related disease and that I had to do further tests. The Thais were nice people. They did not want to deport me immediately or lock me in some place. What was disappointing was that they did not tell me what was wrong especially in a country that has developed a lot in HIV education, care and support."

The research findings show that the host country officials do not provide any form of referral, treatment, care and support to a migrant if s/he is found to be HIV positive or is carrying an STI. The only form of referral, although not followed in all destination countries or in each individual case, is to inform the Sri Lanka embassy or consulate authorities to take the migrant away and make arrangements for the quickest possible deportation. In some if not all cases, the embassy staff provides referral points for the migrant to contact and seek further tests, treatment, care and support upon arriving home. Until then, the infected migrant is in a state of mental shock at the inhuman treatment received in the host country and the sudden loss of investments they had made for employment abroad.

REINTEGRATION

There is no formal reintegration scheme for migrant workers who return home failing a mandatory testing in a destination country. While asked on whether the Sri Lanka Government provides medical assistance or relief if any migrant worker is deported on health grounds, the SLFBFE official answered: "Not to my knowledge". It should not be forgotten that the SLBFE reimburses medical expenses on submission of receipts provided the migrant is not HIV positive. Though one has to commend the National HIV and AIDS programme for their efforts in counselling people with HIV, it is regretted that there is no special facility for migrants to access and this often leads to stigma and discrimination.

All STI clinics in the country and the central clinic at De Saram Place are fully geared to counsel people requiring testing or treatment. Persons with HIV, once registered with the national programme, are also referred to the Infectious Disease Hospital (IDH) where a special section is dedicated for treatment and care. Additionally, the national clinics also refer people to Lanka+, which is dedicated for the wellbeing, support and care of people living with HIV. However, in the absence of proper and organised information or direct referral services, sometimes it takes deported migrant workers a long time and effort to reach these services.

> "I went to the National STD clinic in Colombo a few weeks after I returned and got myself tested again. They told me I was positive. A gentleman gave me counselling for about 45 minutes before I was tested. When I came for the results, the same person spoke to me for another half an hour. He gave me two addresses and names to go to. One was the IDH hospital and the other was to Lanka+. I am now a member of Lanka+ since 2004. Dr. Malith (not real name) at the IDH hospital is like a brother to me. I go there even to discuss my personal problems." (HIV Positive male migrant worker)

The SLBFE has an insurance scheme for migrant workers covering injuries, disabilities and death resulting from physical abuse. However, a much felt need by the migrant workers is the provision of a comprehensive SLBFE Insurance package that will take care of such medically tested unfit cases as hepatitis, TB, malaria, and HIV. At present, the HIV positive migrants are not covered by this scheme,

> "I think that HIV+ people cannot get insurance." (Lanka + President)

There are some provisions in relation to medical testing, but they are not very comprehensive. They certainly fall short of adequate coverage of lost investments which might ensure the chance for a proper reintegration, at least in financial terms. There are clauses in the insurance scheme, for example if a migrant is found to be unfit on arrival and is deported, for reimbursement of the cost of airfare not exceeding Rs.25,000/- . There is also a clause that includes payment for an unexpected pregnancy; however the real cost a female migrant worker has to pay in such instances, in terms of psychological suffering, human dignity and social status, remains unaccounted for. The policy covers compensation for migrants who return home within three months due to ill health. However, not all migrants seem to have proper information or swift access to this insurance, as evident from the reflections made by a female returnee MW:

> "It has been three weeks since I have come back to Sri Lanka. I have spent a lot of money for medicines. Still my joints are painful. I went abroad with a lot of loans. I have to pay them back and I have had to sell my jewellery also. I am mentally down due to this reason. That's why I have come here to see if I can get my insurance at least".

Moreover, some could be deceived by their recruiting agents and never have access to the actual insurance scheme, as evident here:

> "They didn't give me the insurance papers, they said they will insure me after I go but when I returned they hadn't done that. To Kandy itself (I went), now that place isn't there it has closed down. That man who took me there took me to a bank and tore the insurance papers and said that's the end of your insurance and that he will send it through the post". (Female returnee domestic worker from Saudi Arabia)

Further, some deported on health grounds failed to claim the insurance due to access problems, as shared by another female returnee migrant worker from Saudi Arabia:

> "You have to collect it within 15 days, and I didn't want to come to Colombo, because of the distance".

Reintegration of migrant workers, especially those with HIV needing treatment, care and support, is clearly a responsibility that is yet to be fulfilled properly by the concerned authorities. In this situation, specific steps need be taken, as expressed by the Lanka + President:

> "The embassy in that country (that deports person with HIV) should be informed about Lanka +. We cannot help them financially but mentally we can help them to cope. If we have budgets and the approvals given, we can come and talk at the SLFEB training sessions, we can talk to recruitment agencies and testing centres, we can provide pre-test and post-test counselling.We would like to open Lanka+ offices in the outstations; we could print information."

Sri Lanka is still a long way away from ensuring the health and well-being of migrant workers, and the introduction of appropriate migrant-friendly policies and programmes is long overdue.

Vietnam

Vietnam is currently sending more and more of its nationals to work in foreign countries. In 2005, there were 70,594 migrant workers recorded as going for employment in a foreign country, of which 24,605 were female; in 2006, that number rose to 78,855 workers, of which 27,023 were female. With a view that

> "sending workers to foreign countries is a socio-economic activity that helps create jobs, increase income, develop professional levels and improve working manner for Vietnamese workers" [29],

the Ministry of Labour, Invalid and Social Affairs has set a target of sending 80,000 workers abroad in 2007.

It is estimated that the remittances from Vietnamese migrants are currently some US$1.6 billion[30]. Most Vietnamese go to work in Southeast Asian and East Asian countries. The two main destinations in 2005 and 2006 were Malaysia (24,605 and 37,941 respectively) and Taiwan, Province of China (22,784 and 14,127 respectively). Other countries with significant numbers of Vietnamese migrant workers in 2006 included South Korea (10,577), Laos (5,731) and Japan (5,360). There has also been a rapid increase in the numbers being sent to Gulf Countries, with the combined numbers of migrants being sent to Qatar and the United Arab Emirates rising from 881 in 2005 to 4,364 in 2006[31].

For documented Vietnamese migrant workers who go to another country to work, it is necessary that they pass a health examination, which includes an HIV test. The main purpose of these mandatory health tests is to get approval for going abroad, following the requirements of the receiving countries. However, the Law On HIV/AIDS Prevention And Control (No. 64/2006/QH11), Article 27, states:

> "HIV testing shall only be conducted on the basis of voluntary of persons to be tested".

Further, Article 28 states:

> "1. Compulsory HIV testing shall be conducted in the case that there is an official request for judicial appraisal or a decision of an investigative body… or a people's court. 2. The Minister of Health shall issue regulations on compulsory HIV testing in certain necessary cases for diagnosis and treatment purposes."

In spite of these laws, practice shows that the mandatory tests are carried out as part of the process of sending workers abroad. The pre-departure tests are implemented for screening prospective migrant workers; only healthy candidates can go ahead with training as preparation for foreign employment. However, the testing policy of Vietnam is clearly stated in the Joint Circular No. 10/2004/11-BYT-BLDTBXH-BTC of the Ministry of Health, Ministry of Labour, War Invalids and Social Affairs and the Ministry of Finance, which guides the implementation of medical testing for Vietnamese migrant workers going abroad. It does not state that medical testing is mandatory for those who go to work abroad; however, it does give a list of health standards for being qualified to go abroad and a list of diseases that are grounds

for disqualification. The circular also indicates the steps that hospitals have to take to apply for permits to provide testing and issue health certificates, and the fees that can be charged. However, there are no clauses about monitoring these activities.

PRE-DEPARTURE

Testing of Migrant Workers

In relation to the testing of migrant workers in Vietnam, a common practice for recruitment companies and hospitals is to sign a contract that states each party's responsibilities in such testing. Specifically, the recruitment company is legally responsible for sending the correct person, meaning that they do not engage in the corrupt practice of sending a 'replacement' to pass the health exam for someone else, while it is the hospital which is legally responsible for the results recorded on the health test form. This contract states that in the case where a migrant worker is deported upon arrival due to health status, the destination country's health test results must be confirmed with the hospital in Vietnam that did the testing in order to attribute responsibility for the incorrect result. According to the law, if the hospital is responsible for the incorrect health test result, that hospital must pay for the one-way ticket for the deported migrant to return home[32].

Some destination countries, for example Dubai, do not require health certificates from Vietnam because migrant workers must apply for visas in that country itself. In these cases, in principle the migrant workers need to be tested upon arrival only. However, a lot of recruiting agencies prefer to have their recruits tested before they go abroad in any case, to avoid having workers being deported for being unfit, with the waste of money this involves. Recruiting agencies also encourage potential migrants to take a medical test for HIV and hepatitis before registering with them, to avoid being disqualified upon arrival.

By the end of 2006, a total of 70 hospitals had been granted permission by the government to provide health testing and issue health certificates for migrant workers. Although there is no policy to restrict private facilities from providing health testing for migrant workers, at this time only 5 of the hospitals are not public, comprising four private hospitals and one hospital under a medical college. Certification is done as specified under Joint Circular 10/2004 by the Ministry of Health and Provincial Department of Health. The Ministry of Health certifies hospitals under its jurisdiction as well as hospitals under other ministries and private hospitals. Private hospitals also fall under the control of the Ministry of Health and must fulfill the same qualifications as any of the other hospitals under the Ministry. At the provincial level, the local Departments of Health are in charge of certifying hospitals to provide testing services and health certificates for migrants. However, specific countries have assigned particular hospitals as the only authorised ones to conduct testing for them, as shared by the General Manager of a private hospital:

> "We have contracts with Ministries of Health of some countries such as Taiwan, Province of China, Malaysia. For example, Malaysia allows only 4 hospitals and Taiwan, Province of China allows only 5 hospitals in Vietnam to conduct health testing for migrant workers.Testing content is also based on national rules".

For transparency, there is a price list for each item of the test provided in accordance with receiving countries' requirements, which might vary from one country to another. All include HIV testing. The price list is announced in the Joint Circular 10/2004, and the financial bureau checks charges recorded against

the sum collected to prevent staff from absconding with money from fees paid. According to migrants, total charges paid for testing varied from VND 400,000 to VND 600,000 (between US$25 and US$40). This often is considered very costly by the prospective migrants, as a female undergoing testing expressed:

> "The cost was too expensive. In my hometown, the price was only 100 thousand VND and lots of inconvenience as well."

Moreover, the validity of certificates lasts for only 3 months and if a migrant worker cannot leave within that time for any other reason, they will have to take the test again.

> "We hadn't finished learning language yet. Do you know? The validity of this certificate is within 1 to 3 months. If we don't fly within next 2 months, we have to pay 500,000 for another medical test." (Prospective female migrant)

Testing centres authorised by the Ministry of Health are available in each province. However, some receiving countries like Taiwan, Province of China and Malaysia[33], which constitute a considerable percent of the Vietnamese workforce going abroad, only accept health certificates from four or five centrally located hospitals that are located in either Hanoi or Ho Chi Minh City. This adds related travel expenses for migrants living in other provinces, who must travel to take the tests. Some hospitals have devoted a ward solely for the purpose of migrant workers' health testing. All tests and services are done within these wards for the migrant workers' convenience and to reduce the chance for misdiagnosis. This expedites the testing as compared to other hospitals, where migrant workers have their tests in the same ward as general patients, including people who come to get health certificates for driver's licenses or other purposes.

To expedite migrant workers going through the testing process, most recruitment companies have a contact person to accompany groups of migrants to the testing facility and guide them through the various steps. In one private hospital, there were signs that guide and instruct migrant workers about the tests placed on its walls. The migrant workers are called in numerical order.

Provision of information about the tests does not seem to be considered or followed as part of the standard procedure. According to medical staff in testing centres, informing migrants on testing is the responsibility of recruitment companies, and they argue that the majority of migrant workers know what tests are done during the examination process anyhow. In reality, destination countries have different lists of disqualifying diseases, so even though there is a core list of diseases and conditions tested, the comprehensive list varies from country to country making it difficult for migrants to know all the conditions being tested. Research shows that migrant workers who underwent health testing have no clear information available, as reflected in this sharing by a prospective female migrant:

> "Our company announced to take 500.000VND and abstain from food until the check-up finished."

In a focus group discussion, when asked if information was given about the tests, all participating members expressed, "No advice provided". When asked what tests were done, most could say something about the testing procedure for urine, X-ray, blood and the body check, for example, without knowing exactly what the tests were for.

> "Firstly, urine test, blood test, then weight and measures, what's next?" (Prospective migrants in a focus group)

> "Dermatology and venerology". Agreed the first participant and further added, "That's it, then X-ray, that's all." (Prospective migrants in a focus group)

Although the Law on HIV/AIDS Control by the National Assembly requires that the testing of HIV must be implemented on a voluntary basis, the fact that receiving countries require an HIV test seems to override this law. Unfortunately, since the testing is seen as being a requirement, all practices related to the provision of voluntary testing seem to be discarded. For example, there is no official consent form signed before testing is done. According to the hospital directors, migrants voluntarily come for testing because they need the test results for going abroad, so a consent form is unnecessary. Besides, most hospitals work directly with recruitment companies, which do all the paper work, so it is assumed that the responsibility for consent would fall on the recruiters rather than the hospitals.

> "These procedures are done when workers register with the recruiting centre or agency. We just take care of health testing." (Hospital Administrator)

> "No, they weren't (migrants giving consent). This is the task of companies." (General Manager, private hospital)

A "Request for health testing to go abroad" is required to be signed at the hospital before the test. This form does not inform workers about the medical testing though: it is a waiver that states

> "I (we) will not hesitate to pay all the testing fees and agree that no refund is made if the agency does not accept the test results."

When asked, most migrant workers were unsure about giving consent. Some of their comments include:

> "Yes, we have filled in the form in our company (but not sure)".

> "I remembered to sign in the form. Signing before we went to check-up. We can not had a check-up if not sign in the document".

It seems that a routine practice of signing a form is followed, but does not fulfill conditions of informed consent.

According to a hospital director, Vietnamese migrant workers do not receive counselling before medical testing either because "It is the task of the (recruiting) companies." This attitude is shared by other health professionals:

> "We have no counselling because the labour export companies have the responsibility for registering the workers to go to many different countries". (Managing Director, private hospital)

The Head of a Laboratory added that the medical staff "do not have the time". The migrant workers reflected the same as none expressed to have experienced any pre or post test counselling, "No, the doctors didn't explain anything," said a female worker planning to work in an electronic plant in Taiwan, Province of China. While asked if they were told anything about HIV, the response was "Nothing", by a group of female focus group participants.

In other words, counselling does not seem to be considered a significant part of testing for migrants, a sentiment that was echoed by the provincial hospitals, who shared that because migrants can be disqualified upon arrival for certain diseases, especially HIV or hepatitis B, they need this testing prior to departure, which makes counselling unnecessary. This is illustrated by the comment from an Administrator in a Ministry level hospital:

> "One thing we must be clear is that this testing is to see whether the migrant worker is fit or unfit. Therefore, if a worker is unfit, he has the right to have later test or not...These are two different things. It is different matter from when he goes for a medical examination on his own."

Generally, migrant workers do not feel discriminated against in the testing process. They do, on the other hand, feel embarrassment. All female workers reported feeling shy during the X–ray and dermatology examinations, where they are asked to take off their clothes, sometimes in front of other women undergoing health testing.

> "We also went in, took off all the clothes to check whether we have skin disease or not." (Female prospective migrant, sharing her feelings of shame)

> "In general, young male doctor do heart examination which made me feel nervous and made my heart beat fast." (Young female worker going to Taiwan, Province of China)

Some male workers expressed that they felt uncomfortable when being examined in the nude. It is said that in some hospitals, to ensure that they do not cheat, workers are observed when they give the urine sample. Even though they are observed by someone of the same sex, there was a sense of indignation expressed by the migrants.

Language does not seem to be a problem in the health testing process, as both prospective migrant and medical personnel speak Vietnamese. However, during the testing process, most potential migrants found themselves puzzled by the procedures. One such person shared,

> "Yes, not so comfortable, they didn't help us find our way much, we had to find by ourselves".

Moreover, low education levels limit the migrants' understanding about the examination and the results, due to the use of medical terminology and a lack of pre-test or post-test counselling. For example, the use of the terms 'positive' and 'negative' in reference to HIV status proved to be confusing.

> "When I received my result, they gave me the concluding note: negative HIV. I thought that negative means HIV-infected and I cried out terribly until someone told me that there is no problem. But I still felt afraid." (Female worker planning to go in Taiwan, Province of China)

Feedback by most migrants shows that although they think that the medical staff is qualified they also felt that the medical staff were unfriendly and generally unhelpful. The following are comments by prospective female migrants:

> "When having the X-ray test , if we didn't strip off quickly, they would ask us to get out."
> "No.They even said they were busy and pretended as if we were dumb.When I had the medical again, the doctor even ignored me."

> "No, they grumbled all the time. How mean they were! As if we paid money to ask them for help. Especially the woman at the dermatology and venerology."

Some said that they had found the facilities hygienic and safe, while others disagreed.

Migrant workers, often desperate to go overseas for work, might try different strategies to pass the health test. Due to a lack of knowledge and any proper information, they may, however, employ strategies that are detrimental to their chances. For example, when a group of people go to the toilet together to provide a urine sample, they may use someone else's urine for whatever reason. This has backfired though, as a hospital director explained that a whole group of women were declared pregnant, due to their sharing a particular person's specimen. In some hospitals this has resulted in the practice of doctors or nurses observing the patient as they urinate. However, some simple instructions are given to help deal with an upcoming testing, as shared by the Director of Recruiting Agency:

> "Migrant workers have cautions to not drink medicine, and not eat breakfast in order to do blood test."

After the health testing is completed, the results are reviewed and copied for the hospital's records. The determination is then made as to whether the migrant workers are fit or not, and health certificates are issued for those who are deemed fit. This is a sealed health certificate signed by the Head of the Health Committee. Results are given from between three days and one week later, and confidentiality seems not to be an issue of concern. In most cases, three copies of the results are sent to the recruiting company, because, according to the Head of a laboratory department in a private hospital,

> "they need to be informed that they cannot send this worker abroad because of a failed health test…. We give the result to the contact person (of the recruitment company)."

Once they have received the test results, the company keeps one copy, one is sent to the receiving country's agency, and the last is given to the migrant worker. Many migrants find it convenient that the results are handled by the recruitment agency, as expressed by a prospective male migrant:

> "Because if I myself have the medical test, I will take the certification but going with a group, they send to the centre, it's good, I don't have to wait to take it."

Yet this sentiment is not shared by all, as indicated by a returnee male migrant worker from Malaysia:

> "I didn't know (test result) because the company got the result but they didn't inform us. I didn't know because the company received it, not me."

Generally, the main consideration among migrants is whether they obtain the fit result, to ensure they can go abroad for employment; any further details are not of much importance. However, this lack of clarity or information on test results leaves migrants completely unprepared for results that indicate a health condition and the implications. These range from being found unfit in Vietnam, or even worse, being sent back home upon being found unfit in a receiving country. A deported and bewildered male migrant worker from Malaysia shared his absolute ignorance regarding the tests and the results in Vietnam prior to departure:

> "They sent me nothing, the middleman merely told me that "You are OK". The middleman had done everything about the tests for us, the result was given back on the following day after the testing day. No, I don't know (test information). Everything I know is what they had said. They said that I reach the standard."

It appears that migrant workers may also be verbally informed of their results publicly. In one hospital, it was observed that a group of migrant workers stood around a hospital staff member, who called out the names from the test results. Most were told that they had passed, while some were informed that they needed to sign a 'commitment' document because they had a health problem that was considered temporary but required treatment. A few were informed of a failed result, and apparently without any counselling. The temporary unfits receive the prescription for treatment and could re-test again upon completing treatment. This is reflected in the sharing by a prospective male migrant who came a second time for testing:

> "Because the doctor needed to recheck the disease. I have pneumonia, they gave me the prescription and the medicine. I bought the medicine and got back to the test."

When a migrant worker is tested HIV positive, it seems that no confidentiality is maintained as the hospital reportedly informs the company first, and then the company notifies the worker, as explained by a Recruiting Agency Director:

> "We would tactfully inform him that he is unfit, and he should go to the doctor for specific advice."

The same practice is confirmed by a General Manager of a private hospital:

> "But in case it's HIV positive, we will tell the company first because this is a sensitive problem. So we will record as a suspected case of HIV positive and won't affirm that. Then we transfer it to National Institute of Hygiene and Epidemiology (NIHE) to do confirmatory test."

Hospitals providing health tests for migrant workers do not have permission to confirm HIV positive results. If a hospital finds a positive result, they will send the sample to the NIHE or an authorised hospital for confirmation.

> "First you need to understand that we are not equipped to do confirmatory tests. In this hospital the preliminary step takes place, the first screening of people on HIV. When a sample tests positive it will be send to the laboratory in the city that is approved to conduct confirmatory HIV tests." (Head of a laboratory)

Confirmatory testing is also used in cases where a migrant is deported for a health problem found through testing upon their arrival in a destination country, but which had not been discovered prior to departure. To resolve the dispute over who is responsible for the misdiagnosis, the re-test is done at a senior hospital, where the migrant worker needs to give a blood sample again. If it shows the same result as the original test (negative), then the hospital does not have to bear the responsibility of paying the related transportation expenses of the returned migrant. However, where no party in Vietnam is blamed for the misdiagnosis and the subsequent deportation, because the misdiagnosis is attributed to the difference in testing systems of Vietnam and the receiving country, reimbursement for transportation may be obtained through the Department of Overseas Labour Management.

Monitoring of Testing Centres

The Ministry of Health appoints staff from the Department of Therapy to monitor the health testing process. The monitoring, however, is conducted for the whole hospital, not only for the ward or sections that provide health testing services for migrant workers. Moreover, monitoring is focused on the equipment and testing process rather than provision of information, securing of confidentiality or respect.

> "Quality control and assessment of the tests are used.The equipment is checked every morning. Look (shows papers).When there is no signature from the doctor in charge, the equipment will not be used until the signature is there." (Head of Laboratory Department, private hospital)

"The Ministry of Health even monitor in accordance with the process, so we just comply with the process. And the process is depending on each technique, such as how to execute HBsAg for finding out Hepatitis B, or for finding out HIV infected persons is depending on the process which the hospital bases on. The false result leading to migrant workers return is blamed on who concluded it. And the Ministry of Health must handle this. Otherwise the Department of Overseas Labour Management also handles this." (Head of General Planning Bureau in a hospital)

As for the specific hospitals contracted by host countries to conduct testing, the monitoring seems to involve strict quality targets for test results. Punishment includes the cancellation of the contract.

> "We have a contract with Ministry of Health of Taiwan, Province of China. Taiwan, Province of China allows us to do health testing for migrant workers to Taiwan, Province of China but if there are even 2 workers returned then the contract will be cut off." (General Manager, private hospital)

Impact of Results

Prospective migrants usually go for the medical test to get a health certificate about one month before departure, which means that they have already started occupational training. As mentioned, the examination results are only valid for three months and migrants often take the medical test as one of the last steps. When workers receive their results, they face three possibilities: they are either fit, meaning they can fly abroad immediately, or else unfit, which has two categories. One category is classified as temporarily unfit, where, upon completion of treatment, they can get re-tested. Depending on the outcome of the second result they can re-test again if the result is unfit again, and they can re-test as many times as they like, assuming they can meet the high cost, until they are declared fit. One person said that he re-tested three times before receiving a fit result. In some cases, those who were temporarily unfit but have been re-tested again and found fit, have to sign a waiver stating that the hospital does not have to bear any responsibility in case the migrant is deported due to the same health problem that was identified and treated.

> "Then we make firm commitment. For example, someone have high blood pressure, he must commit that he will pay all expense by himself when the foreign partner find out problem and expel him." (Prospective migrant worker going to Qatar)

The period of waiting for testing and re-testing, and getting the results, can play havoc in the life of the prospective migrant and their entire family. Two female prospective migrants who were declared

temporary unfit were found to be devastated with the news. When asked whether they had received any support or assistance from the company, both shared: "Nothing, they only said to try to treat well."

One said she was "sad, anxious, worried"; the other said:

> "I was too sad as well. I have spent too much on it. 500 thousand dong for medicine, X-ray, 500 thousand for checking-up and 2 and a half million I had to submit for my company. I am also discouraged, I feel very well but the result show that I have problem with my lung."

There is also the result which states the migrant worker is permanently unfit. This means that the prospective migrant has a disease or health condition that cannot be treated and disqualifies them from going abroad. In this case, the migrant has to tell the recruiting company to stop processing their application for migration, including enrolment in any training or paperwork needed to obtain a visa. At this point, the applicant usually returns to his or her home town, dejected and worried. Now that they have an unforeseen health condition, they are unable to go abroad, but some have already paid substantial amounts of money for the processing fees which cannot be refunded.

In addition, the worker may also feel ashamed at having to inform their spouse, family members, friends and others in the community that they cannot go abroad as planned. Many do not even know what health condition they have; they are only informed of whether they can migrate or not. These migrant workers are further abandoned by hospitals once they have received a permanently unfit result, as there seems to be no referral system to ensure they receive further services or support. Hospitals seem to take the position that the only duty they have in relation to testing is to assess whether migrant workers have any of the diseases or health conditions that would disqualify them from working abroad. Hospitals will provide information on where to get services, but it is then up to the migrants to take further action.

If they are still healthy, rejected migrants will usually not do anything about their health because they have already spent their money. Others may try to arrange another test, while many others are simply unable to afford treatment. In most of the cases, they are just informed by the recruiting agency that they cannot go because they do not pass the health test, and if they need to know the condition, they have to come and talk to the doctor at the testing hospital.

> "No, we are recruiting agency, we select them in order to work abroad, if they are unfit, just let them leave, they have treatment themselves and support depended on each case." (Director of a Recruitment Agency)

> "No, as they are unfit. One thing we must currently determine is that, this testing is the health testing for the fitness or not of migrant workers.Therefore, if a worker is unfit, he has his right to have later test or not, and the hospital do not intervene." (Head of General Planning Bureau of a hospital)

It seems that the testing of migrant workers is viewed in isolation from the need for referral and treatment services. None of the parties involved in medical testing - recruitment companies, receiving companies nor hospitals - seems to provide any assistance upon an unfit result as their role is simply to test health status for certification, not to assist migrant workers with their health.

ON-SITE

On-site tests are taken in the receiving countries; the tests are for a range of conditions, depending on the host country. Tests for HIV and pregnancy for female migrants are mandatory. On-site testing usually includes a test taken immediately upon arrival or within the first ten days of work, and then again periodically during their stay. This could be every year, or every 2 or 3 years, depending on the host country and the type of employment. If migrant workers fail the tests, they face the risk of being sent back to Vietnam. If this happens, poor workers suffer the most financially and socially.

In receiving countries, there seems to be no proper information, counselling or referral for testing of Vietnamese migrant workers. In those countries, testing is given using English, which could be difficult for new arrivals, especially the low educated Vietnamese migrant workers. Migrants have shared that there are risks in using certain medicines which are usual back home, as the tests in host countries might find stimulants and reject them as unfit. Moreover, during the 1-3 months gap between the fit test result obtained in Vietnam and the departure for the foreign country, a migrant could become infected with something new or could get pregnant. This has resulted in some migrant workers testing unfit in the host country and therefore being deported.

> "Yes, a examine paper will be available for 15 days or a month, so female workers can be pregnant in the period from their examination day to the day they leave Vietnam." (Director of Recruitment Agency)

> "Another problem that we have to face with is the problem with the nerve. Recruiters (in host country) test the nerve reaction which we don't have in Vietnam. If they find out that there are some problems with the workers' nerve, they will not accept them. There are many reasons for this. They could be very healthy at home, but when they come to a new country, they have to face with the problem of new environment, different weather and living condition, so their nerve would not be as stable. This is the reason why the workers were returned due to health problems." (Representative, an association of migrant workers)

A male factory worker who was deported from Malaysia without any information, counselling or treatment was found to be still in shock at the monetary loss he had had to suffer. He had no idea about what infection or condition had caused his test result to be unfit. All he could share on the reason for deportation was:

> "That was because of my state of health. On my returning, they sent to me a letter, foreign partner said that my state of health was not safe enough to continue working for them."

While asked if any health advice or information was given, or if he was taken to any health service centre in Malaysia before deportation, the answer was a simple "No".

REINTEGRATION

Being deported results in the loss of the large sum of money spent by the migrant worker on going abroad for work. Together with the financial loss, returnees also suffer psychologically. Some lose hope and self-esteem, some worry about facing their spouse, family members, and neighbours. For instance, one woman who was deported back for testing HIV positive is said to have left her home village and cannot be found. Most migrant workers who have been deported do not care for their health. One reason is simply because they have not been counselled or even informed properly on their health status. Also, they have lost all their investment spent on foreign employment, and are left to deal with the loss on their own. Health is often neglected in the face of financial struggle; besides, they often do not have any money or resources left for treatment, especially when they do not have a clear idea on why they were returned, or what disease they have.

Although long term migrants do not receive any financial compensation, those who are tested upon arrival and are found unfit and deported at least receive reimbursement for the one way return trip air fare.

> "If the worker is returned due to hospital incorrect conclusion the hospital will pay one way plane ticket to Vietnam. It is assigned that hospital certification is valid in 3 months, if the worker retest after 3 months then that's not hospital's responsibility. But normally, workers returned in 6 to 7 months still are supported 1 million dong by hospital." (General Manager, private hospital)

However, the refund seems to be insignificant compared to the huge loss faced, as explained by a deported male migrant worker from Malaysia:

> "The total expense was 26 million VND and I was returned 6 million VND, the fee of visa, ticket price and some other expenses. Many people received nothing when they were returned home."

Moreover, some may never have access at all to this refund, as reflected by another deported male migrant worker from Malaysia:

> "No, they didn't compensate anything. They should have compensated for me. But that was the fault of the company that brought me to Malaysia. The disease couldn't appear in such a short time!"

It seems that some deported migrant workers do not have a clear idea on policies and procedures regarding refunds, so claiming them could prove to be problematic. When asked about the refund, one deported male migrant worker from Malaysia answered:

> "Now is still not yet but it is coming soon… as that foreign partner had already sent me a letter. A few days later, I will come to the company in Hanoi in order to consider how they can solve my problem. No matter what they do I accept."

He further added:

> "They did not do the tests until 10 work days passed. They talk to me that I am not healthy enough to work for their company. Could you tell me how much is the compensation for the returnee who has situation like me? We returned immediately on the following day after when foreign partner organised the health testing, we worked 10 days before that too."

When asked about his treatment, he responded:

> "Myself. I am very sad. Because of the lack of money, I still not go anywhere, I stay at home. Not yet (on receiving support). When we left, we paid 19 millions for recruiting agency in Hanoi, 1.5 million for medium company, added payment for the middleman that is 24-25 millions. They (family) are sad about me of course, because that happened too suddenly. They think that all who go abroad would like a happy ending, in the future we come home in order to contribute not only for family but also for society, so as to do that job…. Everyone surrounding me, my parents, my family are very sad."

Although this deported person does not necessarily represent the situation of all the deported cases in Vietnam, it gives a clear indication that the necessary supports in terms of financial assistance, treatment, care, support or referrals upon return to Vietnam are still largely missing.

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1 Bureau of Manpower, Employment and Training Sources. 2006. Bangladesh.

2 National Policy on HIV/AIDS and STD, Bangladesh, under the title 'Mandatory Testing' para#1, p 34

3 ibid, under the title 'General Guidelines for HIV Testing' para#3, p 29

4 Recruiting agent's Conduct and License Rules. 2002. Clause 7 (f).

5 US 1$ equals to 70 Taka approx.

6 National Policy on HIV/AIDS and STD under the title 'General Guidelines for HIV Testing' Para# 9, p 29.

7 ibid, under the title 'Who has the right to know the result' Point # A, B & C, p 34.

8 Dubai does not require a pre-departure medical fitness, so an unscrupulous agent might easily arrange to have a false fit certificate, the migrant worker would have no problem flying to Dubai but upon testing unfit there will be deported.

9 Teacher is what the migrants call the staff of the recruitment agency that conducts training at the pre-departure training centres.

10 See http://www.iomindia.org

11 See http://meaindia.nic.in/parliament/ls/2005/08/03ls13.htm. Accessed on 12th July 2007

12 Annual report, found at http://www.naco.org

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16 Jumhur Hidayat, Chairperson of BNP2TKI

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22 PPM was established in 2004, as a part of Coherent Service Centre (Pusat Pelayanan Terpadu) of Raden Soekanto Hospital (RSRS). According to the MoU with IOM, PPM provides medical and psychological services for victims of trafficking.

23 Department of Labour, Ministry of Labour and Transport Management. Annual Information Bulletin. Nepal. pp 2062-2063,.

24 National Center for AIDS and STI Control Policy for HIV Testing and Counselling, Nepal. This stipulates mandatory Testing for HIV is not allowed in Nepal, but compulsory testing can happen if required by law, for example, for recruits to the army and police. Compulsory testing refers to testing which is required in order to access a particular benefit or service (e.g. visa employment, medical care, armed forces, police, etc) but where the individual has the option of rejecting the service or benefit and thus avoiding the test.

[25] USD 1= 70 NRs.

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[27] Sri Lanka Bureau of Foreign Employment. 2005. Annual Statistical Report of Foreign Employment.

[28] The Central Bank of Sri Lanka Annual Report, 2006.

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[32] Joint circular No. 10/2004/TT-BYT-BLDTBXH-BTC of Ministry of Health, Ministry of Labour, Invalids and Social Affairs and Ministry of Finance on guiding implementation of health testing and certifying for overseas Vietnamese workers dated December 16, 2004.

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C

DESTINATION COUNTRIES

Migrant's blood sample pass through the hands of health worker

Bahrain

Bahrain is a major destination country for migrant workers. The country is currently experiencing a construction boom and is promoting its tourism industry, both of which are fuelling the trend of migration to Bahrain for work in the construction and service industries. Another significant form of employment for migrant workers is as domestic workers: this is specifically for females.

Bahrain's total population of 707,160 includes 268, 951 expatriates (38%)[1] who account for over 50% of the country's workforce. A major proportion of the migrant worker population comes from India, but there are also significant numbers coming from Bangladesh, Philippines, Indonesia, Pakistan, Nepal, Ethiopia, Eritrea, Somalia, Thailand, Sri Lanka and a number of countries in Eastern Europe. Workers from these countries mainly provide the workforce for 3-D jobs (work that is regarded as dirty, dangerous and demanding), or work in the entertainment sector. Bahrain also receives a smaller number of expatriate workers from the United States, Australia, South Africa and Western Europe, who tend to be employed in well-paid jobs with private companies or in the education sector. This research, however, focuses on migrants employed in the construction sector, as semi-skilled or skilled manual labourers, or as domestic helpers. These are the most vulnerable sectors where migrants find work.

Bahrain, as one of the Gulf Cooperation Council (GCC) member countries, follows the mandatory health testing of migrant workers in line with the rules and regulations of the Gulf Approved Medical Centres Association (GAMCA). Upon arrival, all construction workers and manual labourers are referred to the government's centralised health facility for migrant workers, Al Razi Health Centre, which is a GAMCA centre. According to the centre's own records, a total of 87,000 migrant workers were tested in 2006, meaning an average of 350 workers are tested per weekday.

Mandatory health testing for domestic workers is undertaken in a decentralised fashion; tests can be done at local health centres in the area where their employer lives. These health centres are accredited, licensed and operated by the Bahrain Ministry of Health. While the majority of foreign workers are documented, it is widely accepted that there are quite a few 'floating' migrants working in Bahrain. These are workers without the required documents, which includes being without a positive health test result. According to NGO workers and health professionals, these undocumented workers have evaded or escaped the testing process out of fear of the consequences of being declared unfit.

Bahrain does not require migrant workers to undergo pre-departure health testing in their country of origin unless they are from certain Sub-Saharan African countries. While some recruitment agencies and sending countries' officials recommend and in some cases require it, in our research findings, there was little evidence of a standardised process of pre-departure testing for migrant workers. Some had undergone testing in their home countries and others had not. For example, most Filipinos interviewed stated they had been tested in the Philippines, all Bangladeshis interviewed stated they had not been tested in Bangladesh, and some Indians interviewed stated they had been tested before leaving India, while others had not.

For a number of respondents, pre-departure testing appeared to give a sense of security or legitimacy, but for other workers the fear of being prevented from temporarily migrating for employment made them avoid health testing in their home country or trying to manipulate the results.

> "They didn't tell us anything, they gave us eye-test, x-ray and general check up. Because I had done the medical before [I left India] I had no worries." (Male Indian garage worker)

> "If you're working in this kind of business then you have to be careful. Because we cannot go out of our country if we don't have all this physical check up already. If you are a legitimate contract worker you have to pass all the tests before you go to Bahrain… But before you go to Bahrain, if you fail there you cannot come here. So you don't have to worry about it… We are physically fit because we are legitimate – if you are not legitimate then that's the worry." (Female Filipina waitress)

> "You know, they are supposed to undergo a medical in their own country. In many countries this either does not happen, or workers slip through other channels and avoid it, or are able to manipulate their results [by paying etc].They probably travel with disease." (Migrants' support NGO worker)

To ensure monitoring of testing policies and procedures, GAMCA mandates that testing centres in sending countries undergo annual inspection by the GCC Executive Board Technical Committee for Gulf Countries, to ensure that they follow standards set by the GCC Health Ministries Executive Committee. Additional inspections are carried out if a complaint is filed about a particular centre, or if a high number of workers found unfit in a receiving country are being passed by a centre in a sending country.

> "The Gulf Technical committee carries out annual inspections of health centres in sending countries. The centres are inspected to see if they meet standards set by the GCC Health Ministries executive committee. Additional checks are carried out if there are complaints regarding a particular centre, if a consistent number of unfit workers are given fit certificates from a particular centre.These centres will have penalties if they don't meet the standards." (GAMCA Official)

Testing Procedures and Handling of Results

Following government laws, migrant workers are required to undergo mandatory medical testing only once per employment contract while in Bahrain. This is usually done on arrival. However, if they change employer or sponsor, the worker needs to do the test again, or return home and re-enter Bahrain with a new visa. Barbers and those working in the food and beverage sector, in hotels or restaurants, need to test every year.

GAMCA testing guidelines prescribe a series of tests in sending countries, but in Bahrain itself, only a selective number of tests are conducted. All migrant workers in Bahrain are given chest x-rays and examined for pulmonary tuberculosis, but individual tests, including for HIV, vary according to the profession of the migrant worker. Female migrant workers are required to take a pregnancy test. As part of meeting GAMCA requirements, testing centres are obliged to have all equipment necessary to undertake the prescribed tests, meet international standards of quality control, and laboratories must have quality control certification by GAMCA.

GAMCA has established a monitoring process for the inspection of new centres and the evaluation of existing ones. Through this, new licenses can be recommended and old licenses can be renewed or revoked. Penalties including warnings, fines and/or temporary license suspension. An internal Ministry

of Health committee monitors both the public and private health centres that provide mandatory health testing services to migrant workers. The private centres must be certified and endorsed by the Ministry of Health, via the Al Razi centre.

A Bahrain Ministry of Health official explained:

> "We test mainly with a clinical examination: blood pressure, vision, screening for any diseases. Some occupations are given blood test to check for HIV, hepatitis B and C and syphilis. All expatriates are given chest x-rays and checked for pulmonary tuberculosis. Process: go from X-ray station to blood pressure and vision station to physician. Sequence: X-ray, nurses' station for blood pressure and vision, physician for general check up."

However, almost none of the workers interviewed were aware of which health conditions or diseases were tested. Most could only state that they underwent a physical check, an X-ray and had a blood sample taken. When asked if they were told what they were tested for, the most common answer is a straight "No," and most reported having no idea at all about the tests.

> "No, we didn't talk about the tests." (Male Bangladeshi construction worker)

> "They take the blood, the urine." (Female Filipina domestic workers)

The research findings indicate that language diversity among health centre staff is low. GAMCA guidelines do not require staff to be able to speak migrants' languages, although both health professionals and migrant workers mentioned this as an area for potential improvement in the mandatory health testing system. According to a doctor from a private testing centre frequently used by migrant workers, language barriers contribute to the lack of information provided to workers by medical personnel at testing centres.

> "Because sometimes I feel there is a gap during the conversation, with the language problem, [this is] a very big problem. So maybe they cannot explain what happened and what to do next."

With regards to gender and cultural sensitivity, all respondents indicated satisfaction with the process and treatment by staff. All stated that they were segregated according to gender while being tested, and that doctors were gender matched. All respondents indicated that they felt comfortable and satisfied with this arrangement.

Al Razi Centre, the main public health testing centre for migrant workers, appears to have the necessary medical and technical facilities, but it is not very well lit, there is little sign of ventilation, and conditions do not appear to be as hygienic as might be expected, especially in regard to the toilets. Accordingly, the migrant workers interviewed gave an overall rating of cleanliness at the centre as 'medium.'

Through observation, it was noted that the clinic had a small number of posters displayed on general health issues, such as hygiene, smoking and diabetes. There were also a small number of posters and cartoons in English, Arabic and Hindi script, but none of the materials referred to the mandatory testing procedure. General comments from migrant workers indicated satisfaction with the standard of care and the conditions of the centre overall. Although there seems to be sufficient seating in the waiting room, the main complaint made by migrants was in regards to the crowded conditions.

Physical accessibility to testing centres was not mentioned as a problem by any of the respondents. Al Razi is on a main road in Bahrain's capital city and close to a central bus station. All domestic workers interviewed said that they were taken to a health centre by their sponsor. According to a doctor working in a private health centre, the decentralisation of testing centres also has improved accessibility for workers.

The average testing time does not appear to exceed an hour, although waiting times can be much longer, resulting in a worker losing the day's earnings. Responses to questions on the financial arrangements at testing centres varied. Some workers lost their wages because of time spent being tested, some said they had paid for the test themselves, while others said their employer bore all the costs of the test, including transportation.

> "The medical took maybe half an hour - sponsor paid." (Male Pakistani garage worker)

> "For the X-ray, it was one day... and then it was two days for the other tests. The company cut one day salary because I went back again for two days." (Male Bangladeshi construction worker)

GAMCA guidelines indicate that migrant workers should indicate their consent by signing an English/ Arabic form on their medical report. However, this form cannot be understood or filled out by migrant workers who are illiterate. Moreover, many workers stated that no consent or signature was taken from them at the time of testing, and several interviewees indicated that it was their sponsor who had signed the consent form for their test. The findings confirmed that there is an inconsistency between the prescribed practices and the actual experience of migrants undergoing testing in these centres. Although, as one respondent indicated, logically no 'consent' is actually necessary since the tests are mandatory.

> "A form must be filled out by the applicant and signed by the sponsor, presented to reception and fees paid." (Ministry of Health official)

> "No [consent is take], all tests are mandatory. They [staff] tell us we'll take 'x-rays, blood pressure, urine test, go to the doctor." (Male Indian office workers)

> "No… there was nothing like that [consent]." (Male Bangladeshi construction worker)

None of the workers, health professionals or government officials spoke of pre-test or post-test counselling. Each time migrant workers were asked about this, the response was negative. From our overall findings, no counselling or information specific to the workers' situation as migrant workers undergoing mandatory testing is provided. Based on government officials' and health professionals' responses, counselling does not appear to be part of any testing practice or policy. As with the issue of informed consent, no workers seemed to expect any counselling services either, as confirmed by male Bangladeshi and Indian garage workers:

> "No, nothing like this, they just gave us the test."

Our findings also clearly indicate that there is very little concept that migrant workers own their personal medical information or have a right to privacy. This extends from the process of pre-employment mandatory testing to policies and practices regarding workers found to be living with HIV. For example, issues of confidentiality and privacy are breached at various stages of the mandatory testing process. This might be during the actual testing proceedings or resulting from the handling and disclosure of results.

Test results and related data are jointly owned by the testing centre and the Economic Development Board (EDB), which is initiating a programme to computerise the pre-employment health testing process. All GAMCA centres also share medical information on workers tested at GAMCA centres through a shared database of information. This sharing of medical information is mandated by the state, as confirmed by a National Aids Committee official:

> "By law, if any persons are found to have a communicable disease then the Public Health Department (Ministry of Health) must be informed."

On a more personal level, it was observed that workers, particularly female domestic workers, were seen waiting with, or were taken for testing by, a local. This is assumed to be their sponsor or some other authority figure. While the practice of sending workers accompanied by an individual who is presumably more knowledgeable about the procedure can possibly assist with language and can be comforting and useful to the workers, it can also potentially compromise privacy in testing and handling test results. A number of workers interviewed reported that their results were given directly to them in an open fashion, or collected by their sponsors.

> "They give [results] to the sponsor." (Female Filipina domestic workers)

> "They put the papers on a table (indicates with hands 'spread out'). It was open, not in an envelope. The men had to find their picture and take their result." (Male Indian garage worker)

Accessibility to treatment, care and support for migrants

Confirmatory tests are only undertaken if workers test positive for HIV. Information on workers who test positive for HIV is passed from testing centres to a number of additional institutions. Bahrain's policy requires that all HIV positive cases detected by health centres must be reported to the Ministry of Health Public Health Department. This is done by filling out a specially created form for reporting HIV positive cases. The Ministry of Health then informs the National Aids Committee, who arranges for a confirmatory test. If the worker tests positive for HIV a second time, the National Aids Committee then arranges the migrant worker's deportation with the sponsor and the General Directorate of Nationality, Passports and Residence (Immigration).

Test results are available within 7 days of taking the test or, for a higher cost, within one day. There does not appear to be any consultation during the disclosure of results, and most migrant workers stated that they collected the results themselves. This was not the case for domestic workers: all domestic workers interviewed reported that their results were sent to or collected by their sponsor. This is also confirmed by the Doctor in a private testing centre:

> "If the result is ok… they will come to the office and take the report. And if it is not ok, they will say 'call your sponsor' or 'give this letter to your sponsor'."

Supposedly, in the case of a treatable illness, workers will be referred to another health centre or hospital. However, among those migrants interviewed, only two people indicated that they were informed about referral for treatment.

There are three categories under which a migrant is declared as unfit. Workers who test positive for a communicable disease, such as HIV, hepatitis B, malaria, leprosy, tuberculosis or an STI are declared unfit. Those who are found to have chronic conditions such as chronic renal failure, chronic hepatic failure, congestive heart failure, uncontrolled hypertension, uncontrolled diabetes mellitus, cancer, psychiatric or neurological disorders and physical disabilities (including colour blindness, deafness) are considered unfit. And pregnancy among female migrant workers is also grounds for being declared unfit.

Migrants found to have active TB are provided with two weeks' treatment before being deported. Other than that, there was no evidence of a referral system for workers that are declared unfit. While migrants found to be HIV positive are reportedly advised to seek treatment in their country of origin, there was no indication of referral for treatment either through GAMCA centres or otherwise, and very basic HIV counselling is reportedly provided prior to their deportation. Moreover, antiretroviral treatment (ART) for HIV-infected persons is only available to Bahrainis. A joint campaign by the Ministry of Health and United Nations Development Programme (UNDP) has been launched to raise awareness on HIV as a means of preventing its spread, but it is unclear whether migrant worker communities are targeted and how such activities will reach them.

Treatment for non-communicable and relatively minor illnesses discovered during the mandatory testing is available to migrant workers, although they may have to bear the costs themselves. It was found that very few of the migrants interviewed had medical insurance. Access to health centres poses a problem for workers living in labour camps due to their location. Also, site foremen or middle managers often deter workers from seeking medical help for work-related injuries to avoid incurring costs to the company. Moreover, there are no NGOs or organisations specifically providing health care, support or information to migrant workers. Although some sending countries' embassies hold regular medical camps, some workers may be reluctant to turn to their embassies out of fear of dealing with the authorities and the consequences of being found unfit.

Impact of results

A fit result allows a migrant worker to gain or retain employment in Bahrain, even though this status is dependent upon them maintaining their health. Workers who are declared unfit, on the other hand, face the serious consequence of deportation. Although this is the current policy, not everyone agrees with it, as indicated by this National Aids Committee official:

> "Once detected, either through pre-employment [test], check up, or blood transfusion, we have to test again for confirmation. If test results are positive for HIV a second time, the person will be deported. It is my dream that if he is able to work, then he should be able to. He has a right to work if he is able to work."

Unfortunately, one of the strategies to deal with an unfit status or potentially negative results is to become a runaway or illegal worker. These people notoriously end up in jobs with the worst conditions, including salary, working hours and physical conditions. Fear of deportation because of health problems also prevents workers who may have communicable illnesses from seeking treatment, which may be inadvertently leading to the spread of these diseases. The doctor in a private health centre said:

> "I mean once he will come to know he is unfit the authority will ask him to call his sponsor, then he feels that there is something wrong…. They just give the papers [and are told] 'ok go.' So those who are living (here) for a long time they know, ok, maybe you are unfit, don't go back to your sponsor - run away."

When asked about the impact of negative test results, respondents described financial ruin, emotional distress, familial suffering and stigmatisation within their community as results of being declared unfit and deported.

> "You think so much about your money, you spent the money and then nothing.You're going back. It's for nothing, you don't have money."

And again,

> "Some people put the land for [sale] because they want money to go to Bahrain or whatever, and then they go back and they don't have their land. No house, nothing. That is true." (Female Filipina domestic workers)

> "Uh, I have seen some people, those who wanted to commit suicide.What else [can I] say? How will he face his family, how will he return the money, what will he do now? And maybe all his family, he's scared [of] his family. We don't know what is going on there. But this man who came here by this amount of money and [is] unfit here, he is, I mean he is a dead person in his country, I can say this, I saw so many people like this." (Doctor, private health centre)

Official parties in Bahrain appear to bear no responsibility for the impact of an unfit result on workers once they have been deported. There is no referral to health care or support providers in the workers' home countries through the GAMCA network or otherwise, although there are reports of community groups involved in aiding workers through legal assistance to ensure proper compensation or by providing financial assistance on their return. The only concern of the Bahrain Government seems to be to secure its position, and any attempt by the unfit migrant to return through official channels will be thwarted by the GAMCA shared database. A GAMCA Official explained:

> "A number of GAMCA centres are linked electronically to the main office in Riyadh (share a database). Bahrain's Ministry of Health is moving towards an electronic system for processing migrant workers' files as part of a labour market reform programme."

Dubai

The United Arab Emirates (UAE) is comprised of seven emirates, of which the second largest is Dubai. Dubai's focus on trade and industry has transformed it into the leading trading port in the region. Within the UAE's resident population of 4,100,000, only 20% are citizens . The rest are migrant workers and their families. As of 2005, there were 2,738,000 migrant workers in the UAE, comprising 95% of the UAE workforce in the private sector[3]. In other words, the UAE's economy is entirely dependent on foreign workers, more so in the booming economy of Dubai.

The UAE economy, traditionally fuelled by the oil sector, has expanded during recent years, with other sectors growing at a remarkable pace. Much of this is labour-intensive. For example, in 2005, wholesale and retail trade, restaurant and hotel businesses grew by 15%; the manufacturing sector by 13.9%; and finance, insurance, and real estate sectors each by 12% [4].

The economic success has resulted in substantial international investment and in a construction boom in the UAE. Particularly in Dubai, construction is one of the leading sectors of economic growth (growing 10% in 2005), and is amongst the biggest and fastest growing construction markets in the world. One prominent feature of construction activity in Dubai is the construction of large-scale projects. According to the Ministry of Economy, Planning Sector, there were 512,495 construction workers employed in the UAE[5], with much of the construction activity concentrated in Dubai.

According to the Ministry of Labour, the number of migrant workers increased by 17% in 2005, compared to 2004[6]. Although there are no official statistics available on the breakdown of the migrant workers by their countries of origin, according to research, the majority of migrant construction workers come from India, Pakistan, Bangladesh, and Sri Lanka, all male, and mostly illiterate or with a low level of education. Moreover, a large number of migrant workers are also engaged in hotels and restaurants, offices and trades, domestic work (generally females), entertainment, cleaning, salons, and as drivers. In these jobs, nationals from Philippines, Indonesia, and Nepal are employed in large numbers along with workers from the above mentioned countries. According to the 2006 Annual Report of the Philippine Overseas Employment Administration (POEA), a total of 99,212 documented overseas Filipino workers (OFWs) were deployed to the UAE. Of this number, 60,190 were re-hires and 39,022 were new hires, indicating the remarkable growth of employment in UAE.

Migrant workers arrive in Dubai with visit visas by invitation of a sponsor (family, friend or employer), which allow them to stay for two months. There is a possible extension of one month. Within this period they have to join or find work and process their employment documents, otherwise they have to leave Dubai or become an undocumented worker.

Unlike most host countries, the Dubai government does not require a pre-departure medical test done in the home country. Migrant workers employed in the private sector in the UAE are sponsored by UAE citizens under employment contracts lasting for between one to three years, subject to renewal. Prior to

having the contract, identity card and visa, a mandatory medical test is a must. If this is failed, the result is deportation, as set out by UAE law.

The duration of the work permit depends on the nature of work or the employer. For instance, a work permit for construction or office workers is for three years; for domestic workers it is two years; and for barbers and food and beverage (F&B) related workers, it is one year. The latter have to do an additional test to obtain a Municipality Card, which is kept with the employers for necessary display during monitoring visits by the Municipal authority.

When a migrant worker obtains a working permit, s/he also gets a medical card that serves as health insurance. According to the law, the employers are supposed to provide emergency health care for their workers by giving a health card that permits them to use government-owned hospitals. This health card is also issued along with the work permit, and passing the medical test is a must for this. Once a migrant worker's work permit expires, to renew the permit, s/he must take the medical test again. Once again, failing the test means one must leave the country, or be deported, regardless of how many years s/he has resided and contributed to the development of the UAE.

Medical Testing

Migrant workers who arrive in Dubai and apply for working visas have to undergo a medical testing procedure almost immediately. They must certainly complete it within three months, which is the initial visit visa period. The basic medical test consists of blood extraction for tests for HIV and hepatitis A, B and C, and an X-ray for tuberculosis.

> "In Dubai one has to do medical to get visa. After this, 3 years later when the visa period is over then again one has to do medical to get visa. First time they test X ray and blood. Next time they only test blood." (Bangladeshi construction worker)

> "No test done in India. Did test after coming Dubai.That is the rule of UAE. If you come to work, you have to take a medical and if fit then you get the ID card of the company. It was blood test and took an X-ray of back and front side. Urine test also. No, I don't know what they test.They send the report directly to the PRO. They don't show the report to us. Pregnancy test I think they can do it only by urine test. May be they are doing it. May be they are doing the AIDS test and all." (Female clerk from India)

Other tests may be required, depending on the job category of the migrant worker or the requirements of the employer. These include, for example, a pregnancy test for female domestic workers, and skin checks and a VDRL test for food and beverage workers.

> "Food handlers need to undergo a different set of medical tests: physical exam (PE), VDRL test [for sexually transmitted infections], and stool and urine exams to check for bacteria or parasites." (Staff, Visa Medical Hospital)

> "It depends on the employer, they test the housemaids for one thing but not the professionals… Like, they require pregnancy test for housemaids but not the professionals." (Owner, Private Medical Clinic)

> "If a person is working in hotel and he is found hepatitis B positive, just a carrier and not infectious, then if the employer is good he will give him other visa, will say you can not work in there but work as clerk or driver, change visa. If employer not good, he will cancel visa and the migrant has to go back home." (Senior Lab Technician, Al Maktoum Hospital)

> "In Dubai, if people from any other country come to work, they have to get visa.To get visa, here the following check-ups are made, e.g. HIV, HBV, HCV. If the person is from medical profession and he is found + for any of these then his visa is not given. He must return to his country.And if he is found to be HIV+ after 2/3 years of getting visa, then he is handed over to the local Municipality Inspector.They will keep him in isolation room for 2/3 days.Within this time, his passport and ticket will be arranged, visa cancelled and will complete quick action to send back to country.The main problem in getting visa is if someone has HIV then no matter which profession he belongs to, his visa will not be approved. But if it is HBV+ or HCV+ for a food handler, then his visa will not be approved. But other profession people, such as labour, hair cutter, driver, teacher, businessman these all will be given visa, no problem." (Laboratory Technician, Rashid Hospital, Dubai).

The general feeling of migrant workers during testing is that of fear. This is the fear of being declared unfit and having to lose the investments they have made.

> "I feel afraid when testing. Don't know if my blood is good? If I pass test? If they find problem they will send me home. Not give visa. I spend forty-two thousand Sri Lankan Rupees to come to Dubai. If I fail medical I loose all money." (Sri Lankan Kitchen Steward)

Among the significant number of migrants covered in this study, none could recollect having been asked for consent, or anyone explaining to them about the tests and the possible results and consequences. Nor could anyone recollect undergoing any pre-test or post-test counselling. This was also confirmed by staff of a testing centre:

> "No counselling is done here.We do not inform the patient also. It is confidential, no?"

During the visit to a testing centre, the one Declaration Form found to be routinely in use was one to be signed by a female migrant worker before undergoing an X-ray examination. In it, she states that she is not pregnant.

During their first test, the migrant workers are usually accompanied by a company official, employer or family or friends. The test will be at the nearest medical fitness testing centre, situated in a hospital or clinic. There are a large number of testing clinics and hospitals in Dubai offering the relevant medical test services for a visa and, from the interviews conducted with migrant workers, workers have no difficulty in accessing one.

The Human Resource department of large companies prepare the medical test forms in advance and take the migrants in groups in their own transport to attend the medical test and return. However, other migrant workers have to fill in the forms on their own or get assistance from the agents sitting nearby. The latter will type the forms at a cost of 10-15 dirham. For first timers, especially for the more uneducated migrant workers, language is often an issue, as shared by a Bangladeshi construction worker:

> "The first time when I went three years ago for test, there was a long line. I went three days and returned. Did not know Hindi or Arabic. But now have learned everything. There is no problem anymore."

Females have a separate testing place, but a long wait is common.

> "It takes long time. One and half hour to two hours is needed." (Bangladeshi Female Domestic Worker)

So it is not the actual medical test itself which takes time, but the long queues waiting to take the coupon from the first counter, and then again sitting or standing in line to be tested. This was highlighted to be a problem especially because there is no separate provision for the large migrant worker community of Dubai.

> "Went 8 in the morning and returned 12 at noon.Takes long time for testing. Long line. I wait for one hour (for testing), sometime sitting, sometime standing.There is chair but more people. Some people have to stand and wait." (Indian labourer)

All this can result in the loss of a valuable day's earnings, especially for the less privileged labourers or construction workers who are not given a day off to do the test.

> "There is long line in the medical. Some companies make people do the duty after medical testing and some give leave. In the govt. hospital it takes minimum five hours.We went 7 in the morning and returned 3 in the afternoon. The company gives leave for the morning only and in the morning time there are more crowds. In the private clinic one does not need to stand in line. It (test) is done in 10 minutes. But the cost is higher." (Bangladeshi labourer, Dubai)

> "For medical testing take two or three hours. All the people who need visa from any company and residence visa and any visa they will go to test. First I will sit.When serial no. come then I will go and stand up in the queue. It is long queue standing ½ hr. to 1 hr. If I can go back to work that day I will take duty. If late no duty.That day salary cut." (Indian construction worker, Dubai)

> "HR fills all forms, pays money and finish all the procedures. My duty is just to go and give test. Medical means I just go, they take blood, take stool, check hand and skin.That's all, finish. 10 minutes business. But it takes longer because there are many people. Each time I went there waits 100 to 200 people." (Indian chef, Dubai)

Migrant workers generally expressed their satisfaction about the general environment and cleanliness of the testing centres. Both male and female laboratory technicians perform the tests. No male migrant workers reported any concerns regarding the testing process in Dubai, since it involved only blood drawing and X-ray, in contrast to the naked body check some reported to have experienced in their home country in India, Nepal and Sri Lanka. There are separate testing places within the same facility for male and female migrants and females participating in this study also said they had not faced any major problems. However, a female Pakistani Clerk (an advocate by education) shared a particular problem she faced, to which she took offence:

> "Although Blood taken by lady doctor, X-ray by lady also, a male doctor was asking question first (uneasy laughter) about period (menstruation). So I felt embarrassed. Male doctor should not ask sensitive question.There should be female doctor."

Although the medical test is an integral part of a migrant worker's life in Dubai, evidence shows that there is little or no information made available about it to any migrant worker. This includes all nationals covered in this study, and is irrespective of whether the person is illiterate or has the highest university degree.

During visits to test centres, no information material related to the test was found to be available for the general migrant workers, except at one place where a large board next to the coupon counter advertised an Executive Health Screening Service, offering 'No queues, Quick procedure, Comfortable surroundings, Same day delivery of test results and health card - just a call away'. This is clearly for the more affluent rather than the general migrant workers.

During visits to observe the testing process, it was noted that after initially taking a (number) coupon from the counter, the migrant workers then have to sit and wait. The wait could be prolonged, often exceeding an hour or more. Most spend the time just sitting, waiting for their number to be called. Once their completed forms, passport photocopy, pictures and so on have been passed by the thorough official check in the adjacent office, numbers and names are called out loud. These persons then go and sit or stand in a smaller waiting room, next to the serology lab. When asked, the migrant workers confirmed that although the tests involve relatively simple procedures, they are at this point in fear of the results and the possible outcome of deportation. Next they go to the lab once their name is called, and sit in one of four chairs, and their blood is collected by one of the four technicians, quickly, without any exchange of words. Next, they proceed to the X-ray room. Nowhere in the process was there observed any form of verbal or written information, let alone counselling.

In the absence of any formal information from the employers or company authorities, migrant workers rely on hearsay from fellow colleagues regarding the testing, which mostly inspires fear. Many are found to have misconceptions that people are tested and deported for cancer, heart diseases, or meningitis, but most knew that they are being tested for HIV. Many expressed that they would like clearer information about the tests, the results and the policy for the migrants who fail the test, but the environment in testing centres does not even allow people to ask any questions.

> "There is no question of talking! Who will ask question?! We can take breath of relief if we can go and finish medical quickly! No, there is nothing like consent also." (Indian Chef)

> "In the medical they do not tell us anything about test. Here work goes so fast that there is no scope of telling anything.There is long line. One comes and gives blood, then next person, it goes on like this. Why they are taking blood that can't be known.There is no chance to ask any question. After this we have to go to do X ray in another place, in counter. Why X ray is done that we do not know exactly. But we guess it is for heart test.There is no chance to talk due to huge crowd. Everyone has one word, O Allah, O Allah, quick, quick." (Bangladeshi Clerk)

Common among migrant workers seems to be the fact that they are not even aware that they have to pass a medical fitness test in Dubai until they arrive and are asked to take it. A young newcomer from New Delhi, a graduate who had found employment as a saleswoman, was shocked and screamed out loud as she learned for the first time that she had to do the medical test in Dubai:

> "I have to take test here again? Why? I have tested already (in India). Why will they test me again? What for?"

She seemed very frightened. Her Bangladeshi colleague, a mechanical engineer by education, shared:

> "She don't know because until the visa comes, nobody will tell her anything. If she fails here, she must go back even if she was ok in India. She must return home.They will send her back swiftly.They will keep only healthy persons. If someone has any disease, then he doesn't have any place here in Dubai."

The lack of information and awareness is shared by migrants from all national backgrounds, as reflected in the following:

> "Blood and X-ray in Dubai. That's all. Sorry, what test that I don't know. Sorry. May be company knows." (Sri Lankan driver, Dubai)

> "We have to know about all diseases. How we become medical unfit? What is test result? What is policy for unfit people? If I become unfit, what compensations or treatment will be given to me that I want to know." (Male Nepali waiter, Dubai)

> "No, no, no, I don't know, because they don't give us any report, any information even. They should provide, no? Every person, what they tested, what they got, so I know I am ok or not. Medically unfit – I don't know, this is the first time I am hearing this.They don't inform us, so how should I know? They are not giving us any information.They should make each person's medical file and hand over to that person." (Female Pakistani clerk, Dubai, an advocate by education)

> "Company only informed me that your blood will be tested. Company told me two days before that you have to pass your medical exam for getting your visa. The company or medical centre doesn't inform me that if you fail in medical test, what will happen to you. At the time of medical, the medical person or company didn't inform me what type of medical test it is. Just they told me to give blood." (Indian clerk, Dubai)

> "One becomes unfit because of blood. Doesn't happen anything for X-ray. In blood, if it is jaundice kind of disease or AIDS found then people will be sent back home. I have heard it from other people. Company doesn't inform us anything. Just this, you have become unfit, go back to your country. No, nothing is said during medical test either." (Bangladeshi male housekeeping staff, Dubai)

According to the testing centre staff, the cost of the medical test is around 500 Dirham, which includes the medical card. Those migrant workers who had to bear the expenses themselves also reported the test cost as between 440 to 500 Dirham, depending on the hospital or clinic. The larger companies seem to bear all the costs of the medical tests, including transport, any paperwork and the collection of the results.

> "Medical expenses paid by company. And medical centre is near to my company. Transportation is arranged by company. Some company (small) charge 525 dirham to their employee as a medical fees." (Indian clerk)

But construction workers or labourers employed in small companies, and migrant workers employed by individual sponsors who work in small establishments, have to bear either the whole medical test costs on their own, or at least the costs for the health card. Under Dubai law, all this should be paid for by the employer. As a strategy to cut short the costs, migrant workers may not renew the health card, which is of only one year duration, and so live without access to government hospitals for the remaining two years of their stay in Dubai.

Some pay for the medical test outright, or some have the cost deducted from their salaries later. Many such migrant workers expressed that due to their low earnings, the test cost is a heavy burden. Some construction workers expressed their frustration and even anguish not to be able to claim the test cost from employers. One Pakistani driver working in a construction company became very angry during the interview and insisted on a record to his complaint:

> "Write down please. Any problem? Big problem. Personal pay. Not company pay. 230 dirham I paid myself for test. Company should give it! That is Dubai rule, no? We can't make them pay. We are helpless."

His fellow colleagues nodded in agreement. One Indian Construction worker reflected the same, like many others participating in this study,

> "Health card charge I will pay 300 Dhs and company pay 200 Dhs for medical test. Company collect 20 & 25 labours.Take by bus onetime to testing centres. PRO goes with us.We type forms by people sitting in hall. PRO gives typing charge 15 Dhs. But later cut from our salary this and 300 Dhs for health card."

This study also found that the delivery of test results, in terms of time and recipient, varies.

> "As far as lab is concerned about test results, we do it same day but it is up to the M Post how long it takes to deliver. In case of emergency, we try to give it immediately.We give only Fitness Certificate. Not results. Because it is confidential.According to WHO, you can not give positive result, that is why we give only fitness certificate. Here we are only for testing.You are fit, fitness report is given, that is our only lab responsibility." (Senior laboratory technician in Al Maktoum Hospital)

In other words, it is not the actual test results that are given, but only the 'Fitness Certificate', and thus the migrant workers do not have access to their own health information. However, most seem unconcerned about this; the main interest remains to successfully obtain the report declaring them fit which will ensure they can stay and work in Dubai.

There is the system of sending the report by post, as a notice, hung at the entrance of the testing centre, clearly states: 'Medical Fitness Centre in Department of Health and Medical Services is pleased to provide Medical Fitness Certificate delivery service through EM post courier, delivery fees 10 Dhs'. Most reports are sent directly by post to the company or employer, as confirmed by the research participants.

> "The results go directly to the Hotel. You only know that you passed when the Hotel releases your medical card and you are told to go to the Labour [office]." (Filipina waiter)

> "We do not get the medical test result. Company collects the result. We only get the ID card." (Bangladeshi salesman)

However, the result could be collected by the migrant workers themselves, which seems to be the case for the less privileged groups of migrant workers, including the construction workers and the casual labourers. They often have to handle their affairs on their own and face problems because of it. As shared by an Indian construction worker,

> "I have the test every three years. I don't have the report. Company takes it. If I take report, that is problem. I have to go to the hospital, that day no duty. So no salary and taxi charge. So it is better that company take the report."

Or, as stated by another Indian driver working in a construction company,

> "Take report 2 days later. Report in Arabic, English both. After testing they give token. There is time and date in the token. I can go and get report and someone with token they give to that person.They give fit certificate."

Although there is a major belief found among the migrant workers in Dubai that anyone failing the test is deported instantly, in practice a positive test result will lead to a confirmatory test, and then to a third and final test, before the case for deportation is settled. The Senior Laboratory Technician in Al Maktoum Hospital explained the process in detail, which in fact involves some thorough investigation to confirm the positive test results:

> "Our Medical Fitness Centre in Al Maktoum Hospital is under Department of Health and Medical Services, Government of Dubai. We do the medical fitness test here for visa. If the first test is found positive then we do second time re-test here. After the second test, we inform the Epidemiology Department and they inform the Ministry of Health. From then, they handle it, they test again. The Epidemiology Department has a person, that person and company's PRO and migrant worker come.We take the second sample and test.Then positive, we refer the file and give to Epidemiology Department. They will do the formalities and they will inform the Ministry of Health. Ministry of Health test is done in Municipality Hospital.After that if positive, then deport.The second test is done separately.We take the person to main lab, not in this lab, not in front of all these general people.Yes, he is afraid, but we tell your sample taken was broken. So we are taking again. He will come with his PRO or in-charge and go back with him to work. That report we give within one or two days, immediately. We do Elisa Test.We can not do confirmatory test here. Confirmatory test is done in only one central place, in Al Wasl Hospital where they do Western Blot and there the final test is done."

A process of confirmation also exists for TB, as described by another testing centre staff:

> "So in case a problem happens in x-ray, then we need to send this for sputum test, which takes three days…."

This re-test process was also confirmed by an Indian chef, recounting the experiences of deportation of two of his own staff:

> "Yes, they do confirm.They do re-test to see if any mistake is made.They tested twice the Filipino girl (waiter) before sending her back home. There came another Russian girl (waiter) about three years ago. She worked for 15 days. She was also tested twice. Everybody said she failed test. So she was sent back also. She was very good in work. So I know that they test twice."

Again, this was reflected by an Indian driver who has lived and worked in Dubai for over a decade and has watched the fate of many of his fellow colleagues and friends:

> "Unfit people could be given two chances. If fails then go back to India.They call the company people, this person is unfit. It is his report. Send him back home. Finish. Company send the people home. Give salary if due and only ticket. Nothing extra or compensation is given."

Deportation

Though officials were reluctant to discuss some of the more sensitive issues, a high official in AL Maktoum Hospital admitted in a personal conversation that the testing of the migrant workers is to protect the health of Dubai citizens from infectious diseases, especially from HIV. He claimed it is effective, since all the detected HIV positive migrant workers are deported immediately.

This same view is also manifested in the perception of the majority of migrant workers participating in the research, that mandatory testing and thereby swift deportation of HIV positive migrant workers is

primarily to keep Dubai citizens free from AIDS. However, migrant workers are aware that this strategy is not concerned to prevent HIV infection among migrant workers themselves, since many new people get infected during their period in Dubai itself, as identified through mandatory testing and deportation. As observed and narrated in detail by migrant workers, the process of deportation followed by the authority is completely open, ruthless and inhumane. It is a total violation of the human rights of the deportee. Each time the subject of deportation was raised in an interview or focus group discussion, there were experiences shared of fellow colleagues, friends or relatives, a few of which is shared below.

> "This AIDS patients, doctors inform to the police and company. Police same time come and catch this patient and put in jail separate room. After company take action, his visa cancel and send back to his home country within two or three days. No treatment, given nothing. No compensation given. I know two persons sent back.They were very afraid. I felt very bad.This disease should not come to anybody. There is no medicine. But in Dubai people are getting AIDS. So I am worried." (Indian construction worker, Dubai)

> "In 1995 my friend Masood (not real name) from Pakistan did medical. Police call and said Masood take your medical report to police clinic. Police catch him after he went. He was taxi driver.They put in hospital jail. After one week they sent him back to Pakistan. No treatment, no medicine given. One day I go to see him in jail. There was one small window. I talked. I ask what happened Masood? He said I have AIDS. I was there for 2-3 minutes only. No more talk. It was jail in Kuwait hospital. It was one room with closed gate. There were 4-5 people inside watching TV. They had also AIDS." (Indian driver, Dubai)

> "Here in my company, one man was sent back home within 3 days. He was told, AIDS is found in his blood. From medical, report was sent to office, informed police also. Here rules are very strict.There is police inside the medical.There is lock-up.They told him he has to do second medical. He said, Ok, I will go. After going they kept him in the lock-up.They took his blood and said it will take some time to give report. During this time he has to stay in lock-up. They called and brought his wife. They also did her test. They also kept his wife in lock-up. Lock-up means an empty room just next there (test centre). There is a thick iron gate like jail. All those who are going out and coming in outside can see them staying inside. No, there is no chair or bed inside. They don't keep them there for many days. After that police took them directly to the airport.They brought ticket, passport and sent them back to their country in India. It is not for Indian or Bangladeshis, people from any country will have the same fate in such case." (Bangladeshi office boy, Dubai)

> "One of my relative was deported after 10 days. I went to see him at airport. I saw him. I was not allowed to talk with him. He was under handcuff with two policemen. In his passport he got lifetime banned stamp.That means he can't come again in country. He was not given any treatment or counselling by government. The company has paid his dues. But what he worked for, they didn't pay any compensation to him. Medical centre informed him that you have AIDS positive. For a few days he was upset. But when he reach in India, the relatives have given support to him.The relatives admitted him in govt. hospital. Now he is under govt. custody." (Indian clerk, Dubai)

As reflected, once the results are confirmed and the migrant worker is declared unfit, the Ministry of Health is notified, as well as the Immigration department, which is responsible for sending the person back home. Since the Dubai government does not require a pre-departure mandatory testing done in the home country, many migrant workers face the medical fitness test for the first time in Dubai, unaware and uninformed about the tests and deportation policy. This is seen to be a problem by the Indian Senior Laboratory Technician in the Testing Centre:

> "In other countries like Saudi Arabia, they are asking for migrant workers to test in home country and come as fit but in Dubai people are coming and then testing here for the first time. So it is problem."

Thus, deportation seems to have become a regular phenomenon in the migrant worker community in Dubai, but an action that has little apparent impact in stopping new infections and more deportations of migrant workers. Furthermore, persons with hepatitis, TB or who are pregnant can be deported, as shared by the migrant workers. A Bangladeshi female domestic worker stated that sometimes Khaddama (maid) is made pregnant by the landlord and then she will be deported back home.

> "From the medical centre they give report, this person is sick. Send her back to country. No, not police, the Malik (landlord) send her back. If child comes in someone's womb, they will send her back home there and then. No, they don't do abortion here.They just send back home."

Another Bangladeshi construction worker shared:

> "If someone has got jaundice, cancer and AIDS then they are unfit in medical. They will be sent back home within one week. We have heard in other companies people came and were sent back home. Company sends them back.They will not give salary or anything else, only will purchase the ticket and board him in the airplane. One person (Bangladeshi) from Mymensingh was unfit. He was found with jaundice. He was sent back home."

And again, the fate of a Filipina waiter was sealed as she was tested unfit for hepatitis and suddenly has to face the termination news.

> "A Filipina girl was deported. I felt very bad. But what can I do? Government rule. Company has nothing to do. She was told today is your last duty…..This is all your dues. Company doesn't cut money in such cases. She left 3 days later. She cried, cried a lot." (Indian chef in Dubai)

It was generally stated that deported migrant workers are given their return flight ticket by their employer or company together with their salary dues, if any, but no compensation is given to cope with the loss of the huge investments made by the migrant worker for employment in Dubai. Nor is any compensation given for up-coming treatment and care back home. There is no known insurance scheme offered by either the home or host country for such unfit persons, and the need for some sort of safety net for such situations is urgently felt by migrant workers.

> "Unfit people sent back to home but they are healthy and can work. New (coming to Dubai first time) people if unfit should give them ticket and some money.They spent lots money 1 lakh rupee to come to Dubai. If unfit lose all money." (Indian construction worker)

Impact of Medical Testing

Once an unfit migrant worker is sent back home, they can no longer return to Dubai, because this is put on their immigration records and a 'DEPORTED' stamp is put on their passport. To avoid this, people who come to know of treatable infections sometimes return home on their own for treatment, with the hope of getting cured and returning to Dubai again. The irony is, even though the prosperity of Dubai is dependent on the presence and contributions of migrant workers, when it comes to the health and well-being of these workers, it is deemed a personal responsibility, and their right to work is denied even where treatable infections are being attended to.

Similarly, some pregnant female migrant workers have to undertake the risky steps of abortion, which is illegal in Dubai. The owner of a private medical clinic who is sympathetic to Filipina migrant workers shared:

> "I have patients who come here to have a test voluntarily. When they turn up positive for TB, I advise them to go back home. They can be treated there and after their treatment, they can come back. If they are found out or if they get tested in a government hospital, they will be sent home with a permanent record. They can no longer come back." He further added, "There are many women here who have gotten pregnant and the big problem is they are undocumented. Then they resort to abortion because they won't be able to continue working here. Abortion is illegal here so they just buy this Cytotec. The side effect of the drug is bleeding so they use it to abort. And they also buy this from other Filipinos for 100 Dirham per tablet. I asked the priest at the church to discuss this in his sermon. But it still happens."

Some migrant workers, when asked for a re-test, sense the impending danger of deportation and run away from the workplace so that they can continue living and working in Dubai illegally. This is seen as a better option than facing the indignity and financial loss that deportation brings in.

> "One person in my company was asked for re-test. He leave company and go outside. He live outside by supply company. He is no permanent worker, he is casual worker. He is a carpenter and good worker. Casual worker get more salary. The permanent worker gets less salary. Company gives all allowance, visa, accommodation. Casual worker don't get this. This is why if labour get per day 70 Dhs and casual labour get 96 Dhs. That carpenter is earning good money and his health is good also." (Indian construction worker in Dubai)

> "Many of those who become unfit run away. But their food, stay, ticket everything has to be borne by themselves. He has to come by spending huge amount of money. If he return home, it is his loss. How will he survive after returning home? So they stay in Dubai illegally. He don't have 'potaka' (ID card), don't have medical card. He don't have anything. If he falls ill, he won't be able to go to medical. And if he is caught then he is a living dead. He will be put in jail and then sent back home." (Bangladeshi labourer)

As long as the aim of mandatory testing remains to screen and get rid of unfit migrant workers, those who might be vulnerable to such infections will continue to invent ways to evade the system rather than adopt preventive measures to remain safe. This situation is reflected in the sharing made by an Egyptian Hotel Front Desk Manager, who said,

> "In Dubai, the regular 2 months visit visa is 120 dirham and urgent is 220 dirham. Extend for 1 month is 500 dirham. After that you have to go out of the country and same flight you can come back, say with a stopover in Iraq. I will buy the visa for 120 and sell 15,000 as sponsor to a girl. If you don't have the residence visa, renew after every 3 months and no need to exit. No need to do medical test. These entertainment girls are staying in Dubai for years like this without any testing. They are not tested but the migrant workers are tested and thrown out of the country! If the locals get AIDS they get treatment but not the expatriates. This is discrimination, all should be given treatment."

Although the Dubai rule does not require a pre-departure medical fitness certificate from their home country, to avoid detection and deportation from Dubai many migrant workers resort to a pre-departure test to ensure the safety of their investment in employment in Dubai. This is a trend found especially among the migrant workers from various host countries who have come through the recruitment agencies. Many of them will have been asked by the agencies to have a medical test in their home country.

> "I have come to Dubai spending 2 lakhs taka (US 3000$ approx.). If I become unfit in medical after coming here then I will be sent back home. So, even though Dubai government doesn't ask for test in home, still it is necessary to do medical health check in home paying 10 thousand taka and come only after learning you are fit." (Bangladeshi housekeeping staff)

Passing a test done in their home country adds to the sense of security among the migrant workers, as noted by a Nepali cook in Dubai:

> "When I go to get medical test in Dubai, I have confidence, my medical report will be pass because before that I got medical pass report certificate from Nepal. People who went to work abroad should get medical pass report certificate from their country. People come without testing in visit visa.When they go for employment visa, they have to take Dubai medical test. If they are unfit they will be sent back home. So test before coming to Dubai is better."

Access to Treatment, Care and Support

The research findings show that there is no option for treatment in Dubai for those who fail the medical test, something which was shared over and over again by migrant workers regardless of occupation groups or nationalities.

> "In this country they are very much afraid of diseases. No, they don't give treatment, just send back home.The big diseases are TB, jaundice, cancer. So many people are sent back home if medical report comes bad!" (Bangladeshi female domestic worker in Dubai)

The lack of treatment and care for those declared unfit is a concern of many migrant workers, even those who have passed the test, but who fear the same discrimination would happen to them if by any chance they also were found unfit at some time in the future. A human solution is called for:

> "UAE govt. should support unfit person.The UAE govt. should provide medical treatment, compensation and moral support to (unfit) employee." (Indian clerk)

> "I am fit that is OK. If not I need result. If treatment given and allowed work in Dubai that is good." (7 Indian construction workers)

Neither could any form of a formal referral system be identified, not in Dubai nor in the home country. The large companies do seem to inform the concerned Embassy officials before a worker is deported, but there is no known experience shared by migrant workers during this study where an Embassy extended any support to a deported person. Indeed, it seems that the possibilities for an unfit migrant worker to seek assistance from her/his own Consulate or Embassy are very limited. The Consul-General, Philippine Consulate General expressed,

> "If they fail the medical [test], they are sent home directly.They don't go through us anymore, but we are informed. The sponsor calls us. What I know from our sources here is, their sponsors take them directly to the airport… Sadly, we are not aware that OFWs have been sent home because of HIV."

This situation seems to be echoed by the experience of migrant workers as well. Following an Indian construction worker,

> "If labours are facing any problems (deportation) our embassy should help them. But Indian, Bangladeshi and Pakistani all the embassy don't take care of their labourers."

In a problem ranking and solutions exercise, a group of 7 Indian migrant workers came up with this observation:

> "Embassy don't care about labours. Don't help labours. Embassy (should) take action to help labours with all problems and also health problems."

While asked on the provision of counselling and treatment in Dubai for confirmed HIV positive migrants prior to their deportation, an Indian Laboratory Technician answered,

> "For expatriates, they don't want to give any such thing (counselling/treatment).They just want to send them back, finish.The local people get treatment for HIV infection but not the migrant workers."

This is a clear discrimination of right to treatment and care faced by migrant workers, especially in a wealthy and developed country like Dubai where treatment and care facilities are readily available for the locals. Migrant workers are excluded. Although migrant workers with HIV or hepatitis are deported without any treatment, the ones diagnosed with tuberculosis are reportedly given some initial treatment before deportation. According to an Indian construction worker in Dubai:

> "If TB, they give treatment, some time one week and sometime fifteen days. After that no good send back home."

This fact was confirmed by testing centre staff:

> "TB, same as HIV, send to Epidemiology department. There is a Community/Preventive Medicine & Travel Clinic, next to this medical centre within Al Maktoum Hospital premises. TB patients are referred for treatment there."

However, the limited scope of treatment seems to reflect an agenda which is not purely for the benefit of the infected migrant worker. If this was the case, the worker would be given complete treatment in Dubai, or at least a reasonable supply of medication to take home along with proper referrals. On closer inspection, this initial treatment is designed more to temporarily contain the disease. Many migrants in this situation cannot be repatriated immediately, possibly waiting for confirmatory tests or the processing of the deportation. Any treatment therefore seems more to ensure the safety of the local population during this waiting period, rather than the health of the individual migrant worker who has the infection.

Along with treatment and care issues, the need for information and awareness seems to be growing among the migrant workers in Dubai. For example, in the face of growing experiences of deportation due to HIV infections and experiences of AIDS awareness actions in home countries, many have been prompted to ask for information and better awareness on testing as well as HIV and AIDS issues in Dubai for migrant workers.

> "In India also, all place advertise this AIDS is very dangerous virus. TV, newspapers, radio, bill board, special doctors, everybody tell about Aids. In Dubai there is no information on AIDS. Only in hospital there are some boards for AIDS. Dubai is full with sex workers. Labours can get AIDS. Like India, in Dubai also information on AIDS necessary for labours because they don't know about AIDS.They get Aids and back to home." (Indian construction worker, Dubai)

> "Aids spreading in Dubai. Information on Aids is necessary for all labours in Dubai." (Indian construction workers)

> "Here people should be informed about tests. If people knows what will make them unfit, then they will become aware, become cautious. In Dubai sex work is found everywhere, people are going all the time. Government is allowing it. But the way cigarette is made, and then in its body it is written smoking is harmful for health, similarly if people were informed, then even if they went to sex workers, they will be aware how to save them. AIDS won't spread. Now people are getting AIDS in Dubai and being sent back home. Something (awareness) should be done about it." (Bangladeshi male housekeeping staff, Dubai)

> "They (unfit HIV positive migrants) are sent back. There are so many other departments in ministry here, they have to think and do to aware people on these tests and the consequences so that people remain alert and stay safe from infections. Like India,AIDS awareness is necessary for migrant workers in Dubai." (Senior lab technician, Dubai)

The lack of information, counselling, treatment or even referral that currently characterises the testing process for migrant workers is a far cry from an ideal migrant-friendly testing imaginable especially in a developed and prosperous country like Dubai. Isolating the interests of the local population from that of the migrant workers, especially in the area of health, has not been a wise approach. It is only by protecting the health and wellbeing of migrant workers as an integral part of the Dubai society that the total wellbeing of the Dubai population is similarly protected. The health issues of different groups of people are closely interlinked, and the safety of one group cannot be ensured by denying the rights of other groups. Therefore it is time to look at what positive changes need to be made in the policies and practices in Dubai, to bring a shift from the current discriminatory testing practice to one that is rights-based and migrant-friendly. In this way, success for Dubai will be better guaranteed, since the health and wellbeing of the migrant workers will be enhanced, together with that of the entire Dubai population.

Hong Kong Special Administration Region of the People's Republic 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. Of the foreign domestic workers employed in Hong Kong, SAR of China in 2004, 54.8% were from the Philippines and 41.2% from Indonesia. The Hong Kong, SAR of China government does not have any restriction, quota or preference on the nationality of foreign migrant workers employed in Hong Kong, SAR of China; the fact that most foreign domestic workers come from the Philippines and Indonesia is largely the result of the way employment agencies work and the preference of the employers. There are also an indeterminate number of migrants working in Hong Kong, SAR of China without valid work permits.

Hong Kong, SAR of China is a capitalistic society where the decision to employ a foreign domestic worker is based on the cost-effectiveness of this option compared to hiring a local. Most employers of the foreign domestic workers in Hong Kong, SAR of China are ordinary people who have little consideration or awareness about the needs and rights of foreign domestic workers. This is influenced to some degree by the fact that these employers may have limited financial resources themselves, making it prohibitive to fulfil basic needs or rights of the foreign domestic workers who are under their employment.

This research focuses on the 'health testing' (i.e. screening tests for apparent healthy persons) experiences of documented foreign domestic workers from the Philippines and Indonesia, with some additional information provided from others involved in the issue. Data were collected through the following means: a review of Hong Kong, SAR of China SAR government publications, the use of questionnaire surveys and focus group discussions with foreign domestic workers. 108 Filipinos and 97 Indonesians were individually surveyed, and focus groups were conducted with 22 Indonesians and 12 Filipinos. Fifteen telephone interviews of employers of foreign domestic workers (ten employing Filipinos and five employing Indonesians) were conducted, as well as interviews with NGO workers and a visit to two employment agencies and health testing clinics.

Laws and Policies

In Hong Kong, SAR of China, entry visas for migrant workers will be granted only after an employment contract is signed by both parties and approved by the Immigration Department. These visas expire 14 days after the employment is terminated. Employment contracts for foreign domestic workers are for periods of no longer than 24 months, so foreign domestic workers need to have their employment contracts re-signed every 24 months to continue working, otherwise they become undocumented. Some packages offered

by the employment agencies in Hong Kong, SAR of China allow the employer to refuse the foreign domestic worker provided and request a new one within a certain period of time without additional service charges, if the employer can prove the worker's performance is unsatisfactory.

In Hong Kong, SAR of China, the government does not require anyone to provide a medical certificate or report for entry visa purposes. This means that there is no explicit policy requiring mandatory health testing for migrant workers before coming to Hong Kong, SAR of China, nor during their period of stay in Hong Kong, SAR of China[7], nor when applying for the renewal of employment contracts. However, the Standard Employment Contract for a Domestic Helper recruited from abroad states that

> "The Parties hereby declare that the Helper has been medically examined as to his/her fitness for employment as a domestic helper and his/her medical certificate has been produced for inspection by the Employer." [8]

So, foreign domestic helpers need to be medically examined before signing the work contract before they go to Hong Kong, SAR of China, meaning that mandatory medical testing is a requirement of foreign domestic workers as a stipulation of their contract, but is not mandated by the government.

Moreover, employers do not need to prove to the Immigration Department that s/he has inspected the medical certificate; once an employer signs the contract, s/he is considered to have inspected the medical certificate, regardless of whether s/he has actually done so. The contract does not specify the time or place where the medical examination needs to take place, further asserting that there is no policy requiring mandatory health testing for foreign domestic workers in Hong Kong, SAR of China. Employers are also not required to have the foreign domestic worker that they employ to be medically examined again when subsequent new employment contracts are signed.

On the other hand, while there is no policy requiring foreign domestic workers to be medically examined in Hong Kong, SAR of China, there are no government laws or policies that forbid employers or employment agents from requiring the migrant workers to have health testing in Hong Kong, SAR of China. Government guidelines do, however, require that employers pay these fees, rather than transferring the cost to the foreign domestic worker, should a health test be requested by either party. In this way, if a migrant worker is asked to have a health test in Hong Kong, SAR of China by the employment agency as part of the service package offered to the employer, the fee will be paid by the employment agency. If the health test is not included in the employment agency's service package, or the foreign domestic worker is not recruited through an employment agency, the employer may still ask the foreign domestic worker to have a health test in Hong Kong, SAR of China, and the fee must be paid by the employer. When a foreign domestic worker under contract in Hong Kong, SAR of China wants to seek a new employer through an employment agency in Hong Kong, SAR of China, the agency may require the worker to pay for health testing fees, but the worker can, in turn, request reimbursement from the new employer under the new contract.

In Hong Kong, SAR of China, public health care facilities only conduct laboratory tests for persons with signs and symptoms of disease or illness. As a result, all health testing has to be conducted either in clinics or in laboratories. There are no known clinics dedicated solely to testing of non-local residents, meaning, both local residents and foreign domestic workers use the same services.

Experiences and knowledge of foreign domestic workers and their employers

Although health testing before arrival is required by contract, between 1% and 4% of foreign domestic workers who came from Indonesia and Philippine respectively had not been tested in their home country before coming to Hong Kong, SAR of China. Whereas even though no mandatory health testing is required once in Hong Kong, SAR of China, our surveys found that 97% and 67% of foreign domestic workers coming from Indonesia and the Philippine respectively had actually gone through health testing in Hong Kong, SAR of China. This figure coincided with the 87% of employers that reported that their foreign domestic workers were re-tested upon arrival in Hong Kong, SAR of China. The tests conducted, as reported by the foreign domestic workers, are listed in the table below.

Most foreign domestic workers reported that the same items tested in their home countries were also tested in Hong Kong, SAR of China. What is interesting to note is that except for the chest X-ray, the percentage of items reportedly being tested by Indonesian and Filipino workers vary greatly. However, according to data gathered from testing clinics, employment agencies and employers, there is no difference between the conditions tested among workers of different nationalities, meaning that many workers are not aware of what tests are being conducted. Conditions tested vary from clinic to clinic depending on the prices charged, however, the majority of clinics test a basic set of conditions, including HIV, STIs, and pregnancy, and there is an x-ray. Responses by employers also showed that employers are not fully aware of what their employees are being tested for.

Table: Specified tests by country as reported by foreign domestic workers

Nationality of the workers	Place of testing	No. of workers	HIV Antibody Test	Pregnancy Test	Sexually Transmitted Infections	Chest X-ray	Others (e.g. urine and stool test, eye test, dental test and psychological test)
Indonesians	In home country	**97**	17%	94%	20%	87%	21%
	In Hong Kong, SAR of China	**95**	18%	94%	21%	87%	23%
Filipinos	In home country	**104**	49%	79%	38%	88%	10%
	In Hong Kong, SAR of China	**72**	40%	67%	29%	86%	19%

Table: Percentage of specified items being tested on foreign domestic workers as reported by their employers

HIV Antibody Test	Pregnancy Test	Sexually Transmitted Infections	X-ray, lung	Other
62%	62%	46%	54%	0%

It was found that among the foreign domestic workers re-tested in Hong Kong, SAR of China, the requirement for re- testing Filipinos mainly came from their employers (75%) while the requirement for Indonesians came mainly from recruitment agencies (78%). This figure might reflect a concern among employment agencies in Hong Kong, SAR of China that there is either a lack of trust or some doubt about the reliability of the test results done in Indonesia.

Meanwhile, about 77% of employers reported that the request for re-testing domestic workers came from the employers themselves, while 23% reported that the requirement came from the employment agencies. If a worker refuses to be tested for these conditions in Hong Kong, SAR of China, some employers may doubt the validity of the results of the medical testing in the home countries and the honesty of the workers. This is considered due cause for termination of employment within the first month, which can be done without extra charge to the employer. There was also a minor misconception among 1% of the workers who stated that the requirement for re-testing came from the Hong Kong, SAR of China government, which goes against the policy in place of not requiring health screening tests for anyone who is apparently healthy.

Moreover, it seemed that some foreign domestic workers could either not differentiate between the health screening for employment and the diagnostic tests given when a person does have signs or symptoms of sickness, or else they could not distinguish the health provider that was giving these tests, or they were confused as to the purpose of their visit to hospitals. In this regard, 10% of the workers reported that their health tests were conducted in a hospital. As a matter of fact, public hospitals in Hong Kong, SAR of China do not conduct health screening tests for foreign domestic helpers. The cost of conducting the test in private hospitals would be much higher than in private clinics or laboratories, and therefore, very few employers choose hospitals to conduct health testing for their foreign domestic workers. This was corroborated in responses by employers where none of the employers or employment agencies interviewed reported that the health tests were conducted in hospitals.

Table: Source of requirement of testing as reported by foreign domestic workers who were tested again in Hong Kong, SAR of China (could choose more than one source)

Nationality of the workers	No. of workers	Employer	Recruitment Agency	Hong Kong, SAR of China government	Self
Indonesians	95	25%	78%	1%	
Filipinos	72	75%	27%	1%	1%

While government policies state that all medical costs, including the cost of screening tests for foreign domestic workers, should be paid by the employers, about 17% of the workers interviewed reported that they paid the cost of the tests themselves. However, as mentioned above, this could also be explained by the fact that some workers may be confusing the health screening tests with a regular diagnostic test, so this figure might be inaccurate.

> "It's expensive. I paid for the medical check up in the Philippines. I was tested twice and paid all by myself." (Filipina, working in Hong Kong, SAR of China for five years)

Foreign domestic workers also seem to pay for medical costs themselves most of the time. This was because they did not want their current employers to know that they had been for medical consultations, as it might be seen that they were unfit, which might result in being fired. Some workers also paid for a health test when they began to look for another employer after their contracts expired, and thus might not claim the cost back when they got a new employer.

Most of the employers interviewed said that they did not require their employees to undergo another health screening test to renew their contracts. However, for those getting a new contract from a different employer, about half of those who had already been working in Hong Kong, SAR of China were required to be re- tested by their employer. One employment agency stated that the standard package for employing a new migrant worker includes a health testing, regardless of whether they had been working in Hong Kong, SAR of China or not. Another agency said that health testing is not mandatory for hiring a domestic worker, and that it is up to the employer to decide whether he/she wants the domestic worker to be tested.

About 95% of the testing was conducted on an individual basis, with less than 5% in groups, yet only 52% of Indonesian workers and 22% of Filipino workers surveyed reported that pre-test counselling was given when they underwent health testing in Hong Kong, SAR of China. More than 80% of the pre-testing counselling was given by the doctors, with nurses giving the counselling the rest of the time. About 27% of the Indonesian workers and 62% of the Filipino workers reported that the procedure of the testing was explained to them during the test. On the other hand, post-testing counselling was given to only 52% of the Indonesians and 16% of Filipino workers by doctors.

> "The procedure was very simple. There was no explanation. I would appreciate if more information about the medical test and the items involved are given." (Indonesian volunteer)

> "Several people were inside the room, including 3 medical staff and several local Chinese patients. They speak Cantonese.When it's my turn, the doctor asked me simple questions and took my blood. There was no explanation." (Migrant domestic helper who volunteered to take a health check up at a clinic)

Only 36% of the Indonesian workers and 53% of the Filipino workers received a copy of the test results. Most workers in the study mentioned that they were verbally informed that the results were 'okay'. While 75% of employers stated that the test results were sent directly to them from the clinics or laboratories doing the testing, the other 25% reported that the results were sent to the employment agency first and then passed on to the employer later.

> "The medical terms cannot be easily understood. I want to see the report of my health check up." (Indonesian domestic worker)

> "The check up service was poor in Hong Kong. No result was given to me. I have the right to know the result of my testing." (Filipino domestic worker)

As for the consequences of failing the test, while only about 33% of workers believed that they would be dismissed and sent back to the country of origin, most employers (61%) said that they would dismiss a domestic worker for a health condition. NGO workers also had the misconception that employers have the right to send unfit workers back to their home countries immediately, without any compensation.

> "My sister had to go home. She had worms in her stomach." (Filipino domestic worker)

The law, however, says otherwise. According to Hong Kong, SAR of China law, only a medical practitioner can declare a person as permanently unfit for work, with the requirement of such as a declaration being that the person's working ability is permanently impaired. If a medical practitioner considers a person as temporarily unfit for work, that person is granted sick leave and the employer cannot terminate that person's employment while s/he is on sick leave. Employers are also not allowed to terminate a female employee's contract because of pregnancy, and the woman is entitled to maternity protection. Yet, if the worker is not on sick leave or under other employment protection conditions, Hong Kong, SAR of China law does allow the employer to terminate employment immediately, as long as the employee is provided compensation of one month's salary and the inclusion of the fare for an air-ticket for foreign domestic workers. As a result, employers wait until right after the domestic worker has completed sick leave to terminate the worker's employment.

> "Some employers are bad. Send back to the Philippines, very stupid. Don't consider the employees. Employers should be considerate…Simple diseases, they must be considerate. Don't send back to the Philippines; help her to cure or see the doctor." (Filipino domestic worker)

Some workers, 45% of Indonesians and 33% of Filipinos, believed that they could get re-tested if a health condition was found. It was not asked who should pay for the cost of re-testing; however, it could be assumed that the majority of employers would not want to pay such a cost unless they really wanted to keep that specific domestic worker.

In Hong Kong, SAR of China, a number of non-government organisations (NGOs) help those workers who fail the health test. Assistance provided includes assisting foreign domestic workers with re-testing, and if a health condition is found, helping the worker to seek proper compensation from the employer. These NGOs also provide assistance with referral for treatment, as well as by assisting with provision of paralegal help, counselling, support groups and follow-up. Unfortunately, only about 20% of the migrant domestic helpers were aware of the existence of NGOs that provide these services.

When comparing the health testing service in Hong Kong, SAR of China with that in the workers' own countries, most of the workers considered it fair to satisfactory, with very few considering the service in Hong Kong, SAR of China as being poor (see the table below). Most of the clients of clinics where migrants get health testing were local people, meaning that there is no clinic specifically for migrants. The staff of the clinics handled both local people and foreign domestic workers in similar ways. There does not seem to be any obvious or structural discrimination, but very few special considerations of the cultural needs of foreign domestic workers were noted. For example, only one of the staff in one clinic was able to speak a little basic Indonesian, and although there are several Filipino doctors practicing in Hong Kong, SAR of China, most employers would have difficulty in identifying them and finding the address of their practice.

> "It will be helpful if some leaflets are in Indonesian language." (Indonesian domestic worker)

Then again, many of the migrant workers felt they were treated rudely by clinic staff due to bias and negative attitudes. This may have influenced the rating migrants gave health services in Hong Kong, SAR of China, as shown in the following table:

Table: How did you find the health testing service in Hong Kong, SAR of China compared with the one conducted in your own country?

Nationality of the workers	No. of workers	Very satisfactory	Satisfactory	Fair	Poor	Very poor
Indonesians	95	6%	34%	60%		
Filipinos	71	14%	38%	42%	6%	

"Some of them were nice, friendly but the doctor was rude.The doctor doesn't like me because I am a domestic helper, and have dark skin" (Indonesian domestic worker).

"The service is poor in Hong Kong. I was discriminated as a Filipino domestic helper. I was treated differently from the local by the medical staff. I was treated like a servant.The nurse was no good and her attitude was bad.The nurse was yelling at me." (Filipino participant)

Japan

Japan is a destination country for migrant workers. Since the late 1980s, its growing status as a major global and regional economic player has contributed to a marked increase in the number of foreign migrant workers coming to Japan. According to the Immigration Bureau of Japan, at the end of 2005, there were about 2 million migrants who had a foreigner registration. This number is about 1.6% of the total population of Japan[9] and is increasing.

Because of this, the issues of migrant workers are becoming more significant. This is exacerbated by demographic changes in Japan, which has been transformed by an aging population and a dwindling birth rate.

Thus the basic rights of migrants, including health rights, are assuming greater importance in terms of national interest and potential policy changes. The current immigration law of Japan (Immigration Control and Refugee Recognition Law (Cabinet Order No. 319 of 1951, Last Amendment: Law No.43 of 2006) includes the power to reject the landing of persons if under a certain health 'categories'. Categories mentioned refer to infectious diseases defined by the Law Concerning Prevention of Infection of Infectious Diseases and Patients with Infectious Diseases (Law No.114 of 1998, Last Amendment; Law No.106, 2006). As the preface to this Law mentions,

> "(it is a fact) that here there had been groundless discrimination and prejudice against patients of infectious diseases."

This referred to the older legislation in Japan, where there was a law that prohibited the entry of the people with HIV until 1999. This was defined by the Immigration Control and Refugee Recognition Law, which existed for ten years, from February 1989 to March 1999. It has subsequently been through positive revisions. The box below tells the story.

Japan: Change in Laws & Policies Regarding HIV Testing & Migration

The Immigration Control and Refugee Recognition Law (before the revision of 1999): An additional clause (a special case of refusal of the landing) 7: The person who is infected with a pathogen of acquired immunodeficiency syndrome, and who has a risk to infect the pathogen among many others is regarded as a patient defined by Article 5 Clause 1 (Immigration Control and Refugee Recognition Law) for a certain period. This additional clause was attached to the Law with the enforcement of the Law concerning the Prevention of Acquired Immuno Deficiency Syndrome (AIDS Prevention Law No. 2 of 1989) at December 1989.

There were several different comments and criticism about this AIDS Prevention Law. For example, some pointed out the problematic consequences of the fact that it emphasised the

control of HIV as an infectious disease at the expense of the protection of the rights of patients and consideration of their dignity.[10]

In September 1998, as part of a review to ensure such laws reflected contemporary experience, the AIDS Prevention Law was abolished together with the Infectious Disease Prevention Law and Sexual Disease Prevention Law. Instead, the Law concerning Prevention of Infection of Infectious Diseases and Patients with Infectious Diseases was approved in October 1998 and enforced in April 1999.

Following the repeal of the AIDS Prevention Law and the establishment of the new law, the clause that mentioned the rejection of entry of people with HIV, as mentioned above, was also deleted. The refusal of entry is not mentioned in the 'Immigration Control and Refugee Recognition Law'.

Testing and Employment of Migrants

In 1995, Japan's Ministry of Health, Labour and Welfare developed "Guidelines for AIDS in the work place," which outlines the considerations on HIV testing[11]. The guidelines state:

1) employers should not conduct HIV testing of workers as a criterion for selection of employees and they should not conduct HIV testing during employment;
2) employers should maintain the confidentiality of any information they may have regarding the HIV status of their employees;
3) employers should not discriminate against workers who are HIV positive if they are healthy.

In addition, a study meeting on "The Protection of Health Information of Workers" in 2004 included information on the HIV status of workers under a section dealing with important points relating to health information that need special consideration[12]. The meeting report states that,

> "The handling of information on the infection status of diseases with chronic status such as HIV/AIDS, hepatitis B, etc, and of genetic information such as the result of colour perception tests is an issue that needs to be discussed particularly carefully. Employers should not collect this information as a general rule, unless employers need to take specific considerations regarding the work or as a special professional requirement. Because information about HIV status can lead to social prejudice and discrimination against people with HIV, this information should be considered extremely confidential. Even if an HIV test is conducted with consent, it may be problematic as to whether voluntary consent was really gained or not.Thus, it is desirable not to conduct an HIV test, even though the person has agreed."

All of the above are just guidelines however, and have no legal enforcement. Still, these guidelines have contributed to the policy of not requiring mandatory testing for the employment of migrant workers. The five migrant workers interviewed in this study, three undocumented Burmese males working in a restaurant and two Thai females working in a massage parlour, verified that they had not been required

to have a medical test by their employers nor have they been required to take one since they were in Japan.

However, on closer inspection, there are cases to be found where HIV status is used to determine employment status for migrant workers. A lawyer, Shinichi Sugiyama, has brought to court cases of human rights violations of people living with HIV[13]. The court has had to rule on several cases, including where there has been the illegal firing of workers with HIV, where there has been the violation of privacy relating to HIV testing by the employer, and where there had been HIV testing without consent. According to Sugiyama's report, the number of human rights problems regarding HIV status is considerable, but only a few cases concerning rights violations of persons living with HIV have reached the courts in Japan. In an in-depth interview for this research, the lawyer shared this:

> "...The case of "Chiba" was the one where the company introduced HIV testing, targetting only foreign workers, without permission or consent, behind closed doors. Even the doctor... the hospital accepted the HIV tests in spite of the fact that they knew (the guidelines)…I have heard similar stories from elsewhere...such as the stories about a health check-up... Thus, I think, before we talk about mandatory testing, there are many cases of HIV testing without workers' knowledge." (Shinichi Sugiyama, lawyer)

Although it is difficult to generalise from just a couple of cases, there is a realisation that in spite of progressive policies and guidelines against mandatory testing, there are employers who still perform testing without notifying workers, including migrant workers. As pointed out by the lawyer,

> "the fact that this hospital accepted the testing from a company is a sign that it is highly possible that this case is only the tip of the iceberg…. It is very common for Japanese companies to carry out the health check-ups for all employees entering a company."

Voluntary Testing - Public Testing Centres with Services for Migrants

In Japan, there are facilities available that provide migrants the opportunity to test for HIV voluntarily, of their own will. There are 68 Voluntary Testing Centres listed on the "HIV Testing and Counselling Map" that have regular services for migrants or foreigners.[14] To suit the varying needs of clients, in addition to regular opening hours during the day on weekdays, there are 17 open at night and 14 open during the weekend. 55 of them charge no testing fee, while the others do charge.

These centres offer tests on chlamydia, syphilis and HIV, among other conditions. 13 centres deliver same-day results, while 48 centres give the results after 1-2 weeks, with the remaining 7 centres giving the results anywhere form the same day to within 1-2 weeks, depending on the kind of tests.

Some of the centres provide interpretation services for migrants, as shown by language in the following table:

Table: Languages that testing centres provide

Language	# of centres
English	52
Spanish	6
Portuguese	6
Thai	3
Tagalog	2
Italian, French, Khmer, Vietnamese, Mandarins, Cantonese	1 each
Others: multiple language (not mention specific language)/Need consultation/ can arrange the interpreters if the necessity is informed before the testing day	12

Most services are limited only to the English language, which is unlikely to be suitable for the majority of the various nationalities under the foreign registration in Japan. The largest populations are from Korea (598,687), China (519,561), Brazil (302,080), Philippines (187,261), Peru (57,728), and the United States (49,390). There are some 296,848 'others' [15]. In one of the centres visited during the study, the doctor listed some of the nationalities that have used services at the clinic:

> "As for the Asian foreigners, Korea Taiwan, Province of China, Chinese, Cambodian, Vietnamese, Pakistani, Thailand, India... I just say the nationalities that have come in...then, Philippines and Australia"

These testing centres do not serve migrants exclusively but provide the same services for Japanese. Thus, it is difficult for them to cater to the special needs migrant workers may have. The lack of attention paid to migrants' needs at testing centres is reflected in Japan's basic policies, including the Guidelines of Prevention of Acquired Immune Deficiency Syndrome (AIDS) Prevention Policy[16], which does not mention guidelines for testing migrants or foreigners at all.

There is also no clear policy regarding testing for migrants or foreigners outlined in the Guidelines on HIV Same-day Testing using Rapid Testing Kits in Public Health Centres in Japan[17]. This was the product of the study group on the Enhancement of Opportunities and Quality Fulfilment of HIV Testing and Counselling, and these guidelines were developed to reduce the gap between the AIDS Prevention Guidelines and the actual practice of local governments. Only in the document Cases Collection of the HIV Testing and Counselling, created by another study group, has the case of HIV same-day testing centres specifically for foreign residents been mentioned (in the Kanagawa prefectures[18]).

In relation to voluntary testing, language is a major issue. This study found that three strategies are currently being employed at testing centres to overcome language barriers with migrants. Firstly, there is utilisation of the attendant or any accompanying person as the ad-hoc interpreter; secondly, there is use of printed language materials; and thirdly, there is the use of professional interpreters or language-competent counsellors.

Each testing centre uses either one or more of these strategies, according to the policy or the situation of the testing centres. In the first case, where testing centres use the attendant or a person who accompanies the migrant worker to the testing centre as the interpreter, the latter could be a friend, colleague, family

member or even the employer. These ad-hoc interpreters are not trained as medical interpreters, and this raises issues of privacy and confidentiality as a concern, among other issues. For example, when employers come to the testing centres with workers as the attendant and act as interpreter, then they will also know the results, which could lead to the employee being fired.

> "Sometimes south-eastern Asian women visit this centre with Japanese men.There are many cases of a Japanese man and woman of South-eastern Asia coming here as a pair. Because there are Japanese men who want to know the result of the woman, the Japanese man often listens to the explanation together. It is difficult to confirm the consent of the women (in regards to this) due to her language. But we cannot confirm if the woman really wants the Japanese man to listen to the result or not. I have to believe only what she says. If I ask "Do you want him to attend?", and then she answer "Yes, I do", I cannot confirm like "are you sure?" Because we don't ask the occupation, we don't know the truth, but this testing centre is used for the health check-ups for person working in such place, and then the manager of such work takes the women to the testing. In practice, there are cases where the couples do not seem to be husband and wife." (Staff,Voluntary Testing Centre)

When testing centres cannot prepare other options for language support, they may choose to reject persons who want to take the test using an ad-hoc interpreter. Among the testing centre staff interviewed in this study, some shared that they provide the test with consent "in principle" while others stated that they reject any cases of ad-hoc interpreters, even if there seems to be consent on the part of the migrant being tested.

There are no clear guidelines available in policies or in testing centres on how to deal with such situations. The lawyer interviewed expressed the importance of gaining consent directly from the person being tested, not from the ad-hoc interpreter.

> "After all, it is an issue of consent. There is an argument that the testing centre should take consent directly and appropriately from the person being tested…the interpreter should be prepared by the hospital side, I think...the interpreter of the hospital takes consent and consultation like "Are you OK to take this test?","Yes, I am OK", it seems the first principle. It is a principle but I feel...so-called group medical examination (in a company) has not done to such level.When they are sued, the point is whether there was consent or not... Of course, even if it is illegal, they don't enter prison, but in the name of an illegal violation of privacy, the person tested receives compensation for damages."

The second strategy, having printed materials in the language of the migrant being tested, is used solely for explanation about the test. There are limitations on the use of such language materials though, as centres do not receive many minority groups of migrants, and on top of that, sometimes literacy is an issue. This is what the staff of testing centres shared:

> " Well...we prepared all documents needed for the testing in their language. So this is what we use. But the document can only inform about those issues that are written in the document. After all, in the case of HIV, what is most important is to proceed with the conversation to reflect the emotions of the person being tested, particularly if there is a good chance that person might be positive.Therefore …it is important to have the content reflect the condition of the person being tested, I think. In this way, it is most important that the person is provided pre-counselling or post-counselling verbally.Then, verbal plus document is acceptable." (Staff,Voluntary Testing Centre)

> "Information materials are printed in not only Japanese, but also Spanish, Portuguese and English... in the case that such foreigners come...we have prepared materials for those foreigners whose ratio coming here is highest among various migrants...we have prepared so that they can understand the test even if there is no interpreter." (Staff, other Voluntary Testing Centre)

The third strategy focuses on offering trained, professional medical interpreters. This, of course, is considered the best option for migrants. However, in the context of the small number of migrants attending these centres in comparison to the Japanese, they sometimes have difficulties providing these professional medical interpreters on demand because it is not cost-effective. For this reason, migrants have been rejected by same-day testing centres (which offer rapid test kits) or referred to other testing centres when faced with situations where they were unable to prepare a professional interpreter in time and would have had to rely on an ad-hoc interpreter or printed materials.

> "In this testing place, particularly for the test in the second week, we have interpreters and counselling for English, Portuguese, Spanish and Thai during testing hours ……. so we can provide services in their home language. Perhaps other testing centres don't provide such services. Basically, we don't have financial resources to provide such services for all languages. When they need another language, we refer to other testing centres that have that language." (Staff, Voluntary Testing Centre)

Experience shows that there is room for much improvement in the area of language support. It would be beneficial to have a clear policy, and, in order to develop migrant-friendly testing, it is also necessary to determine the appropriate and feasible language services needed in Japan. The difficulty is that utilisation of these services by migrant workers is generally low in terms of actual numbers.

> "In total, about 1500 people have used this test service so far. Regarding the number of foreigners - there is little." (NGO Staff working in Testing Centre)

And again,

> "As for the number, I don't know the correct number, but it is not so much."

The highest attendance is among English speakers, followed by Spanish. The reasons for low utilisation are varied, but include low awareness of health among migrants, and the tendency of some Asian migrant populations to prefer to listen to the advice of friends and relatives rather than seek out services. The most decisive factor is thought to be the lack of information available about the services though.

> "Even though there are communities of foreigners, the information of our testing centres is not put in the network of such communities. If foreigners who come to Japan have not learnt about health in their own language, then they will tend to have a low interest in public health. If so, they will not come to our testing centre as well as not have any interest in making use of the testing. Also, although the local government provides advertisements in the English newspaper, this might be pointless because the bigger communities are of the people from China, Malaysia or Thailand. So they have to provide the information for such peoples but the information is only in English, I don't know why. The persons in the English zone originally have high educational background. So, the foreigners using English tend to come to this centre. But actually, this testing centre has to also be used by the people who come from the high epidemic areas. But because the health information of this testing centre is not spread among such peoples, the number is low." (Staff, Voluntary Testing Centre)

> "People know to come here through the test map in the Internet (provided by the Japanese Foundation for AIDS Prevention) or the advertisements published by the government. But, because the governments have not provided information targetting migrants, the public information doesn't reach out to migrants, except those who can read Japanese." (Staff, Voluntary Testing Centre)

> "But, after all, unless the information is spread by word among migrant communities in Japan and we can get them to trust that this testing place is safe, they will not come. Therefore, we also make efforts to spread the information about this testing centre through support organisations." (Staff, Voluntary Testing Centre)

The lack of knowledge and information about public health centres was reflected in the interviews with migrant workers in this study. Albeit it is a small number, none of the five had heard of the voluntary testing centres.

> "Public health centre? I do not know it." (Burmese male migrant worker)

> "What is it? I do not know it." (Thai female migrant worker)

However, once informed about them through the process of this study, the interviewed migrants expressed their interest to use the free services of testing centres. As the undocumented Burmese male migrant worker expressed:

> "Surely, because they don't know, and language problems. If provided, they surely would want to go. Normally they can not speak well, mostly just know (enough Japanese) for convenience of their workplace."

He also stressed the conditions necessary to enable health providers or the government to provide a health check up appropriately for Burmese migrants in Japan.

> "Interpreter for them and spread the information about the check-up, and no fear that they will be forced to go home. But nowadays situation, even police can make them to go back."

Although not representative of all migrants, the current situation shows that conditions are not conducive to promoting voluntary testing among migrants, with significant barriers of awareness raising and language to be overcome.

Considering migrants' situation, the prevalence of newly infected HIV cases appears to be disproportionately high. According to official statistics regarding the number of newly reported cases of HIV among foreigners, there are 91 cases of HIV (10% of the total reported cases in Japan including Japanese and foreigners) and 65 cases of AIDS (17.7% of the total reported cases including Japanese and foreigners). As the population of foreigners is only 1.6% of the total population including Japanese and foreigners, so these percentages, emphatically for AIDS cases (17.7% compared to 1.6%), seem disproportionately high[19]. The AIDS figure might imply that migrants seek out and access medical facilities only once they have already developed AIDS symptoms, which is in contrast to the Japanese population, who can easily access testing and treatment.

Closing the Gap towards Migrant-friendly Testing

On a positive note, mandatory testing in Japan is officially non-existent as part of the immigration law. HIV status is not regarded as a condition of entry. Additionally, the policy of the Health Ministry mandates against the use of HIV status as a determinant of employment. However, in practice, it is evident that there have been cases of migrant workers being tested without notification and/or informed consent. We do not have sufficient information to objectively judge whether the mandatory testing being done covertly (i.e. testing without notification, determining employment by HIV status, sacking employees because of HIV status, and so on) is the tip of the iceberg, pointing to a grave situation for migrants generally, or if the cases that were found are exceptional. However, we can say that there is a grey zone that allows

testing under less than ideal and even problematic conditions to occur, as demonstrated in voluntary testing centres where employers can attend and know the test results and thus the HIV status of their workers.

So, even though there is no formal mandatory HIV testing for migrants, Japan still needs to take further steps in developing a migrant-friendly testing system, and making voluntary testing truly voluntary.

Republic of Korea

In the era of globalisation, more people are moving across international borders to pursue decent jobs and wages. South Korea (hereafter Korea) is no exception to this global trend, and with its economic success it has attracted migrants as a destination country. In this report, the research focuses on Korea as a destination country even though its workers go abroad to find work as well.

Currently, about half a million migrants work in Korea, both legally and illegally. Those entering the country through legal channels are processed through the Industrial Trainee System (ITS), which was instituted in 1993. As the volume and nature of international migration has continued to expand, the country has become increasingly concerned about the possibility of communicable diseases accompanying these migrants, including HIV. In August 2004, HIV testing was introduced along with the new Employment Permitting System (EPS) for migrant workers; and in December 2006, this policy culminated with the merging of the Industrial Trainee System under the EPS.

> "Isn't it a very natural thing for us as a government agent to examine the health condition of foreigners who enter our country to protect the health of our people? I mean to prevent our citizens from being infected with communicable diseases including HIV? In addition, since we are a public institution that connects the workforce with business owners, that is, a government body, we have the responsibility to introduce healthy people who have no physical problems that would cause problems for them in doing their work. These are the main reasons for implementing a health examination, which includes an HIV test, for foreign workers." (Officer of the Employment Permitting Services)

In light of this alarmist position, which disregards best practices regarding HIV, it is generally known that the Korean government has adopted a strict policy and implemented restrictive regulations against migrant workers with HIV to prevent them from entering or staying in Korea.

As part of the enforcement of this policy, a mandatory HIV examination is required of migrant workers as a pre-condition to departure, immediately upon entry, and periodically during their stay in Korea. These restrictions on migrants' entry and residency based on HIV status or infection with other diseases are intended to prevent the spread of disease; in fact, these policies may have the exact opposite result. Migrants infected with a disease that is considered grounds for deportation who wish to remain and continue working will try to avoid the authorities and become undocumented, making it more difficult for the migrant to access health services, and possibly resulting in related health conditions remaining untreated and potentially spreading such as Tuberculosis. These policies may also discourage migrants from accessing HIV prevention information, counselling, testing and support, increasing their vulnerability to HIV infection.

Considering the potentially deleterious outcomes of the current policy, there is an emergent need to examine the present policies on HIV and health testing for migrant workers in Korea, and to urge the Korean government to reconsider its current stance regarding these policies, laws and regulations.

HIV and labour migration

Migrant workers began to enter Korea in the late 1980s when there was a serious labour shortage, especially in the manufacturing sector. The first groups to arrive were Chinese, who share a similar culture and who can speak the Korean language. They were followed by Filipinos, Pakistanis, Bangladeshis and Nepalese workers. The number of migrant workers increased from a few hundred to 70,000 in just 4 years between 1988 and 1992. Two Government policies then spurred the influx of foreign workers to Korea: the legalisation of employment of foreign workers using the Industrial Trainee System (ITS) in 1991, and the Korea Federation of Small and Medium Business (KFSB) in 1994. Since then, the number of migrant workers has continued to increase and reached 468,326 as of December 2005. The nationalities of migrant workers coming to Korea has continued to diversify and now includes over 50 countries such as Indonesia, Vietnam, Thailand, Bangladesh and Mongolia.

Migrant workers in Korea have three characteristics that make them vulnerable to HIV. First, there is a large population of undocumented workers: migrants who either were smuggled into the country, entered on a visitor or tourist visa but work for money, or have left their designated workplace or overstayed their designated work period. A second characteristic is that there is an unbalanced sex ratio among migrant workers in Korea, with far more males than females. This often results in these men seeking out commercial sex. Thirdly, the majority of migrant workers are in the sexually active age range starting at twenty years of age up to people in their thirties: this group accounts for 70% of the total migrant worker population.

In Korea, HIV is legally classified as an epidemic disease. The Communicable Disease Prevention Act designates HIV infection as a Class 3 contagious disease. Furthermore, the HIV/AIDS Prevention Act, established in 1987, also stipulates various activities and requirements regarding HIV, such as testing and reporting for the disease, as well as care and management of people found to be positive for HIV.

The designation of HIV as an epidemic disease has resulted in migrant workers with HIV being disallowed from entering Korea regardless of their sojourn status. Basically, the Korean government does not require all foreigners to submit their HIV status before entering, just those under the ITS, meaning labourers. For industrial trainees and employment-permitted foreign workers, the Korean government, under related employment and immigration agencies, requires pre-departure HIV testing, and denies entry to those who are found to be HIV positive. This is practised even though there are no laws or regulations stipulating this requirement for HIV testing; in other words it is an immigration policy, not a health related policy. Basically, migrant workers who do not submit a certificate showing they are HIV negative cannot get a visa. Upon entry to the country, migrant workers are then required to take another HIV test while they receive post-arrival orientation. Upon passing that test and becoming employed, migrant workers are then required to take an HIV test every year they stay in Korea.

Testing procedure

Upon arriving in Korea, migrant workers enter an orientation center managed by a government recruiting agency, the Human Resources Development Services of Korea, where they undergo various medical checkups including an HIV test. Usually, the tests are implemented in large groups, ranging from 50

upwards to as many as 500 people in a big hall. Although medical professionals administer the entire process of tests, they process them quickly in order to take care of as many people as possible in one day. Before the test, migrant workers are asked to sign a medical document that is written in Korean. Migrants, in general, do not understand the contents of the document and sometimes there is no interpreter present to explain it. According to one group of migrants,

> "They gave us a paper but everything was written in Korean so we didn't know what it was about. They just make us sign it….. No one explained about the test.They just said that they are busy."

Testing is done under time pressure, especially when larger groups are involved, one major reason why so very little information is provided.

During the test, migrant workers are not aware of what they are being tested for, particularly with respect to HIV. They only know that they are having a blood test, as blood samples are drawn. Hence, HIV tests among migrants are often conducted without the informed consent of the migrant worker.

> "We do not tell them in advance what items are included for their health examination and do not ask for a written consent either. Because a health examination, including an HIV test, is required by every workplace of their employees before starting work, and the items in the health examination are general and basic things, both foreign workers and we do not care much about it. Foreign workers and we just regard the health examination as a form to be filled out. Especially for foreign workers who come to Korea to earn money, a health examination is nothing important and moreover, they are not even interested at all in the topic of HIV/AIDS because they think they are not at risk or it has nothing to do with them." (Health official in Korea)

As there is no consent and there are large numbers of people testing at one time, there is also no pre-test or post-test counselling provided. This may mean that migrants are also unaware that they are being tested for HIV: one Mongolian worker stated he did not know the HIV test was included, and other migrants in the focus groups were equally surprised.

The fact that no counselling or information is provided seems partly due to the attitude of the health staff giving the testing, the time pressure to finish the test as quickly as possible and language barriers. Comments from migrants in Korea attest to this:

> "No.There was no one who could offer us counselling. Someone just told us,'Okay, now it's time for blood-sampling. Come here.Take this test now.' Then we just followed him/her."

> "They did (explain the test), but in Korean."

There does not seem to be a policy requiring counselling to accompany testing, and attempts by health officials are constrained. As one health officer said,

> "For foreigners, they usually come as a big group so we are not offering any specific pre-test or post-test counselling. But when they have some questions I do answer before or after the test.That's about it."

Those who pass the health test upon arrival continue in the training or orientation camp, and then are simply instructed to proceed to their contracted workplace without ever seeing their test results. If a migrant worker has an HIV positive test result while in the arrival camp, the individual is given the benefit

of a confirmatory test. However, the person is kept in the orientation center without being told why, until the diagnosis is confirmed by the Korea Center for Disease Control and Prevention (KCDC). If the second test shows a positive result, the employer is notified and the Immigration Bureau of the Ministry of Justice (MOJ) and a local health center are responsible to take that person to a detention center. Here they are kept until they are returned to their home country, which usually takes about a week. Most confirmatory tests are found to be negative, but for the couple of cases a year that are deported upon arrival, it must be quite traumatic. Unfortunately, not only is this practice done for HIV, but also for diseases that can be treated, like tuberculosis, syphilis and hepatitis.

Migrant workers are not aware of the regulations pertaining to testing, nor are they informed by any of the involved parties about them, especially the fact that they will be deported rather than provided treatment or support if they test positive for certain diseases, including HIV. A migrant from Mongolia had been informed in his country prior to departure, and workers from the Philippines also seemed aware of the requirement of testing on arrival, but they simply mentioned being physically fit. Most did not know that HIV was tested. As one worker said

> "Yes, we knew it already from the Philippines. Our Embassy there oriented us.They told us the things that we are going to do there. You'll have 3 days of training and after 3 days, you will have a general check-up from the Korean government. If you pass it, then you are going to finally work. But, if not, then you are going back to the Philippines because you are not physically fit."

And another verified this,

> "At the HR Center and at the company, we don't know if AIDS test is included in the test. But, in the Philippines, we did our AIDS test."

Once in Korea, there is no information provided on this policy though.

Migrant workers must also undergo an annual health test in order to maintain their employment and receive permission to remain in the country. Those employed in big companies usually undergo a medical check-up, which includes the HIV test, at their workplace. These check-ups are conducted by medical personnel who are contracted by the companies from a local hospital. According to a Filipino factory worker:

> "Seven months after (we arrived), our company conducted a general check up again. Our own company conducted the check-up to get the blood sample, the same way."

On the other hand, the employees of smaller companies are asked to go to the local hospitals for the medical check-ups. These tests seem to be paid for by the employers and transportation is provided if necessary.

The testing procedures for annual testing are almost the same as for the pre-employment tests, except that in these tests, the number of people tested in a given time is much smaller. In general, migrant workers taking the annual tests had no complaints about the cleanliness of testing facilities. There did not appear to be any cultural conflicts or gender-inappropriateness of test takers during testing either. There were language barriers, but some simple English was used to overcome this. Supposedly, there were interpreters available for Mongolians, but they were not really there to answer questions but more

to expedite the testing. In other words, no pre-test or post-test counselling was provided in these tests either, and migrants were probably unaware of the inclusion of HIV other than the fact that blood samples were drawn.

When migrants get the results of these annual health tests, they are written in Korean, providing very little benefit to migrants other than knowing that they can continue to work. As one Filipino worker told us:

> "Actually, it was in Korean.We just make a guess.This is my weight, blood pressure, etc."

Results also go to the employer and the Immigration Department, so there is a lack of confidentiality. It is unclear whether there is time for a migrant who receives notice of a health condition to elude authorities or if the authorities will come to arrest that person preceding the delivery of a positive test result. It is clear that migrant workers who have a test result indicating a disease of concern will be deported.

Although documented workers are eligible to receive benefits from the national insurance system for certain conditions just like Korean workers, those infected with HIV are excluded from this insurance. If they are known to be infected with HIV, they are subjected to immediate deportation regardless of their sojourn status or work visa. HIV is not the only condition that results in deportation though. As with the test upon entry, there is a list of diseases that result in deportation. One migrant had this to relate:

> "I know a story that one guy went back to Mongolia because he was unfit [to work due to his] test result but it was not because he was HIV positive, but because of hepatitis."

Even though these migrant workers may have become infected with these diseases in Korea, including HIV, treatment is not provided and they lose their job. They are simply deported, and are no longer considered the government's concern. A Mongolian factory worker and a Filipino worker both mentioned that a migrant can receive a refund of their registration fee (US$500) from the Ministry of Labour in their own country if they receive an unfit result, but expenses for transportation and testing in their home country are forfeited. When some Thai migrant workers in one focus group discussion found out about this policy of deportation for being HIV positive, they expressed indignation and stated that people should be allowed to stay and work. Here is what they said:

> "They were okay when they were in Thailand. That means they were infected with HIV in Korea, so the Korean government should offer them a job, care and support."

> "There's nothing they can do but die if they go back to Thailand. They already spent a lot of money to come to Korea so they don't have much money. It is also very hard to tell the fact that they are infected with HIV. Services like counselling, medical education and health care need to be offered to them."

Undocumented workers are able to avoid mandatory HIV testing as it is linked to the work permit and visa system. However, in this scenario, undocumented migrants are also usually the most vulnerable to HIV, especially those working in the sex industry, because being undocumented usually limits access to HIV prevention information and services, including testing. However, these migrants do have access to voluntary and anonymous HIV testing through Korea's HIV/AIDS Prevention and Support Center for Foreigners (KHAP), which is an NGO. The organisation also provides treatment and repatriation assistance for migrant workers who test positive for HIV. There are religious organisations that reportedly assist

undocumented migrants with access to health testing and services as well, but the scope or reach of these organisations is unclear from this research.

Conclusion and Recommendations

> "There is no specific legal base. There are, however, few people who would doubt the very general purpose of HIV testing to prevent the spread of communicable diseases, a motive that I think everybody can agree with.There have been few complaints about the test from both the people who conduct the test and from the people who have the test. And, we do not discriminate against foreign workers because we implement the HIV test for Korean workers too in the same way that we do for foreign workers. I think you are conducting this research to examine human rights violations or discrimination. But I would like to say that there are very few business owners who can hire people if they are required to observe every standard that international organisations and NGOs suggest regarding epidemic disease, physical condition, gender, educational level, race, etc. There are many important things to consider in the workplace aside from human rights. Anyway, I admit that there are still things to be done legally in the implementation of EPS (Employment Permitting Services). Currently, a task force team created by the Ministry of Labour (MOL) is preparing complementary regulations to cope with the problems." (Korean Human Resources officer)

In this research, when migrants were asked what they wanted or felt was necessary to provide them the benefits of testing, they had a couple of clear ideas. Language was a major consideration in both providing information regarding the test and in receiving the results. In fact, they requested the presence of an interpreter and brochures and documents in the workers' native languages at testing sites. As part of this, they felt that migrants should also be informed that they were being tested for HIV and of the ramifications of this. Since it was their health that was concerned, they also felt that they should receive the results directly. But most of all, they felt that migrants had already sacrificed too much to just be deported if their health test showed that they were infected with a disease, especially HIV. One Thai worker summed it up best,

> "Deporting an HIV positive person is too much! I think the Korean government needs to support them.They came to Korea spending a lot of money and they can still work!"

His colleagues enthusiastically echoed his sentiment in unison,

> "That's right!"

Malaysia

Malaysia continues to rely heavily on foreign labour, particularly for 3-D jobs, which are those jobs considered dirty, dangerous and demanding and which tend to be shunned by Malaysians. At present there are more than 1.8 million documented migrant workers in the country, including 310,661 domestic workers, 266,809 in construction, 645,524 in manufacturing, 166,829 in services and 123,373 in agriculture[20]. It is estimated that an equal or greater number of undocumented workers are present without any valid documents in the country.

The migrant workers come to Malaysia from more than 12 origin countries, including Indonesia, Nepal, Vietnam, Pakistan, India, Bangladesh, Philippines, Cambodia, Myanmar, Laos, Thailand and Sri Lanka. Despite the fact that migrants form nearly 12% of the entire population of the country, there is an absence of policies to protect the health of migrant workers. The health policies in place seem to be rationalised as a form of protection of the locals from communicable diseases and at the same time have become a tool to control migrants. The government sees this strategy as politically correct.

One such policy is the policy of mandatory testing for migrant workers. This was formulated to ensure that the country is free from identified communicable diseases and that the national public health facilities are not overburdened by unhealthy foreign workers with conditions requiring prolonged and extensive treatment.[21] The policy of mandatory medical testing was crafted specifically for foreign workers based on the Immigration Act 1959, section 8(3), which defines which persons are members of the 'prohibited classes' and includes

> "(b) any person suffering form mental disorder or being a mental defective, or suffering from contagious or infectious disease."

This means that any foreign worker with a communicable or infectious disease is denied entry into Malaysia. The policy however does not apply to tourists and expatriates; thus it is discriminatory and biased. It makes the assumption that the poor and the unskilled are the transmitters of disease and thus need to be controlled.

Deportation of migrant workers for health reasons can be traced back to as early as 1993. A directive issued by the Ministry of Health at that time required all medical officers to immediately notify the Immigration Department when they came across migrant workers with infectious diseases such as HIV, STDs, TB, leprosy or malaria. The follow-up actions included deportation of the workers, which was to be handled by the Immigration Department[22].

The policy of mandatory medical testing requires foreign workers to go through full medical testing, including for HIV, to prove his or her fitness in order to be issued a work permit to work in the country. The medical examinations of migrant workers are done based on the format set by the Ministry of Health, which requires the migrants to be tested not only for infectious diseases but also for non communicable diseases such as diabetes mellitus, hypertension, peptic ulcer, kidney diseases and heart diseases among

others. Female migrant workers are also tested for pregnancy, which is not even a disease. The diseases tested are, in most cases, treatable or manageable, and the worker would be able continue to work and be productive after treatment. However, migrants are denied this right: their work permit is cancelled and they are deported.

The policy clearly contradicts the Code of Practice on Prevention and Management of HIV/AIDS at the Workplace[23] which states that HIV positive workers have the right to continue working as long as they are able to work and as long as they do not pose any danger to themselves, their co-workers and other individuals in the workplace. The Code further stipulates that employers should not pratice screening or HIV-antibody testing as a precondition to employment, promotion or other employee benefits. However, the Code of Practice is not a binding legislation, as illustrated by the continued deportation of migrant workers found to be HIV positive.

Malaysia also has in place a National Strategic Plan on HIV and AIDS (NSP 2006-2010), which has identified migrant workers as one of the key population groups who are at high risk of HIV infection. The National Strategic Plan further identified "drafting and amendment of laws and policies that discriminate against specific populations" as one of the actions aimed at reducing HIV vulnerability. However, the government continues to enforce the Policy of Mandatory Testing which discriminates against migrant workers.

The government's policy on medical testing for migrant workers has not been consistent. Prior to the formation of the Foreign Workers Medical Examination Agency (FOMEMA) in 1997, the medical examination could be carried out by any registered clinic in Malaysia. At that point in time, the results were not channeled to the Ministry of Health and therefore the Ministry had no data on the health of migrants. Purportedly, this was one of the reasons for the establishment of FOMEMA. Since then, migrant workers have had to undergo an annual medical examination once they are in Malaysia, at clinics approved by FOMEMA.

Random testing was also conducted on 10% of foreign workers at selected entry points. Additionally, migrants were required to go through mandatory medical examinations at health centers approved by the Malaysian Ministry of Health, in source countries prior to departure. On 1st August 2005, there was a change in the policy requiring all migrants to undergo a mandatory medical examination within a month of their arrival in the country[24]. In April 2006, less than a year later, there was another new ruling which stated that all foreign workers had to undergo mandatory medical testing three times within the first two years of their arrival in the country[25]. Following this, on 9th May 2006, a circular was issued by the Immigration Department stating that foreign workers with a clean medical record for 3 consecutive years would be deemed free from contagious diseases. It was therefore not necessary to submit a medical report for a renewal of a worker's work permit after the third year[26]. In addition, migrant workers no longer need to go through mandatory medical testing in their source country before leaving for Malaysia. However, it was learnt that some source countries such as Indonesia still make it compulsory for its workers to go through a medical examination before going abroad.

It is indeed ironic that fingers are pointed at migrant workers for bringing infectious diseases into the country when Malaysia also receives millions of tourists every year and is also home to a large group of expatriates. The policy of mandatory testing for migrant workers also fails to recognise that migrants are at risk of contracting infectious diseases from Malaysians. But sadly the fact that Malaysians can be transmitters of diseases is never acknowledged.

In other words, the policy of mandatory medical testing on migrant workers is a discriminatory practice that leads to the violation of the rights of migrant workers. Even if the government is able to achieve its objective in weeding out the documented migrants who are deemed unfit, there are still nearly 2 million migrant workers who remained undocumented in the country. This group of migrants is hidden, inaccessible and do not come forward for testing due to fear of arrest and deportation. Moreover, this policy may even push migrants who are infected with diseases of concern further underground, making them unreachable by health services, and increasing any possible health threat they may constitute. Thus, the approach of using medical testing as a preventive measure is highly questionable.

Foreign Workers Medical Examination And Monitoring Agency (FOMEMA)

The lead agency in the monitoring and supervising the medical examination of foreign workers is the Foreign Workers Medical Examination and Monitoring Agency (FOMEMA). This agency acts as the central data base that stores all the information gained from the medical examination of migrant workers. This information is transmitted electronically to FOMEMA by all medical clinics, x-ray facility providers and radiologists approved by the agency to carry out medical examinations on foreign workers. FOMEMA then channels this information online to the Immigration Department and the Ministry of Health.

At present, FOMEMA has more than 16 branch offices throughout the country as well as an X-Ray quality control center. The registration of foreign workers for medical testing has to be done at these branch offices. It is estimated that there were 3,370 doctors, 307 labs and 772 X-ray clinics registered with FOMEMA as of August 2006.[27]

A Standard Operating Procedure (SOP) is used by FOMEMA to supervise and monitor medical clinics on its panel; failure to follow the SOP results in the clinic being temporarily suspended from this panel[28]. The private medical clinics on the FOMEMA panel are also governed by the Private Healthcare Facilities and Services Act 1998 and Regulations 2006 which was passed in 1998 and gazetted in April 2006[29]. According to media reports, under the Act, the private healthcare establishments have to satisfy the Ministry of Health in relation to their staff recruitment plans, training programmes, facilities, standards and quality[30]. The Act also provides a grievance mechanism for the public whereby they can complain to the private clinics and hospital authorities if they are unhappy or dissatisfied with the services rendered to them. These complaints must be investigated and the patients must be given an answer within 14 days of the date of filing of the complaints; severe penalties will be imposed on clinics which fail to do so[31].

But there is an absence of efforts to educate the migrants on the existence of such mechanisms. There does not seem to be any effort made by the Malaysian government or the governments of sending countries to educate or provide information to migrant workers on such matters. Many of the migrants contacted as part of this research were aware that they are required to undergo medical testing and will be deported if they are found unfit. But, sadly, none of them were aware of their rights pertaining to the mandatory medical examination.

Medical Testing Procedures

A typical medical examination as narrated by a doctor on FOMEMA panel is as follows:

> "The doctor verifies the passport details to the worker in the clinic. A Blood Test Consent Form (which is made available in the migrant languages) in the 4-ply Foreign Worker Information Form is detached, given to the worker to sign and blood is taken after consent is given. Urine is next collected. The migrant then goes to the pre-assigned x-ray laboratory for an x-ray checkup. The radiologist enters the result into the FOMEMA online database. The doctor then enters the results of the physical examination into the database. Employers then check the result of their foreign workers within 10 working days through the FOMEMA website or at the HQ or branch offices. With the medical report, the employer can proceed to the Immigration Department to renew the workers' work permit."

A review of the Consent Form shows that it does not contain any information to help the migrants make a decision in giving his or her consent. An extract from the Consent Form reads:

> "I…hereby irrevocably consent and authorise Dr…to i. carry out a medical examination on me including the testing of blood and urine and the taking of chest-x-ray as required by the FOMEMA screening programme and ii. Disclose my health reports/records and any other health information to FOMEMA Sdn. Bhd., the Ministry of Health, the Immigration Department and any other relevant authorities, as and when it is required to do so."

Migrant workers in general have little or no information on the tests they have to undergo. Migrants interviewed acknowledged that they were required to sign a document prior to being examined. However, not many were aware that the form they signed was a "Consent Form", as shared by a Bangladeshi migrant worker:

> "Yes, took sign. All in English. I did not understand. After signing doctor asked me take my urine."

Signing the consent form would also mean that the migrant workers are giving away their right to confidentiality as reflected by the 2nd point in the consent form:

> "ii. Disclose my health reports/records and any other health information to FOMEMA Sdn. Bhd., the Ministry of Health, the Immigration Department and any other relevant authorities, as and when it is required to do so."

The general lack of information about testing was well expressed by a Bangladeshi recruiting agent:

> "They (migrant workers) do not know why the test is taken. The new workers do not know anything about it. Even when I came to Malaysia, I did not know anything or did not understand. After one year we know because we had to renew our work permit."

Migrants were also not provided any pre-test and post- test counselling, leaving them unprepared for the outcomes of test results. None of the migrants interviewed had been briefed on the purpose of the tests. An Indian migrant worker poured out his frustration upon being asked if he was aware that he was tested for HIV:

> "I do not know anything about the test. I do not have test for this. I do not know. That is why it will be good if they explain to us each test result. If the doctor did not tell us, we would not know what test we gone through."

The absence of pre-test and post- test counselling was further reinforced by a doctor who is with the FOMEMA panel clinics:

> "We do not do pre-counselling. We just take consent from them. Saying that we want to take blood for what reason, give your consent."

The research revealed that language poses a major barrier in communication between the migrant workers and the medical personnel, and that communication is mostly limited to instructions relating to the procedures of the medical examination. It was also noted that the migrant workers were afraid to question the doctors as the doctors seemed to be busy and fully occupied. So, most communication was done through the employer and agent. This is reflected time and again in the responses from the migrant workers, and was confirmed by the doctors responsible for the testing.

> "Sister, the doctor was busy, a lot of people.We cannot talk." (Indonesian domestic worker)

> "Chinese doctor. He did not ask me anything. He only asked I eaten or not." (Indian migrant worker)

> "Doctor did not tell anything. I line up for blood, urine and x-ray test one after one. Nothing they talk to me. After the test ask me to leave." (Bangladeshi migrant worker)

> "The doctors were both male and female. They were "nice' but did not talk to me or explained to me the procedures or what they test were for. My agent did all the talking." (Cambodian domestic worker)

> "But sometimes the worker does not believe what the employer is talking, so he comes back to me and asks "Doctor what is wrong"". Language is a barrier, so he will bring somebody." (FOMEMA Doctor)

Although there is a policy that limits the number of migrant workers one doctor can examine to 500 per year, there is no stipulation limiting the number of migrant workers that can be examined by a doctor on a single day. This seems to be a factor in doctors planning their time, which includes the provision of pre-test or post- test counselling. A doctor described how he divides his time:

> "I spend nearly 15 minutes with each one of the workers. A lot of them will inform me earlier when they are coming before they come. Usually I get 10 workers per day. If it is 15 I will mostly divide morning and evening. If 20, then I will tell the employer to send 10 by 10. Because you cannot do thorough check-up on 20 of them. So we do 10 in one day and on the next day, another ten. Some companies would send 100 workers at a time. In such cases, I will give them the dates, where 10 workers come each day until we finish it off. FOMEMA does not fix on how many workers you should do the test on. One can do 20-30, but the quality of testing should be there."

The diseases or conditions the migrants test for are grouped into two categories. Communicable diseases including tuberculosis, hepatitis B, and sexually transmitted diseases fall under Category One conditions, whereby migrant workers who test positive for these conditions are deemed unfit for employment under the guidelines of FOMEMA and Ministry of Health. A non-communicable illness such as hypertension comes under Category Two conditions, where the migrant worker's fitness to continue working is determined by the examining doctor[32]. However, FOMEMA still has the final say in the matter as indicated by a doctor on its panel:

> "Let's say for example, old fracture, rib fracture, the doctor is not very sure, because FOMEMA is very strict on this, so the doctor (x-ray) will write there unfit. But if the doctor writes to me and tells me that there is a rib fracture in the finding, I will get it and say the migrant is fit. It is just a fracture nothing else. Go to FOMEMA, if FOMEMA says it's only a fracture it's ok. But if they say no it's not fracture and they ask to repeat the x-ray it's up to them."

Migrant workers and employers can apply for a re-test if they are not satisfied with the original results. Confirmatory testing only uses the original sample, while x-rays are taken anew. Cost of re-testing is borne either by the employer or the migrant. Confirmatory testing is only conducted upon request from the migrant workers and the employers; it is not done automatically. However, a FOMEMA doctor shared that repeat tests are conducted on migrants for diseases such as malaria and VDRL:

> "Because I know if they can appeal or not, if I see HIV, I will say forget it, pack your bag and go back. If it is the malaria parasite, yes, if they want to appeal, they can repeat the test after 2 weeks. If it is VDRL, they say take treatment for 2 weeks, repeat the test, if it comes back negative, ok."

FOMEMA adheres to the criteria set by the Ministry of Health in the certification of migrants. According to the criteria, a worker will be certified as "Unsuitable for Employment" where there is an indication of communicable diseases even though the diseases are not active at the time of the medical examination.[33] Due to the stringent criteria used by FOMEMA, a worker will still be subject to deportation regardless of the outcome of the confirmatory test, especially in the case of major diseases including TB and HIV. This was confirmed by representatives of two foreign missions based in Kuala Lumpur:

> "Yes, mostly back home the test was ok but here they are found unfit. In such cases we will negotiate with FOMEMA and Immigration for a re-test. FOMEMA will always give time, especially for a minor problem. The migrants will be told to rest for a few days and then do the test again. FOMEMA will give them 2-3 weeks, then can re-test. But, of course, cannot for major diseases like HIV and AIDS. HIV they do not accept."

> "The workers in Malaysia, during the 1st month if they are stated unfit by FOMEMA, we try to appeal through a 2nd medical test. But this is not for all, depends on the employer. FOMEMA told us that it is possible for re-test here for 2nd opinion. If in the 2nd opinion, result is still unfit, so he or she must be sent back."

The researchers were not able to get a clear indication on the number of migrants who were found to be fit after undergoing a confirmatory test, but it is believed to be a very small percentage. The following is the response from a doctor when probed on the matter:

> "That I would not know. Because the moment we sent them as unfit, there is no connection between me and the worker. Because if he goes and appeals to FOMEMA, they will give another clinic for testing. I send as unfit, he comes back, I would not know, unless FOMEMA takes the trouble to send a letter to me."

Cost Of Medical Testing

Male migrants pay RM180 for the medical examination, while female migrants pay RM190. The latter includes an additional compulsory pregnancy test. However, there is no clear policy indication on who should bear the cost of the medical testing. Most often, this is stipulated in the Employment Contract

signed between the employer and the employee which varies from one employer to another. This is clearly reflected by the following extracts from two different employment contracts. The former states that the cost will be borne by the employee while the latter indicates it is the responsibility of the employer:

> "Yearly Medical:Yearly medical examination will be arranged as required by the Immigration Department of Malaysia and cost incurred will be borne by Employee by deduction of salary." [35]

> "Medical Benefit: For every year renewal of work permit, it is compulsory for the worker to undergo a medical examination with the FOMEMA panel of clinics.The medical examination cost shall be borne by the employer." [35]

A doctor on the FOMEMA panel provided a breakdown of the medical examination fees:

> "Medical - employers pay. Employers do not pay from their pockets; they deduct it from the workers. They do not pay.You see, it's 180 for male, and 190 for female. RM60 goes for the medical (doctor's fees), RM25 goes to the x-ray and I think RM15 goes to the lab, I am not very sure, this is the total, the rest goes to FOMEMA of course."

Often employers advance the medical test fees, but later deduct the amount from workers' salaries. This is of course a burden, even more so when workers have also paid for medical testing in the source countries prior to departure, as Nepali workers shared:

> "In Nepal pay 2500 and Malaysia RM180. Total I pay RM 300. Company never pay. Company say you medical you pay. After pay your salary I cut. Company cut RM 300 already."

> "Yes. I also medical. Before I come I do medical test, there I pay money and here also I pay money.That too much.All Nepali got no money.Two time medical cannot pay money. Here I come I pay money and in Nepal I pay. But so many, Nepal not so much money. One time ok but two time is too much. One time ok. Just two medical waste..lah."

Distance and cost of transportation was not deemed as an obstacle by the migrants in accessing the clinic or testing centre. In most cases the employers or agents use their own vehicles to take the migrant workers to the medical examination and therefore the cost of transportation is often borne by them. However, the cost of actual medical fees is indeed an additional financial burden for the migrant workers considering the fact that each year they pay as high as RM1,800 as a payment of levy. Presently, under "sub-contract" agreements, migrants are being brought into the country in large numbers but not given jobs. For these migrants who are stranded in the country with no work, paying for the medical test becomes impossible, as reflected by a migrant:

> "I don't want medical test. I already ok but again here in Malaysia. I don't like it. If we do medical test, who pay the medical charge. We pay. We don't have work also. We are not working now. Now I also not working, One year one time medical. This year I no work 5 months. I cannot go medical. But no working, no medical. Levy also cannot pay. Medical also cannot."

In some cases, the cost of medical testing is spelled out clearly in the Memorandum of Understanding (MoU) signed between the government of Malaysia and the government of the sending country, such as the MoU between the Government of Malaysia and Indonesia on the Recruitment of Domestic Workers. But as MOUs come under the Official Secrets Act, the document is not publicly. Therefore it is impossible for migrant workers to be aware of its content.

Results Of Medical Examination and Strategies To Deal With Test Results

According to the current practice, the results of tests will be channelled online to the Immigration headquarters as well as to the Ministry of Health. The Immigration headquarters will then channel the information to its state offices. Employers can then check whether his or her workers are fit or unfit to work at FOMEMA's Call Center, FOMEMA's Website (online), or at FOMEMA's headquarters or branch offices. Because of confidentiality, the result of the medical tests is either 'suitable' for employment or 'not suitable' for employment. The onus is on the employer to check with the examining doctor on the health situation of his or her workers and the reason for any test failure. However, migrants have no access to information about the state of their own health.

Migrants confirm that they are totally unaware of the results of their tests, as shared by a Bangladeshi migrant worker:

> "Same day in the evening doctor gave the medical report. It is not with me. I received the report and pass it to the agent. I did not open the result. I do not know anything about the medical report. My agent took the report and told me the result is ok."

Another Indian migrant worker told how an agent accompanied him to the test, took the medical report and then informed the work that he had passed. It is a total violation of workers' rights for them not to know the status of their health, especially if they have a health condition, as it hinders the worker's ability to obtain proper treatment, thus jeopardising not only the health of the worker but also the health of his or her spouse, family and community.

Moreover, there is a lack of confidentiality, meaning that some migrant workers may be aware of their colleagues' medical results. The fact that employers have access to the workers medical results can easily result in a breach of confidentiality, as clearly demonstrated in the following example.

> (Answering the question:'How do you know that he got Hepatitis B'?) "The manager told me because I was supervisor in that company, then I told my cousin.The manager also told him about it."

A small breach of confidentiality could lead to news of an individual's health spreading to their community back home leading to stigmatisation and discrimination. These social implications, however, are not taken into account in the development of policy. In fact, the breach of migrants' confidentially in the mandatory medical examination is clearly acknowledged by the Malaysian AIDS Council:

> "The issue of confidentiality as stated in the Malaysian AIDS Charter applies to all who undergo the test unless under specified circumstances as prescribed by our law or policy. There are of course breaches to this confidentiality when it comes to migrants as HIV positive migrant workers upon diagnosis will have the result informed to FOMEMA and the Immigration Department."

The results of the mandatory medical examination, either fit or unfit, can have severe implications on the health of the migrant worker. Testing negative may create a false sense of security:

> "Because scared that I will found to have diseases abroad. Let be tested, so that I won't have any diseases while work in Malaysia."

Those diseases that may lie dormant and evade tests (HIV) may cause the worker to engage in risky behavior. The lack of knowledge and lack of pre-test and post- test counselling makes the worker vulnerable even if they pass the tests. Of course those who fail the tests are certified unfit to work, their permit is cancelled or not renewed, they lose their right to treatment and are deported home immediately.

In contrast, the results of the tests have little or no effect on employers either financially or emotionally. In case of medically unfit foreign workers, an employer can apply for a refund of the levy paid to the Immigration Department[36]. Most recruiting agencies replace domestic workers at no cost. But the replacement only happens if the first domestic worker was certified unfit within the first three months of employment. This is reflected in the following extract from the website of a recruiting agency for domestic workers:

> "TERMS AND CONDITIONS: 3) Agency will replace medically unfit maids within 3 months at no costs." [37]

The severe implications of being found unfit, including the loss of employment and deportation, create a lot of fear in migrants. This is not only an issue for the migrants but also for the recruiting agents. It is understood that in the case of domestic workers, the recruiting agents are compelled to replace a domestic worker who is found unfit within 3 months of arrival. This means a reduction in profit for the recruiting agents. Therefore, to avoid such circumstances, a lot of tactics are used by the recruiting agents to import the workers without going through the proper medical examination.

This was evident in the case of a domestic worker of Indian nationality who was admitted in a local hospital with severe TB. She fell ill within 3 months of arrival in the country. Tenaganita's assistance was sought to ensure her safe repatriation. Upon investigation, it was understood that she was brought in on a Tourist Visa and therefore did not go through a medical examination[38]. In a recent case handled by Tenaganita, 1,000 Bangladeshi workers were brought to work in Malaysia by a recruiting agent and none of them had undergone a medical examination[39]. A similar situation was shared by a migrant worker from India:

> "The agent in India told us we have to go for a medical check up once we arrive in Malaysia.We asked the agent here. He said, he will take us tomorrow but never take us to the test. We asked again then he said, we do not need medical report. They will manage for it. No one go for test. Agent said they will pay some money and get the medical report.They said it is not your problem, we will arrange your passport. I am not sure to whom the agent wants to give money."

Accessibility To Treatment, Care And Support

The policy of mandatory medical testing and deportation also raises the question of treatment for migrants who are tested positive for infectious diseases. A doctor in the field of infectious diseases said that treatment of migrants is difficult due to the deportation policy; only the abolishment of deportation could ensure proper treatment. According to the Infectious Diseases Department of the Ministry of Health, migrant workers with acute diseases will be provided treatment in the country. However, once deemed unfit, they are subject to repatriation immediately. The migrants cannot even rely on their employers as the main concern of the latter is to send the migrant back as soon as possible so that they do not need to shoulder the cost of treatment. This pattern is confirmed by a Filipino domestic worker about a colleague who was deported for failing a medical examination:

> "There was one who was turning yellow. The employer did not want to be responsible. She had a check up and some medicine but she was told to go back home because the employer did not want to pay for medical expense."

The high cost of treatment imposed on migrant workers makes it impossible for them to seek treatment as shown in the case of a Nepali worker handled by Tenaganita.

Brief Story of a Nepali Migrant Worker

A Nepalese worker was taken ill on arrival in Malaysia in January 2006. When his condition did not improve, his employer gave him an ultimatum: either he pays RM20 a day for lodging or he leaves his job. The employer also retained his passport. Another Nepali migrant worker took him to the hospital when he complained of acute abdominal pains. The doctor found that he had a form of tuberculosis. He was admitted and treated in the hospital. He was discharged in March 2006, after the doctors attached a colostomy bag to his abdomen to drain it of waste matter. He was not able to settle his RM3000 medical bill. When he returned to the hospital for follow-up treatment, the hospital staff turned him away. His case was brought to Tenaganita's attention who sought a support letter from the Nepali Embassy, but his request was turned down on grounds that it implied the embassy would have to stand guarantor for his medical bills. Through the donations from kind individuals, he was readmitted to the hospital on 6th April 2006 for follow-up treatment.[40]

As demonstrated, there is also an unwillingness of foreign missions to bear the cost of the treatment for their own nationals. Although the source country gains economically through the remittances sent back by the migrant workers, and Malaysia gains through the levy, which is a form of taxation, and through the cheap migrant labour, neither countries' governments seem to be concerned when a migrant worker falls ill. This attitude reveals the fact that migrant workers are not perceived as human beings entitled to basic rights, but rather as units of production that are expendable.

Exemplifying this attitude is the fact that at present there is no referral system for migrant workers who are found unfit and deported to their home countries. Even a representative of the Infectious Diseases Department of the Ministry of Health admitted that the medical examination conducted by the Ministry was purely for the purpose of screening and not for diagnosis of diseases. Thus, there is no concern for the well-being of migrant workers found unfit. The migrant workers who are found unfit are apparently advised to confirm their status and to get follow-up treatment in their countries. Representatives of Foreign Diplomat Missions in Malaysia are never informed once their nationals are deported for any infectious diseases. It is therefore nearly impossible to track and ensure that correct follow up treatment, support and care is provided for the migrants in the source country once they are deported from Malaysia.

Thailand

Thailand is both a sending and receiving country for migrant workers. However, for the purposes of this research, only the receiving aspect is considered. Thailand's economy has thrived recently, especially when compared to the economy of neighbouring countries. As a result, the number of migrants coming from Burma, Cambodia and Lao PDR to find work in Thailand has continued to increase. Even though migrant workers mainly fill jobs that Thais have relinquished (the 3-D jobs: dirty, dangerous and demanding), and despite the significant contribution they make to the economy, the general public has a negative view of migrants.

With regard to HIV, Thailand was one of the countries that felt the brunt of the AIDS epidemic at an early point in AIDS history, but it has had considerable success in stemming the rate of transmission. Indeed. the country's response has been hailed as a model in dealing with the impact of AIDS on society, in the way the government quickly scaled up prevention efforts, supported HIV positive people and made access to ARV drugs a reality for most of the Thai population. As part of the response to the AIDS epidemic, Thailand has promoted liberal HIV policies that aim to discourage stigma and discrimination. One initiative on this front is the *National Code of Practice on Prevention and Management of HIV/AIDS in the Workplace*, which discourages mandatory HIV testing. Although it has no effective enforcement mechanism, it carries the weight of national authority.

Thailand's Migrant Policy

In 2004, the Thai Government opened the registration system to allow all migrants, including family members and dependents, to register for a general ID card. Those of working age could also apply for a work permit which included health insurance. A total of 1,284,920 migrants and dependents registered for the general ID card (known as the Tor Ror 38/1), and 849,552 registered for a work permit. The proportion of migrants who registered for these two categories, as broken down by nationality, is as follows: Burma 72%; Laos 13%; and Cambodia 15%.

The Thai government then changed its work registration policy for migrants by only allowing those already with a work permit to re-register. The results were disappointing as numbers dropped considerably. After the number fell to 668,000 in early 2006, a supplementary and controversial registration was added that resulted in another 220,800 migrants registering, bringing the total number back up to around 890,000. It is estimated, however, that the total number of migrant workers and family members currently in Thailand could exceed 2.5 million.

One thing that has remained consistent in the migrant policy since it was originally formulated in 2001 has been that those registering for a work permit are required to undergo a health examination. Those who pass are then included under the national health insurance scheme, which allows migrants to receive a subsidised rate for health services at an assigned provider. This is the same as local Thais. When

registering, migrants have to pay a total of 3,800 Baht (34 Baht = US$1): 1,800 Baht for one full year's work permit, 600 Baht for the examination, and 1,300 Baht for health insurance plus administration costs of 100 Baht. Those without a work permit do not have health insurance.

Even though the policy is intended to have the employer pay, the employer usually just pays the up-front cost and then deducts the amount from the migrant's wages. Unfortunately, most migrants are unable to fully enjoy the benefits of the registration that they have paid for because employers often withhold migrants' work permits as a form of guarantee that they will not "run off" and try to find a new employer. Being able to go out in public without fear of arrest is dependent on having this card, thus making it difficult for migrants to freely seek health services, amongst other things.

Health Testing and HIV

Under clause 5.1.1 in Thailand's National Code of Practice on Prevention and Management of HIV/AIDS in the Workplace, established by the Ministry of Labour in January 2005:

> "There must be no requirement for testing for HIV/AIDS or request for a reference certifying whether a person is HIV-positive or negative as part of the screening of job applicants and workers, as part of the employment conditions, or as part of promotion or granting of benefits for the workers."

Accordingly, the health examination for migrants that is administered by government hospitals only tests for seven specific diseases or conditions deemed of public health concern, not including HIV. The diseases or conditions tested are: tuberculosis (TB), syphilis, elephantiasis, leprosy, malaria, intestinal worms, and addictive drug use or severe alcoholism.

Communicable diseases that are detected are classified into two levels. A migrant who is found with a disease classified at the first level is treated and put on probation until given medical clearance. Those found with a disease classified at the second level are often considered a public health threat and are considered incurable. It seems that only in the direst cases are people classified as untreatable, usually following the detection of amphetamine use and advanced stages of the other diseases. When people are found with a disease that is untreatable, they may still be given some treatment but they are not allowed to receive a work permit.

In 2004, out of the 817,254 migrants who took the health examination, 9,352 (1.14%) had a result in a treatable stage (5,399 with TB, and 3,092 with syphilis), while 809 (.09%) were considered ineligible for work. In 2005, only 610,399 migrants tested, with 6,306 (1.03%) having a second level condition (4,118 with TB, and 2,057 with syphilis) and 176 (0.03%) were considered ineligible for work.

Testing

The requirement of a health examination is not intended to be of benefit to migrants; it was instigated as a mechanism for the State to "protect public health." With this in mind, it should be noted that migrants in Thailand are not given an option in relation to taking the examination and are commonly not fully informed about the examination they are taking. Basically, they know that it is part of the registration

process and they need to be registered to become "legal." In this respect, there is no real consent, and the testing can be considered compulsory.

The only forms that migrants are given to sign are the registration documents; there are no consent forms. Since the documents are in Thai, which most migrants cannot read, very few understand what they are signing and the documents are not explained. Regardless of issues of consent, most migrants come away with a simple but appropriate understanding: sign the paper to get the work permit. As Burmese migrants in Mae Sot said:

> "If they say sign, then we sign."
> "We sign because we want to work."
> "We don't know because it is written in Thai."
> "If you want to get registration then you just sign."

The procedures of testing and the diseases that are being tested are not commonly explained by medical staff due to time constraints, the number of migrants being tested at one time and language barriers. As a result, health officers rarely inform migrants about the procedures they will undergo or for what conditions they are being tested, and usually this responsibility is passed on to the employer without any guidance. In answer to a question about whether there is any counselling either at the hospital or workplace, some Burmese migrants in Mae Sot responded:

> "No. There is nothing."
> "We just have to queue and wait."
> "We get (counselling) in the car on the way to the hospital. The manager tells us not to worry, you will get treated…"

And according to a hospital staff at Mahachai:

> "If a migrant wants more information, they can request it from the employer."

Although there is no HIV testing, few migrants understand this. Without clear information on what is being tested, a significant number of migrants believe that HIV is included, and as a result, some migrants expressed that they suffered related anxiety. In fact, only a few of the participants in focus groups could accurately list the diseases being tested. Those who had accurate information had been registered longer and had been tested numerous times.

> "Before, I thought we were going to get HIV test too, but they don't (test for HIV)." (Male Burmese migrant in Mae Sot)

> "Yes, because we go every year we know." (Female Cambodian migrant in Trad)

The fact that blood is drawn creates a lot of the confusion over whether HIV is tested or not.

> "What do they test - we don't know. But we want to know. When they test for malaria they just take blood from our fingertip. They take all that blood." (Male Cambodian migrant in Trad)

> "I think they test HIV." (Male Burmese migrant in Mahachai)

Moreover, without providing information about how to prevent, recognise and treat the diseases being tested, an opportunity to promote health through increased prevention is missed. In some testing locations, information is available, but it does not always seem that it is readily accessible to migrants.

> "I don't have time to read the posters. I have to be on queue and listen for when they call my number." (Male Burmese migrant in Mahachai)

The large size of groups being tested at one time limits the ability to provide information, with fishermen and factory workers being tested in the largest groups. Focus group participants estimated that groups were tested in sizes that usually ranged from between 17 - 30 people and 50 - 100 people, with the largest groups having 150 to 300 people, and one factory with 2,000 employees completed the test within two days.

Compounding this, the period during which workers can undergo the health examination is short. It is not available all year round; the usual period is March through May, but some places may be open until June. This contributes to the large numbers of migrants coming in for testing, with volume especially heavy just before the period closes. Fishermen at sea have the hardest time coordinating their schedule and as a result have low rates of registration for health testing.

Hospitals that provide testing are left on their own to provide information about testing procedures to migrants; there is no national initiative with regard to, for example, production and distribution of materials in migrants' languages. Moreover, there is no requirement that hospitals provide this information. As a result, there is very little information available at testing centres, and, as mentioned previously, employers are then expected by default to provide any relevant information.

When information is provided by testing officials, it is most likely given in Thai which only a handful of migrants are able to understand. Some hospitals use translators, but there does not seem to be any specific training or protocol on how to give information about the health test. This was illustrated at one hospital in Mahachai where there was a Migrant Health Assistant present. This person, who is Burmese, assisted on an individual basis but did not appear to have a central role in providing information. The assistant, although trained in health related information, said that he had not received any special training regarding the health examination or counselling, and this was the first year he had assisted with the health test.

Additionally, employers are impatient to avoid any loss of work hours, so the testing is rushed and migrant workers often have to take the health examination after work hours or on a day off. Those that go during work hours usually lose wages for that day. Transportation is usually taken care of by the employer, but this is not always a good thing.

> "All together, we were at least 60 in the car. It was so crowded." (Female Burmese migrant in Mahachai)

Hospitals provide testing services, ensuring that basic sterilisation procedures are adhered to, such as single-use syringes. The actual testing is usually done on hospital grounds, but in some locations, the hospitals conduct the tests in an adjacent area so as not to overwhelm the regular hospital's functioning due to the large numbers of migrants. Some hospitals even have mobile units that provide the health test

at large factories. When there were mobile units used, although sterilisation of equipment is standard, there is a question as to the level of sanitation of the surrounding environment, as locations mentioned included a shrimp peeling factory, the cafeteria in a garment factory, a parking lot of a Buddhist temple and a garage for parking motorcycles. In most cases though, the few complaints migrants had about testing locations were in regards to the bathroom and the challenge posed by the elements such as high temperatures and rain. This is captured in the experience of female Burmese migrants in Mahachai.

> "Urine box is one use and everything is from a package. Syringe and needle are also new. Only the bathroom is hell."
> "The bathroom was bad and smelly. We just tried to squeeze our pee out quick. It was dark and we could not even see if the pee goes into the cup."
> "Yeah, I peed on my hand and there was no place to wash."

The health examination itself is standard, comprising eight elements, as follows:

1. Registration
2. Urine test done: a litmus test for pregnancy and drugs.
3. Medicine to be taken: 2 large tablets for worms (all migrants) and 1 large tablet for elephantiasis (groups from Burma only). If a woman is pregnant, she does not have to take the medicine.
4. Personal information recorded, including marital status, whether family planning is used ("in order to provide advice"), home (province and country).
5. Blood pressure taken.
6. Physical examination, including a check of lymph nodes and neck for gout, check of fingers and arms for leprosy, and a stethoscope check of the chest.
7. Blood test done. One syringe draws a blood sample for two vials, one for syphilis and one for elephantiasis, both marked with the migrant's ID number.
8. A chest X-ray taken.

One doctor informally noted that an employer could ask for other conditions to be checked for an extra fee, but refused to elaborate. There were reports of individual factories having HIV tests independent of the general health test, but this was not followed up by this research. There was also lively discussion about an unorthodox stool test that migrants working in seafood processing factories were given at the factory: they are brought into a room without explanation, told to pull down their pants and bend over - then a nurse inserts a cotton swab into their anus and twists it.

The medicine that migrants are required to take is one of the points most discussed by migrants. There is a lot of misunderstanding, fear and discomfort associated with this medicine, especially among the migrants from Burma, who have to take an indicator medicine for elephantiasis. Most migrants from Burma say it makes them dizzy and they feel sick. The medical personnel, on the other hand, do not properly explain what the medicine is for, saying things like *"it cleans the blood"* and *"makes the diseases appear in your body"*. This makes migrants even more reluctant to take it, and some even secretly throw it away.

In Thailand, patients generally defer to their doctors without need of explanation because many feel that the doctor knows best. Although this is a socio-cultural trait, it is further reinforced by the fact that doctors rarely explain much because they feel that their patients would not understand. Language-barriers and the time-constraints of processing so many migrant workers at one time add to this 'cultural

backdrop', so when migrants do ask questions, they are treated like children or simpletons and are left feeling that this service is not really for their benefit.

> "If we don't pass, the doctor will tell us our blood is no good. They won't tell us what that means or what disease they found." (Male Cambodian migrant in Trad)

> "They don't like when you ask questions, and they will answer really fast. If we ask again for clarification they won't say again." (Female Burmese migrant in Mahachai)

The fact that they are migrants adds another dimension to the interaction between health personnel and patient. This is partly because of language barriers, but many Thais also have a condescending attitude towards their neighbours, especially those from Burma:

> "They (nurses and doctors) wear white things, but inside, their mind is not white." (Female Burmese migrant in Mahachai)

> "They look down on us." (Male Burmese migrant in Mae Sot)

Of course, this is not true of everyone, and the Cambodian group seemed to feel that they received a friendly service.

> "The nurse who comes to our factory is okay. She even smiles." (Female Burmese migrant in Mae Sot)

> "At ___ Hospital they are nice and polite. ….The people in the hospital doing the health examination were more polite than the Cambodian officials who came for the Certificate of Identification." (Cambodian migrants in Trad)

There were no reports of inappropriate touching or of medical staff taking advantage of their position to gain sexual or monetary favours. Although medical providers did not abuse their position, migrants were not completely free from extortion in the medical examination process. Commonly, the employer pays the money at the time of registration and then deducts the amount from the migrants' wages over time. A lack of transparency allows employers to take advantage of this. Even though most migrants pay the proper amount of 3,800 Baht, which includes the fees for registration, health testing and insurance, a considerable number have paid their employer or agent fees well in excess of the standard rate. In the focus groups, especially among those from Burma, migrants noted paying fees of 4,500 Baht, 6,800 Baht, 7,500 Baht and up to 8,400 Baht, with brokers or agents extracting the extra as service fees.

Impact of results

In most work places, migrants will only receive their results if they are found to have one of the conditions tested, even though some Cambodian migrants did say that they had received a copy of the results. When a migrant is notified of a result, there is uncertainty about what condition(s) has been found as there is little explanation in their language and they usually receive a document in Thai, which they cannot read. Cambodian migrants did note that a form in the Cambodian language (Khmer) is being used, but this is a recent development and only at one hospital in a province bordering Cambodia.

Of major concern is the fact that there is no standard protocol for giving the results, commonly resulting in breaches of confidentiality. Because migrants are generally unfamiliar with the list of conditions tested, a result delivered in an inappropriate way can potentially have very negative effects on the person being notified, such as resulting in stigmatisation and anxiety. As described by Burmese migrants in Mae Sot:

> "They give you a big piece of paper with your number and hang it around your neck.
> In our factory, they shout over the microphone who has a problem, and that they need to go to the hospital again."

> "Office will call the line leader and the line leader will talk to that person.They call by number and by name. It makes other people curious."

> "As soon as they go outside we start to gossip.We all want to know what they have tested and what the hospital does to them."

Confirmatory testing is provided by the same hospital which did the initial testing. However, this is not always trusted by migrants, as many migrants have been called for a confirmatory test and then had nothing found. Those migrants who do have a disease confirmed by this test will be treated if the disease is considered in the treatable stage. The most commonly found diseases are TB (around 61%) and syphilis (around 32%). While treatment is given, the migrant is put on probation until they are given clearance by the doctor. Generally, migrants do not have to pay any extra fees for confirmatory testing; at most there will be a nominal fee of 30 Baht for treatment, which is covered under the health insurance.

Employers are usually given the results or else are notified of any condition the migrant might have, before the migrant is notified. If a woman is tested pregnant, it is marked on her medical sheet so that the employer knows. The policy on confirmatory testing is unclear though, and those who wish to seek out independent confirmatory testing have done so with mixed results. The experience of female Burmese migrants in Mahachai indicates this:

> "The company fired her for TB. She was so upset that she went to Dr. Gawna, and he didn't find anything. She went back to the factory and said she was clean, but the factory didn't believe her or take her back."

> "…The factory said that she needs an approval letter from a doctor. Any doctor is fine. I took my sister to Dr. Gawna.We showed the factory the results and the factory let her come back to work."

Regardless of whether a condition found is treatable, the decision to terminate employment is left up to the employer. This is true for pregnancy as well. Some employers will let their employees rest and complete their treatment and then return to work; others will fire their employees without recourse, depending on the type of work and the condition they are found to have. Migrants working in the food industry, especially in seafood processing factories, face the strictest bosses, while garment factories and fishing boats seem to have the most lenient.

> "In my factory, one person was fired because he had TB." (Male Burmese migrant in Mahachai)

> "(The boss) didn't fire him. He could continue to work on the boat. If fishermen can still work, they won't fire them." (Cambodian migrants in Trad)

Those who are fired face an uncertain fate. Since there is no active linkage between immigration police and the hospitals, once a migrant loses his or her employment status, which is determined by the employer, that individual simply becomes vulnerable to arrest and deportation by police.

The question of HIV testing

When asked about whether migrants would like to know their HIV status, there was general consensus that being tested for HIV would depend on the situation, and migrants would need to be properly prepared first. If there was too much stigma in their community, most of the focus groups participants would not want others to know.

With ARV becoming more widely available and an increasing debate about generalised, opt-out testing linked to treatment of HIV, an unasked question hovers over Thailand's health examination for migrants: "Will HIV testing be included on a humanitarian basis?" Regardless of whether ARV is available and linked to testing, any HIV testing requires full consent accompanied by proper pre-test and post- test counselling, with all results handled and disclosed abiding by national standards of confidentiality. Considering the way that migrants are dealt with in health testing as it currently stands, the Thai health system is not ready to include HIV into its health test for migrants.

There are two main steps that need to be taken to ensure migrants' rights during the present health examination.

Firstly, there needs to be more transparency in the testing process. As much information about the health examination needs to be made available, covering the conditions tested, the rights to confirmatory testing and treatment available to migrants in their languages. Further, guidelines need to be established for health providers to follow in the provision of this information.

Secondly, enforceable guidelines need to be jointly created by the Ministry of Health and Ministry of Labour for employers to follow in respecting health and related employment rights of migrants in regards to confidentiality, rights to confirmatory testing, job security and linkages to treatment.

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5 http://www.uae.gov.ae/mop/UAE_figures/UAE_%2004_files/sheet010.htm

6 Gulf News, May 1, 2006

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C

REGIONAL ANALYSIS

Waiting room where migrants will then be screened before leaving abroad in Indonesia

CHAPTER FIVE:

REGIONAL ANALYSIS

In 2006, the United Nations Office of the High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS) jointly developed and consolidated guidelines on HIV/AIDS and human rights. These guidelines call upon governments to fulfil their obligations under various human rights treaties with regards to, but not limited to, non-discrimination, health and employment. The International Covenant on Economic, Social and Cultural Rights (ICESCR) is a particularly important treaty in this respect. The focus on non-discrimination, health and employment is necessary to reduce vulnerability to HIV infection and to ensure humane care, treatment and support to all. According to the fifth guideline on anti-discrimination and protective laws[1]:

> "Each state has the obligation to ensure that 'laws, regulations and collective agreements should be enacted or reached so as to guarantee the following workplace rights': freedom from HIV screening for employment and training, confidentiality regarding all medical information including one's HIV status and 'employment security for workers living with HIV until they are no longer able to work"

Although countries may have this obligation, there is a distinct conflict between these guidelines, HIV policies in many countries in Asia, and the current practices of many sending and receiving countries in regards to mandatory or compulsory HIV screening for employment. In this part of the report, drawing from the findings of CARAM partners in various countries throughout Asia, the regional analysis will consider the law and policy environment pertaining to migrant workers and their rights regarding mandatory health testing for employment purposes. This section will look at seven destination countries: Bahrain, Dubai, the Hong Kong Special Administration Region of China, Japan, the Republic of Korea, Malaysia and Thailand; and nine origin countries: Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, Philippines, Sri Lanka and Vietnam. In particular, it will assess and compare the origin and destination countries with regards to (mandatory) health and HIV testing in their labour migration and health policies and how these policies are implemented drawing on reflections by stakeholders and, more extensively, the experiences of migrant workers themselves. For the purpose of this regional analysis and convenience, countries are either treated as origin or destination countries; this is not meant to imply that migration solely occurs in one direction in relation to these countries.

In the upcoming paragraphs we will elaborate the policies on health testing and mandatory HIV testing in both origin and destination countries and then illuminate the actual implementation of testing in these countries. In this context, the regional analysis will look at issues of consent, counselling, confidentiality, referral and the impact of results.

TESTING POLICIES

Looking from a human rights perspective at the national policies and laws for the countries represented in this report, it becomes clear that considerations of migrant workers' rights are overlooked. In origin countries, policies and laws that are enacted to protect nationals do not count for prospective migrant workers due to the requirements imposed by destination countries, while once in destination countries, migrant workers are regarded and treated under a different set of rights than those of its nationals. In both origin and destination countries, this results in the violation of equality before the law as migrants are discriminated against on the grounds of HIV status in the context of travel regulations, entry requirements and immigration procedures.

Origin countries

Most of the countries reviewed in this section have national policies in place that either forbid or do not allow for mandatory and/or compulsory HIV testing. In Cambodia for example, Article 20 of the 2002 law on the Prevention and Control of HIV/AIDS clearly states:

> "it is strictly prohibited to any compulsory HIV testing undertaken to indicate pre- or post-conditions for employment (…) as well as for the exercise of freedom of abode, travelling and the provision of medical services or other services."

The Bangladesh National Policy on HIV/AIDS and STD affirms

> "screening for HIV infection or other STD will not be mandatory for travellers or migrants into or out of the country".

Although most origin countries have similar policies installed, contradictory practices for migrant workers are enacted at the same time. In Nepal, for example, both mandatory and compulsory HIV screening is against the law, but at the same time the Foreign Employment Act 1992 (First Amendment) asserts:

> "Health status is the reason for disqualification for migrant workers as per the demand of the receiving country (..) There are no specific conditions as temporary and permanent disqualification but generally diseases such as HIV, epilepsy, heart diseases, physical disorders and mental illness are considered under permanent disqualification."

First, HIV is wrongly referred to as a disease rather than an infection, and secondly, this policy assumes that HIV falls within the same category as heart diseases and epilepsy wrongly assuming that HIV infected individuals are no longer able to work. This is not only an inaccuracy by the Nepali government, it also fuels the already existing stigma and discrimination against individuals infected with HIV, since it fails to recognise that those individuals can lead long and productive lives. In fact, all countries that subscribe to this reasoning contribute to the further undue stigmatisation of people living with HIV.

Compulsory medical exams for migrant workers usually test not just for HIV, but also for STIs (including syphilis, gonorrhoea and chlamydia), tuberculosis, hepatitis, cancer, leprosy, drug use, psychiatric illnesses and pregnancy for female migrant workers. Some medical exams go beyond simply testing to guarantee the condition of their workers. For example, it is a standard practice in Sri Lanka during the

medical exam for female migrant workers to be injected with Depo-Provera, a contraceptive that is used to prevent pregnancy between the testing date and the departure date abroad.

Destination countries

Destination countries withholding entry of or deporting non-nationals based on health testing usually justify this in two ways. First, they claim to be protecting the national public health of their citizens from contagious and communicable diseases, and second, they want to avoid the economic costs of treatment and/or care and support for non-citizens (as mentioned in Chapter One).

According to the first claim, the variety of conditions migrant workers are tested for, including at least the basic set of HIV, hepatitis B, and TB is intended to protect the public from the spread of these diseases. The Rules and Regulations for Medical Examination of Expatriates for Work in Gulf Cooperation Council (GCC) States 2005[2] illustrates this, especially as it emphasises HIV, stating that one of its main aims in testing is

> "to protect citizens of Gulf Countries from diseases and spread of infection."

Other destination countries have oftentimes developed health testing policies for similar reasons as reflected by a stakeholder in the Republic of Korea:

> "Isn't it a very natural thing for us government agent to examine the health condition of foreigners who enter our country to protect the health of our people? I mean to prevent our citizens from being infected with communicable diseases including HIV/AIDS." (Director of Instruction Team of Foreign Workforce Employment Assistance Unit in Human Resources Development Service of Korea, Republic of Korea)

Under international law, and more specifically under the International Covenant on Civil and Political Rights (ICCPR), states are not bound to grant entry to non-nationals. However, human rights law prohibits

> "discriminating against a person in the enjoyment of his/her human rights on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property or other status." [3]

According to the Human Rights Committee of the United Nations, this 'other status' covers health status, including HIV. The denial of entry of people based on their health status and the recurring (annual) health testing of non-nationals is against the very principle of non-discrimination and contravenes basic human rights .

Although HIV-related travel restrictions have no grounding under a public health rationale, denial of travel documents based on HIV status continues to take place in destination countries. While Japan, the Republic of Korea and Thailand have all ratified the International Covenant on Civil and Political Rights, Kuwait, the Hong Kong Special Administrative Region of China and Malaysia have not. This, however, does not mean these governments are exempt from the moral obligation to respect, protect and fulfil human rights of all people within their borders. Yet, the Republic of Korea, Malaysia, and the GCC States all refuse access of non-nationals who have failed their health tests and/or have tested HIV positive. In the GCC States, Thailand and the Republic of Korea, migrants are also required to go through the health

test yearly in order to renew working visas. Malaysia has recently updated its mandatory testing policies in which health tests are required three times: post-arrival, and prior to the renewal of the work permit in the first and second consecutive year.

In some countries, although there are laws against mandatory HIV testing, there are also loopholes that employers may exploit to get around these laws. In Thailand, screening for HIV as part of employment conditions is prohibited by National Guidelines but is not enforced by law. To circumvent the policy, some Thai employers require health exams that include HIV tests for all their employees, not specifically just migrant workers. The loophole is that the employer has access to the results, which violates confidentiality but does not breach the issue of mandatory HIV testing per se. In Japan, similar policies are in place, as employers are not allowed to use HIV tests against workers, and HIV tests cannot be conducted at the time of the selection of workers. Yet, this policy bears no legal enforcement. In the Hong Kong Special Administrative Region of China, mandatory health testing is not required for migrant workers before arrival in Hong Kong, SAR of China, nor during the period of stay in Hong Kong, SAR of China, nor when applying for renewal of the employment contract. On the other hand, the employment contract for domestic workers states that the domestic helper has to take a medical exam to show her fitness for employment and the certificate is shown to the employer. Similar loopholes can also be found in other destination countries which have policies that dictate against mandatory HIV testing.

The more explicit rationale provided to account for post-arrival testing in the destination country, even after a health test has already been conducted in the country of origin, is twofold: the distrust of testing procedures in the country of origin, and the 'window-period' between the first test and arrival in the destination country. The statement by a health official in the Republic of Korea reflects this concern:

> "Workers are required to have an HIV test every year. There are two reasons why we ask for two tests in such a short period of time, just before and after entering [the Republic of Korea]. One is that we are afraid of the possibility of infection within that period, although it is short.The other reason is that there could have been an inaccurate diagnoses, or cases of fraud, from sending countries." (Health official, Republic of Korea)

The second rationale used by countries to rationalise testing is the burden of additional costs of treatment and care for non-nationals. Currently, no destination countries in Asia are known to provide ART for migrants, often under the rationale that if ARV was provided, migrants with HIV would come flooding in for treatment. Although some countries will provide rudimentary treatment for TB, it is often no more than for two weeks – enough time to deport the migrant. Thailand is one of the exceptions, where full course TB treatment is available to migrants under the health insurance scheme.

This rationale overlooks the greater financial contribution that migrants make to these economies, and reduces them to units of production in a simplistic profit equation. In other words, it ignores broader economic dimensions and completely disregards human rights.

TESTING PRACTICES

The big business of health testing

The distrust that destination countries show towards testing procedures of origin countries as illustrated by the testing done upon arrival, together with the regular testing that is done thereafter, may be deemed as "vigilant" on the part of destination countries, but it belies a less obvious third rationale for all of this testing: medical health testing is a booming business in which testing centres, recruitment agencies and their middlemen reap profits. Bahrain estimates that one testing clinic will receive around 350 migrant workers every day, while in the Republic of Korea, anywhere from 50 to 500 migrants are being tested at once. This scenario is repeated in Dubai as well:

> 'Medical is always completely full for testing. House full. There are minimum 150 to 200 chairs. These become full and many have to stand in waiting. If one goes 7 in the morning then it takes minimum 2 to 3 hours." (Balloon Opinion, Bangladeshi migrant workers in Dubai)

The financial benefit of HIV screening is obvious:

> "This is like 500 workers per clinic. It is good profit.You will get RM30000 (8,770 USD) per year, you will get it." (Doctor with a panel clinic of FOMEMA, Malaysia)

Health testing is not only a profitable business for the testing centres, but also for a wide variety of stakeholders involved, often at the expense of migrant workers. Due to a lack of transparency in many origin countries, especially in the big business of health testing, some health officials, recruiting agents, sub-agents or middlemen jump at the opportunity to earn extra money and even offer to change the failed health test into a positive certificate. In Sri Lanka, while the average medical test costs between Rs.2,500 to Rs.4,500, the cost could escalate dramatically for an added vaccination charge for hepatitis or chickenpox, for example, which carry additional costs of between Rs.4,500 to Rs.8,000. In addition to this, the migrant worker must pay a commission or fee of Rs.500 as processing charges to the recruiting agent and an equal amount to the sub-agent. This places the migrant worker in further economic difficulty.

> "What is not fair is that you cannot have (reading) glasses made outside… I told them that my vision is still okay. They told me I have to get it from them. "What do you want? You have to avail of this in order to leave." So I gave in. "How much," I asked them. "P1,000 (approximately 22 USD)." Isn't there a cheaper one," I asked."If you buy this outside, it's more expensive." "Can I have a discount? Can I pay only P500 (approximately 11 USD). I can pay you at once," I said."No, it's for P1,000. Anyway, you are going to the US." So I paid." (Seafarer, Philippines)

As migrants are often unaware of the health tests they have to pass in the destination countries, they pay the extra cost thinking that this will get them overseas. But then they are even more devastated and suffer major financial losses when they are declared unfit in the destination country and deported.

> "I tried to go to Saudi Arabia through an agent in Bombay. I had to take a medical test there and the doctor told me that there is something wrong with my test results. He said if I pay him an extra Rs. 2000/- he could give me a medically fit certificate. I thought that if I can go to Saudi with this certificate, why not? I didn't think it would be something serious." (Deported migrant worker, Kerala, India)

> "They will say that you have some problem, but it can be made fit. Because of having a white spot on my skin they asked for 5,000 Taka.They said that if some money is spent it can be made fit.They also said that they would give us the medicine and fit certificate so that things can be done. Consecutively, they sent documents and medicine." (Migrant workers, Bangladesh)

Since the amount of money needed for a health test can be excessive for migrant workers, it is usually a third party (the recruitment agent, the middle man, the sub-agent, the sponsor or the employer) who pays the money upfront, and then deducts the amount from the migrant workers' salaries. A lack of transparency too often conceals information on the costs of a health test from the migrant worker, and this often results in a considerable amount going directly into the pockets of these third parties.

> "I had to pay 7,500 Baht (230 USD).The agent told me the ID fee is 5,500 Baht (USD 169) .And then, 2,000 (61 USD) is for the agent." (Cambodian migrant,Thailand)

This is found to be true in other destination countries as well. In Bahrain for example, the costs of testing varied among the migrant workers and seemed to depend on the goodwill of the sponsor. Some of the sponsors deducted the costs from migrants' salaries; other sponsors actually paid the health test and transport costs to the testing centre. In Malaysia, costs for health testing varied between RM180 and RM300 (53 and 88 USD). This sum was sometimes paid by the company, by the recruiting agent or directly by the migrant worker themselves. In case of the former two, although some migrant workers are aware of this arrangement, others do not know that the fees are deducted from their salaries. In Dubai, it is typically found that the migrant workers doing labouring jobs, for example in construction work, have to bear all costs of testing themselves, whereas in office- or hotel-based occupations, testing costs are borne entirely by the company.

> "Company doesn't give medical test costs. 600 Dirham salary.There is no overtime. If the 300 Dirham medical cost is given by the company then it will be beneficial for us." (Indian and Bangladeshi labourers in Dubai)

> "Company doesn't give it, all costs are our own. Getting visa, filling form (medical test), all is own responsibility. Company says if you want to have visa then do it on your own. Or leave. The door is open." (Bangladeshi building construction labourer)

The GAMCA monopoly and its effects on migrant workers

Due to the large scale economic development in the Gulf Cooperation Council States and the need for low-skilled labourers, the GCC has opened its doors to large numbers of foreign workers. At this point in time, seven Asian countries act as recruitment grounds: Bangladesh, India, Indonesia, Nepal, Pakistan, Philippines and Sri Lanka. These countries provide one and a half million migrant workers each year on average. In order to obtain an entry visa to one of the GCC States, migrant workers are obligated to undergo a health test in the origin country within a GAMCA (Gulf Approved Medical Centres Association) health testing centre, of which there are now 180 worldwide. Any private clinic can apply for GAMCA certification, but must meet GAMCA's strict standards to be accepted.

The GCC developed rules and regulations for these approved testing centres, dictating the aims of pre-departure testing to protect its own GCC nationals from communicable diseases and to ensure the medical fitness of migrant workers. Although GAMCA officials in the origin countries were reluctant to share the

contents of this book with its rules and regulations, CARAM-Asia managed to obtain a copy in one of the GCC States. Besides the aims of health testing, the book describes the accreditation of testing centres, the methods of testing, the monitoring of testing centres and the penalty system when rules are not adequately implemented. These GCC rules and regulations are strictly implemented, which ensures higher standards of testing facilities and procedures, and proper sanitation and hygiene, as observed in all the participating origin countries in this research. However, while the testing procedure itself and the monitoring of the testing centres are described in detail, there is regrettably no mention of implementing and monitoring regarding practices of informed consent, confidentiality, pre-test and post-test counselling, or referral services and/or treatment options, in case of a HIV positive test result, for example.

GAMCA testing centres in origin countries have proved to be big business for actors involved, which translates to higher costs for migrants. First, GAMCA testing services are usually far more expensive than other testing centres. Second, commissions for GAMCA testing centres are higher than for regular testing centres, as commissions are secured not only by recruitment agents but by their sub-agents and so-called sponsors in villages as well. These higher commissions and higher fees in the centres are directly or indirectly paid by migrant workers themselves. Indirectly means that the costs are deducted from their salary or that the total package of working abroad is higher than when applying for work in non-GCC States. At the same time, when applying for a job in one of the GCC States, the prospective migrant worker is bound to attend one of the GAMCA testing centres. The GAMCA testing centres tend to be highly centralised in most of the origin countries to make monitoring easier, but results in adding extra expense and time to a prospective migrant's application, as migrants tend to live in remote, rural provinces.

Despite popular demand by prospective migrants to decentralise the testing facilities, which is feasible as most origin countries have regional district capitals that are well supported with the necessary infrastructure, it is evident that the group of currently approved centres do not want this to happen. It would reduce the number of migrants using the testing services at the current centres, resulting in decreased profitability. So it is not surprising that GAMCA approved centres expressed a strong view to hold on to their privileged status. In Nepal, for example, GAMCA has recognised 5 medical centres, all situated in the capital, Kathmandu. Prospective migrants living in the remote rural areas of Nepal must travel to the capital for the medical tests and face considerable problems accessing these centres in terms of added cost and time required for travel and staying in the capital. Following the regular procedures, first they have to go to the GAMCA office to register, from where they are directed to go to the testing centres approved by the GAMCA. A group of villagers coming from a distant mountainous part of the country in Pokhara described their experience:

> "We mainly faced with difficulties.The manpower office is elsewhere whereas they brought us here to Kupondole far from where we stayed. It was from there to Tripureshwor where the GAMCA office is situated. From there the next stop was here (testing centre). A lot of difficulties have to be faced. If only this was located near the bus-park. It would have been a lot easier. Moreover if they had told us to get the medical test done by any government recognised hospitals then it would have been a lot easier on our part.We could have easily done that by performing the medical test (in Pokhara) where it would have been easier for us." (Fit Nepalese prospective male groups going to Saudi Arabia)

With this centralisation, migrants have to bear the additional costs of transportation and lodging while undergoing the health tests and waiting for the results. This is even more pronounced for the female prospective migrants who have to be accompanied, as a social norm, by male companions or family members.

Brief Account of a First Time Female Migrant Worker, Sri Lanka.

It took 7 hours to come to Colombo. I came with some other people. I don't know Colombo. The agent brought me to do the medical test and I was told that I passed the test. I am happy. I think I am going to Saudi.

It is very expensive. The bus fare is 600 rupees. I paid 500 rupees to the agent and 2,500 rupees for the test.They have asked me to come back again for an injection (contraception purposes). How can I find the money to come again? I told the doctor that I take pills but she said I have to come again. Can you find out whether I have to come again? I don't know where to stay the night.

Monitoring mechanisms

Policies and legislation can only be enforced when reliable and independent, functioning monitoring mechanisms are in place. Governments of origin countries do not have any control over GAMCA testing centres with regards to monitoring, while the GAMCA centres have no accountability towards governments. The rules and regulations enforced by the GCC States, however, are strictly monitored. The emphasis of this monitoring is on the quality of medical testing itself, not on the rights of migrant workers. Thus, there is little regard for informed consent, pre-test and post-test counselling, rights to confidentiality of testing or the test results, or any requirement for referral systems.

GAMCA approved testing centres fall under a strict punitive system. When a consistent number of unfit workers are provided with fit certificates from a particular health centre, additional checks are carried out by the GAMCA central office. The penalty system works as follows: first the testing centre receives a warning, then it is fined. If these measures are inadequate, their license is temporarily suspended, and if all fails, they are removed from the list of approved centres.

Testing centres in Bahrain are monitored through the Ministry of Health rather than by an independent body, which is similar to government hospitals or private clinics. In Malaysia, monitoring of testing policies is not consistently implemented:

> "I am afraid we do not monitor whether they are giving pre-test and post-test counselling. It is up to the FOMEMA clinic, there is nobody to monitor that part, whether it is being implemented or not." (Representative from the Infectious Disease Department, Ministry of Health, Malaysia)

> "I would like to say that there are very few business owners who can hire people if they are required to observe every standard that international organisations and NGOs suggest regarding epidemic disease, physical condition, gender, educational level, race, etc… There are many things to consider in the workplace aside from human rights." (Official from the Human Resources Development Service of Korea, Republic of Korea)

In the following section on health testing policies and the implications for migrant workers in the region, the research conducted clearly demonstrates that migrant workers are disadvantaged in two ways. First, insufficient policies give free rein for employers to utilise loopholes that have been unintentionally created; and second, migrants' rights are often simply disregarded as being inconvenient.

INFORMED CONSENT

"Public health legislation should ensure that HIV testing of individuals should only be performed with the specific informed consent of that individual." [4]

Informed consent in health testing is the process of communication between provider and client, in which a person learns the key facts about the health test, including its risks and benefits and its consequences and implications, before deciding whether or not to participate. Other elements of informed consent should include how the test results will be communicated and the opportunity for the client to ask questions. If consent for an HIV test is combined with other health tests and/or procedures, the inclusion of the HIV test should be specifically discussed with the client who undergoes the testing. The informed consent should be preferably in writing with the client's signature.

The majority of the origin countries reviewed are obligated by national laws to obtain informed consent from clients undergoing HIV tests. However, the implementation of these laws is questionable at best. In practice, there is often little to no informed consent obtained. Instead, consent may be taken for granted through actions ranging from the writing of the name, a fingerprint or indeed a signature in some countries, to verbal or written consent, as in Sri Lanka, to no informed consent whatsoever, in countries such as India and Bangladesh. It is striking that even in the countries where a signature or fingerprint is required, many migrants do not know the contents of the document they sign, leaving the issue of fully informed consent as questionable.

> "I was asked for a signature in a form, but I was not explained anything about what was written in the form. The form was in English." (Deported migrant worker, Chennai, India)

> "We only wrote our name. I am not literate so I did not understand the form (…) They did not make anything clear to us." (Unfit male prospective migrant worker going to Malaysia, in Nepal)

Informed consent is a charged concept with regards to migration. The migrant worker is (made) aware that refusing the medical test will result in denial of the work permit because of the migration policies in destination countries. Thus migrants often sign documents unquestioningly, without being aware of the contents.

> "We agreed to sign a document, but we did not know what it was for. All we want to do is go abroad, so we did not read it." (Female migrant worker returnee, Sri Lanka)

Although it would make sense that the testing centres should be responsible for ensuring that potential migrant workers are well-informed and understand the consequences and impact of the test results before giving their consent, as that is the point where the actual testing is done, the responsibility of obtaining informed consent is being redirected to recruitment agencies. However, testing centres often wrongfully assume that migrant workers already have the necessary information themselves or have obtained this from other sources:

> "There is no official information sharing about the tests. As the tests are common for all, most of them know through the reports given to the previous test takers. Secondary sources serve as the source

> of information. No procedures exist to take the consent of migrant workers. The migrant workers already know about the tests. So there is no reason why an official consent needs to be taken." (Health Official at a GAMCA testing centre, Kerala, India)

> "Now it is not possible to leave without doing the HIV test. What is consent and what is not? Since they have mentioned it as a compulsory test, it is final, isn't it? There is no choice at all." (Male doctor at GAMCA associated medical testing centre, Nepal)

As will be demonstrated in the upcoming sections on confidentiality and pre-test and post-test counselling, it becomes evident that migrant workers occupy a different category within society. Regulations that apply to other nationals are disregarded for migrants, and they are treated as a separate category. Regarding the process of obtaining consent, for example, there is a marked distinction between voluntary testing centres and those centres performing the required mandatory health tests for migrant workers. Here a doctor at a voluntary testing and counselling talks about standard procedures of consent:

> "Yes, as a government run institution, we follow the NACO guidelines and have a procedure that includes pre-test counselling, signing a consent form, the test itself and post test counselling. The person has to sign the consent form before the test will be conducted." (Official at VTC, Kerala, India)

With regard to consent, the situation in destination countries is no different than the origin countries reviewed: there is no real possibility to choose whether or not to participate in health testing. Even in countries where HIV testing is not a prerequisite for employment, refusal of a HIV test or other health conditions might result in termination of employment. In Hong Kong, SAR of China, for example, where migrant workers do not need to pass a health exam, policies and legislation do not forbid employers and recruiting agents from requiring a health test. If a worker refuses a health test, the employer may doubt the sincerity of the migrant worker and may terminate the migrant's employment.

In the context of health screening for migrants to obtain a work permit or a renewal of visa, informed consent is an idle concept. Several factors impede the practice of obtaining proper informed consent. First, many health officials seem unaware of the right to informed consent and/or of any existing policies that may be in place. In Bahrain, for example, testimonies of both migrant workers and other stakeholders indicate that usually the sponsor gives consent for testing in lieu of the migrant worker concerned:

> "It is mandatory for the residence permit [that migrant workers take a medical test].
> Consent procedure: A form must be filled out by applicant and signed by sponsor, presented to reception and fees paid." (Government official, Bahrain)

This is comparable to the Republic of Korea:

> "We do not tell them in advance what items are included for their health examination and we do not ask for a written consent either. Because a health examination, including an HIV test, is required by every workplace and the items in the health examination are general and basic things, both, foreign workers and us do not much care about it." (Director of Instruction Team of Foreign Workforce Employment Assistance Unit in Human Resources Development Service of Korea, Republic of Korea)

Second, informed consent is largely regarded as solely the giving of a signature instead of an informed choice that is based on understanding what is being tested and the ramifications of the results. Many testing centres in the destination countries reviewed do not bother to verbally provide information about

the health test, and often the necessary documentation is not even translated into the mother tongue of migrant workers. As a result, there is little awareness of the possible consequences of a health test:

> "I don't know [what the paper is for] I don't understand, because I can't read the Thai language." (Cambodian migrant,Thailand)

Third, informal arrangements to overcome language barriers can interfere with consent. Japan, for example, is a destination country that actively recognises the rights of all individuals with regards to health testing for employment purposes. Yet, informed consent may be problematic due to language barriers. For example, when an employer accompanies a migrant worker to a testing centre under the pretence of providing translation, it puts the employee in a compromising position where refusal of a health test could potentially have grave and immediate consequences on the migrant's work contract.

Thus, even in countries where mandatory health testing is not embedded in policies, informed consent remains questionable, and policies that explicitly outlaw mandatory health testing are shown to be insufficient in the context of migration.

PRE-TEST AND POST-TEST COUNSELLING

> *In view of the serious nature of HIV testing and in order to maximise prevention and care, public health legislation should ensure, whenever possible, that pre-and post-test counselling be provided in all cases.* [5]
>
> *(UNAIDS & UNHCR, 2006)*

The tentative nature of this statement is contingent on the phrase 'wherever possible'. Yet all the origin countries discussed in this section recognise and confirm in their policies and laws the importance of pre-test and post-test counselling. The Filipino HIV/AIDS and Control Act emphasises that both these counselling services should be free of charge, while the Nepalese Policy for HIV Testing and Counselling states that

> "all testing should be accompanied by pre-test and post-test counselling and more specifically that the client should be informed of the result of testing only with post-test counselling."

Although many countries' policies make these assertions, the reality is different as neither pre-test nor post-test counselling is given as a common practice. Almost all migrant workers in the countries reviewed denied having received any counselling by the testing centres either regarding the health test or for the HIV test specifically. A notable exception is the HIPTEK testing centres in Indonesia, where mixed group sessions on pre-test counselling were conducted by a certified HIV-counsellor. Testimonies that confirm the provision of HIV/AIDS counselling in other countries are rare, however, and the practice of counselling seems to depend on the goodwill of individuals, rather then institutionalised state policies.

> "A gentleman (government STD clinic counsellor) gave me counselling for about 45 minutes before I was tested. When I came back for the results, the same person spoke to me for another half an hour. He gave me two addresses and names to go to." (Male migrant worker, Sri Lanka)

HIV counselling consists of two important elements. First, its goal is to provide information regarding HIV transmission, prevention of HIV and the meaning of the HIV test results. Second, it focuses on prevention-counselling by jointly identifying a client's unique circumstances, vulnerabilities and risks. (CDC, 2006)

Most countries do not include either pre-test or post-test counselling with their health tests for migrant workers, and the provision of general information on HIV or AIDS is often confused with counselling. A couple of factors explain the lack of counselling. First, testing centres face time constraints due to the large amount of migrant workers who come in each day. While few countries are willing or able to share the information on how many migrants are tested per month, estimates on the number of migrants testing at a single clinic ranges from 150 migrant workers tested per month in India to 100-150 migrants being screened each day in the Philippines. Second, counselling (either pre-test or post-test) is not considered a priority for the testing staff or the migrant workers:

> "Do you really think it is ever possible to give counselling to all these people who come for medical testing? When there is hardly any time to complete the test, is it really practical to waste more time on counselling?" (Female returnee migrant worker, Kerala, India)

The third factor that impedes pre-test and post-test counselling is the unfounded assumption that migrant workers already have adequate knowledge of HIV testing, and therefore do not need additional information. A Pakistani doctor, for example, held the opinion that migrant workers had sufficient access to information on HIV, and therefore felt that no counselling was necessary. Similar attitudes were found in other origin countries, where it was assumed that people would have all the knowledge on HIV they needed through newspapers, radio or television.

On the other hand, several countries displayed a condescending attitude towards the learning and understanding capacity of migrant workers:

> "'Highly educated people will easily understand pre-test counselling but those labour class people how would they know about all these tests? If something says that you have AIDS or syphilis or jaundice ….how would they understand? It is not possible." (Doctor in a GAMCA testing centre, Nepal)

The truth is that there is general misunderstanding or lack of knowledge regarding HIV evident among migrant workers, as demonstrated in interviews and focus group discussions. By not providing the opportunity to participate in pre-test and post-test counselling, migrant workers are being denied access to vital information that could address and dispel their existing misconceptions. This was expressed by a Nepalese migrant worker who stated that she wanted to ask so many questions about HIV, but did not know how to during the testing.

Fourth, training of medical staff in pre-test and post-test counselling issues is either deficient or non-existent. While staff in testing centres are adequately trained in the technical aspects of the testing

procedures, including taking blood, conducting the blood tests and reading the lab results, knowledge and skills on pre-test and post-test counselling are lacking. In India, this lack of training results in a certain embarrassment by doctors or other medical staff when discussing sexuality. Consequently, medical staff often blankly refuse to talk about these issues. In Cambodia, several cases have been documented where medical staff provided misleading and incorrect information on HIV, thereby contributing to misunderstandings on the transmission of the HIV virus:

> '"We explain them to not drink alcohol, to get enough sleep, to be careful with food and not to spread it to one another." (Health professional at public health centre, Cambodia)

> "The doctor said that AIDS was caused by cold, so I have to take care of myself if I am having diarrhoea, coughs or tuberculosis, because then this becomes AIDS. When I was asked to pick up the result, I was fine." (Male returnee migrant worker, Cambodia)

Medical staff of testing centres in some countries recognise their inability to provide appropriate counselling services, and rely on other organisations, institutions or programmes, such as NGOs, recruitment agencies or government-run pre-departure programmes for these services. When a clear understanding has been reached between the testing centres and the third partners, these arrangements function rather well. For example, pre-test counselling in the Philippines was conducted by the NGO Action for Health Initiatives (ACHIEVE), which conducts sessions on HIV and AIDS in the Pre-Departure and Orientation Seminar (PDOS), while in Pakistan it is the care and support NGOs that provide counselling services. However, when these understandings are assumed rather than set out in bilateral and monitored written agreements, there can be a negative effect on appropriate pre-test and post-test counselling services for migrant workers. In Sri Lanka for example, medical staff redirect their counselling responsibility to the recruitment agencies, which, in turn, do nothing.

Finally, adequate knowledge of testing centre staff on policies and laws regarding pre-test and post-test HIV counselling is lacking.

Findings from the destination countries were similar to those from the origin countries with regards to pre-test and post-test counselling. Contrary to international guidelines and contrary to the destination country's specific policies, if such policies even exist at all, pre-test and post-test counselling in general are not being practiced in relation to health testing for migrant workers:

> "Pre-test counselling is just unheard of in any medical clinic in the Gulf countries."
(Deported migrant worker, Kerala, India)

Japan seems to be an exception in regards to ensuring the provision of both pre-test and post-test counselling, as health and HIV policies in general seem to be enforced more rigidly. This could simply be explained by the absence of mandatory HIV testing for employment purposes though, as the voluntary counselling and testing centres take up testing responsibilities. Yet even though there is good enforcement in Japan's case, the quality of counselling for migrants is questionable. The emphasis of counselling provided is geared more towards providing general health information using written materials rather than identifying vulnerabilities and assessing risk behaviours of the individual through face to face counselling:

> " Well…we prepare all the documents needed for testing in their language. So, we make use of it. But a document can only inform fixed issues that are written in the document." (Staff of testing centre, Japan)

The lack of language skills or translation services available in destination countries severely complicates the ability of health officials to communicate with migrant workers. In this regard, Japan faces the same complications from language barriers that operate as an obstacle in the provision of adequate counselling in other destination countries. Yet there are solutions available, as illustrated by voluntary testing and counselling centres in Japan which mainly accommodate non-nationals.

> "As for the result…well… there are two staffs who tell the results. Each of them in a private room. Regardless of the result, we make it a form telling the result one to one in a private room.After all, this is a private matter. In the case of a person whose understanding is difficult if there is no interpreter, one week before, at the time we take the blood, we confirm if he/she wants or needs an interpreter or not. If necessary, we arrange the interpreters." (Staff of testing centre, Japan)

The GAMCA book on Rules and Regulations for Medical Examination does not mention language capacity as a prerequisite for quality health testing, indicating that information and counselling are not considered important. Even when there are opportunities to overcome language barriers in GCC states, they may be easily overlooked. For example, Bahrain recruits quite a few Indians and Filipinos as nurses or lab technicians, who are therefore potentially a great resource for bridging cultural and language difficulties. However, such workers do not occupy the positions which are involved in counselling. Thus, even though there are staff available that have the necessary language and cross-cultural skills, they are relegated to positions that exclude them from the possibility of assisting with communicating with their compatriots during the testing procedure.

Generally, migrant workers are unaware of the testing procedure itself, especially regarding which infections and viruses are being checked. Information received on testing and its consequences are largely provided by fellow-workers instead of by doctors or other health officials. In the Republic of Korea, stakeholders mention the utilisation of interpreter services at least for the Mongolian migrant workers in the country. However, the actual purpose of the interpretation services, whether it is to assist the migrants' understanding of the test, could be disputed depending which viewpoint is adopted: the stakeholder or the migrant worker concerned.

> "The basic language is of course Korean. If they cannot speak Korean, then we try to use English. But if they cannot speak English either, we use an interpretation service I believe is through the Ministry of Labour. Especially in the case of Mongolian people we cannot communicate with them in English at all, so the interpretation service is a big help." (Health worker at a testing centre, Republic of Korea)

> "There were female and male Mongolian interpreters, but I don't think they were for answering our questions or helping us understand, but [rather] for faster implementation [of the testing procedure]." (Male migrant worker from Mongolia, Republic of Korea)

When testing centres lack translation or counselling services in migrants' languages, there can also be an unexpected detrimental effect on migrants' health if HIV is not tested, such as in Thailand. As there is no mandate to provide translation services or explain the testing procedure, and there is no provision of materials about testing in the various languages spoken by migrant workers (Cambodian, Laos, and groups from Myanmar), nor are any guidelines provided to hospitals on the need to inform migrants of the

tests, hospitals are left to take the initiative on their own to provide translation and relevant information. Unfortunately, these efforts are minimal or else the responsibility is passed on to the employer. The result is that without proper information provided on the rationale for taking blood, many migrant workers wrongfully assume that HIV is being tested.

> "I always think of that. Are they testing for AIDS? If I get AIDS then people will gossip about me, and I will lose my job. I always worry about that. But no matter how afraid, we always have to do that, we have to get the test." (Female Burmese migrant, Thailand)

The same lack of information and/or counselling accounts for the many misconceptions regarding the compulsory medicines for intestinal worms that need to be taken by migrant workers from Cambodia and Laos and the indicator medication for filariasis (elephantiasis) for Burmese migrant workers. Since the need for the medicines is not explained at all, migrant workers have come up with their own explanations, with some secretly disposing of the medicine:

> "The medicine is to make our blood warm and makes the diseases in the body appear." (Burmese migrant, Thailand)

> "It is for testing diseases. I heard that if you take this medicine it is bad for you. It makes your blood go fast." (Cambodian migrant, Thailand)

In Malaysia, none of the migrant workers attested to having received either pre-test or post-test counselling. According to some Malaysian stakeholders, pre-test and post-test counselling should be included, however, at the same time, in case of a failed health test result, testing officials do not consider post-test counselling as their responsibility. Commonly, the responsibility of post-test counselling is redirected either to the hospital or clinic where a confirmatory test will be conducted, or back at the country of origin where the migrant worker will be deported:

> "There is some in-depth counselling which we usually give for our own people [Malaysian nationals]. We counsel them, we advise them what the next action should be. You know, go for a confirmatory test for follow-up action, come back and we counsel some more. We ask for contact details. In the case of foreign workers, we do not do that. Basically we ask them to go back and do the necessary action at home." (Representative from the Infectious Disease Department, Ministry of Health, Malaysia)

A number of factors limit the ability to provide proper counselling to migrants during the mandatory health and HIV testing process, including language barriers and time constraints related to the number of migrants tested at a time. Behind these conditions lie non-transparent policies that hamper effective monitoring, and a lack of training on HIV counselling for service providers. As a result, migrant workers are dependent on either individuals within testing centres, recruitment agencies, or organisations working on HIV and AIDS issues, for counselling.

Nevertheless, there should be no excuses for governments and health officials to disregard the rights of people in receiving adequate information and counselling which directly concerns their health. After all:

> "This is a serious matter. This is our health. We want to know."(Male migrant worker from the Philippines, Republic of Korea)

CONFIDENTIALITY OF HEALTH TESTING AND TEST RESULTS

'Laws, regulations and collective agreements should be enacted or reached so as to guarantee the following workplace rights: Confidentiality regarding all medical information, including HIV status.'

(Consolidated guidelines on HIV/AIDS and human rights, p.33)

All origin countries reviewed in this report have developed national laws and policies to protect the confidentiality of people taking HIV tests. These range from a draft National HIV/AIDS policy in Pakistan (2007) stating that HIV testing and counselling will be confidential, to the very detailed Filipino HIV/AIDS Prevention and Control Act (1998). The latter identifies all actors who have access to medical files and are held responsible for handling confidentiality of all medical information, as well as those handling any communication that directly or indirectly can lead to disclosure of information. It also identifies responsibilities for adaptation of policies and protocols.

In almost all countries, the full details of the worker's test results are usually sent directly to the recruitment agency, even though this is considered confidential information. In many countries, it is expected that the agency will then share the full test results with the migrant worker. Apart from breaking all measures of confidentiality, this practice also eliminates any possibility of post-test counselling, as previously noted, which is essential when an individual tests positive for HIV. Testing centres in the Philippines seemed well aware of the rights to confidentiality; however, they were still required to inform the agency if the migrant worker is fit, temporarily unfit, or permanently unfit.

> "The agency is the first to know that there is a problem with person. Now, either the agency will inform him that there is a problem, or if he has a contact number with us, we call him.We only say that the person is unfit, or temporarily unfit, for confirmation.You cannot disclose, because that will create discrimination." (Medical Technologist at a GAMCA Accredited Clinic, Philippines)

Unfortunately, few destination countries have developed standard protocols for handling test results, and migrants are often the last to know, or only find out that they have a condition rendering them unfit under the least desirable conditions. The worst case scenario of this is in countries where mandatory health testing is linked to entry visa or work permits and test results go directly to the Immigration Department of the government concerned. In most cases though, test results end up going directly to the employer or agency. For example, according to research conducted in the Hong Kong Special Administration Region of China, the majority of the test results are sent directly to the employer.

In other countries, test results pass through the recruitment agency to the employer. There are other less obvious breaches of confidentiality, such as in the Republic of Korea, Japan and Bahrain, where an individual who is presumably knowledgeable about the procedure accompanies the migrant worker. Although this can be comforting and reassuring to the migrant worker, it is problematic in regards to confidentiality and disclosure of the test results:

" Nowadays, testing centres offer an anonymous and privacy-protected test. But for a foreign testee, sometimes others enter the room as an interpreter. The attendant enters the room with the testee together

and informs the test result there. If the attendant is the employer and it leads to discharge of the testee after the testing, does that mean illegal practices of the testing centre?" (Lawyer, Japan)

In the context of health screening for employment purposes, it could be argued that a third party will always be bound to know the results of the health test, thus never fulfilling conditions of confidentiality and making "compulsory testing" a more appropriate term. However, there are different degrees in the severity of this breach of confidentiality. For instance, rather than simply informing the third parties of a migrant worker's status as being either fit, unfit or temporarily unfit, agencies and employers are usually informed of the migrant worker's specific health conditions. Even in cases where migrant workers are requested to personally pick up the test results (for example in Malaysia and Bahrain) they are obliged to hand over the test report to their employer, agent or sponsor.

One of the most systematic breaches of confidentiality is carried out by GAMCA. All GAMCA approved testing centres share a database in which the test results of migrant workers are kept. So, for instance, if an Indian migrant worker tests positive for HIV in Bahrain, that person's results will be visible to all testing centres in the GCC states as well as the GAMCA approved testing centres in origin countries, thus condemning that migrant as unfit and eliminating any future possibility of migrating for work anywhere in the GCC.

The data collected in other countries found that there are many cases of the individual's confidentiality being breached, often very publicly. In Bahrain, it was recorded that a migrant worker who went to collect his test results found them scattered over a table together with other test results, all identifiable by photos attached to the forms. In other cases, results have been announced in front of other people:

> "After lunch we all were waiting for the results. I waited for almost five hours. They called each one and said they passed their health tests. Then they called my name and said there is something wrong with my blood. They said I was HIV-positive. I was shocked to hear this. They said the results publicly in front of the others." (Male migrant worker, Tamil Nadu, India)

The ramifications of breaching confidentiality publicly may not only impact on a migrant worker's employment status; if this is at the workplace, the individual may then also suffer social stigmatisation. In Thailand for example, some workplaces publicly announce those who need confirmatory testing, leaving these people open to speculation that can lead to stigmatisation:

> "Everyone was pointing at us and gossiping that we did not pass the blood test. The workers all said it must be AIDS. That is normal for the factory. They will call out and tell you your blood is not clean." (Female Burmese migrant, Thailand)

Breaches of confidentiality, even if for the best intentions, can also have an impact on family life. In Indonesia and Cambodia, there are instances known where families of HIV positive migrant workers were informed by either the testing centres or by the recruitment agencies, without the acknowledgement or consent of the migrant worker. This is problematic as special caution needs to be taken with the handling of HIV positive test results in a migrant's home community, as the social repercussions can be extremely damaging and may expose that person to stigma and discrimination which could negatively affect their mental state and well-being. In terms of revealing a migrant or potential migrant's HIV status to family members, it is especially irresponsible to do so without providing proper counselling first.

At the present time, implementation of health testing in destination countries does not ensure that principles of confidentiality are adhered to, yet there are some hopeful signs. Japan, for instance, has seen a few law suits on behalf of individuals tested without their consent, or when test results were provided to third parties, and has resulted in a more rigid implementation of regulations.

GENDER, DIGNITY AND CULTURAL SENSITIVITY

Privacy during health testing is generally not observed in origin countries. One main reason for this is that migrant workers are usually sent to health centres in large groups by recruitment agencies. Because there are so many people to be tested, clinics want to be as productive as possible, often without regard for the dignity of the migrants undergoing the examination.

According to a Nepalese staff member from a testing centre, migrant workers obtain financial benefits with group testing:

> "Conducting a health has definitely benefits. Doing a health test individually is very expensive. Normal patients are not tested that way [in a group]. But because they [migrant workers] are going abroad for work, we have considered that. For normal patients testing is more expensive." (Staff of GAMCA accociated medical testing centre, Nepal)

Migrant workers, however, do not focus on these supposed financial benefits. As physical exams are usually undertaken in a group setting, where undressing in front of others is standard, most migrants experience shyness and embarrassment. In Vietnam, for example, migrant workers are even obliged to produce a urine sample in the presence of a doctor.

This embarrassment is further heightened in cases when a doctor of the opposite sex conducts the tests. Although health centres in most countries do have female staff, it is not necessarily standard practice that same sex staff examine migrant workers, nor are migrant workers offered the choice to be examined by someone from the same sex. Although group testing separates male and female migrant workers, societal, cultural and religious values regarding nudity, gender and sexuality are not taken into sufficient consideration regarding the gender appropriateness of health personnel. This was expressed by a Pakistani NGO official:

> "Gender is a big problem, because in some labs there is no female staff available. Male staff deals with female migrant workers who feel very uncomfortable due to the staff's questions, language and gestures."(NGO staff, Pakistan)

In Bahrain, state regulations strictly conform to society's gender sensitivity: male doctors conduct the health exam with male migrant workers, and female doctors with female migrant workers. According to the research, this was satisfactory among migrant workers. The problem was that a lack of cultural sensitivity was displayed in the testing centres. In the Hong Kong Special Administration of China, no specific considerations are displayed towards the cultural needs of migrant workers. It was recorded that even though one member of the staff could speak Indonesian (since the majority of migrant workers come from Indonesia), the Indonesian migrant workers had the feeling that they were being treated with less care either because of their status as domestic workers or because of their ethnicity.

REFERRAL

In the context of HIV prevention counselling and testing, referral is the process by which immediate clients' needs for care and supportive services are assessed and clients are provided with assistance in accessing appropriate services. This implies that testing centres should include undertaking any follow-up efforts necessary to facilitate initial contact with care and support service providers in the case of positive test results, as the test centres themselves are not expected to provide these types of services. Although national AIDS policies in origin countries acknowledge migrants' rights to treatment, care and support, specific policies or guidelines on referral are still lacking. The effects of this gap can be seen in the procedures of referral practices, where in testing centres of some countries, potential migrants who have failed their health test have been declared permanently unfit without being informed of their condition. Moreover, most testing centres do not feel that they have any obligations to provide referral services. For instance, a doctor in Indonesia declared that since the testing facility was not a social institution, it could not be held responsible for the follow-up process on ensuring that unfit migrants access relevant institutions or NGOs. In Pakistan, a medical doctor declared:

> "No we do not have a referral network. I think there is no need for a referral network. It is everyone's personal matter and they can go where they want for treatment and support. It is not our responsibility." (Staff at medical testing centre, Pakistan)

Another reason mentioned for the lack of referral by testing centres is the lack of cooperation from governments in facilitating such linkages, as centres often simply do not know where they can refer migrant workers. For example, HIPTEK testing centres in Indonesia have, on more than one occasion, requested the data of all testing centres in Indonesia, including the addresses for NGOs, clinics and hospital units that specialise in treatment and support for HIV infected persons. However, up to the present time, there has been no response from the Ministry of Health. In Cambodia, one testing centre did refer HIV positive migrant workers to a care and support NGO; however, this seemed to be more coincidental than something systematically supported, implemented and monitored by the government.

> "They get more counselling and the staff tells them to prepare their life and how to live with HIV (…) We explain them to go there, because NGOs have good monitoring and good documentation, if the patient is not well they have a good follow-up free of charge." (Government official, Russian hospital, Phnom Penh, Cambodia)

As there is no formal referral process set up between testing centres and care and support organisations or specialised hospitals and clinics, there is no official follow-up with those people who do not pass their health test, which is of special concern for those with HIV and/or TB. This is most pronounced when the condition was found through testing at the destination country, and at most, migrant workers are advised to seek treatment, support and care in the country of origin.

Being deported from a destination country due to a failed health test is even worse. Testing centres in destination countries do not consider the health of a migrant worker their concern once that person has left the country. Since bilateral agreements between origin and destination countries do not address health-related issues, nor do they mention the issues of health testing, the migrant worker is left to face the consequences alone.

STRATEGIES FOR COPING WITH MANDATORY HEALTH TESTS

A combination of push and pull factors influence individuals' decisions to leave the country of origin behind and move to another country and culture. In the case of low-skilled and semi-skilled individuals who make up the majority of the workforce for the so-called 3-D jobs (work that is regarded as dirty, dangerous and demanding), these factors are of an economic and familial nature. In other words, these migrants are not just responsible for themselves but also for their extended family, and it is often the family that is the underlying drive for individuals to enter the migration cycle. Potential migrants do not want to fail them. Health testing forms one of the most important steps in the process of migration. Since failure of a health test shatters all dreams of regular migration and migrant workers realise that failing their health tests would result in the denial of a work permit, they may adopt strategies for trying to cover up real or imagined health concerns.

A host of strategies are shared between such workers, to make sure the health test is passed. They include drinking milk in order to cover up TB scars in Nepal; eating before testing so no disease can be detected; and drinking soy sauce to darken the x-ray in Cambodia. Some people drink beer so diseases will not be detected, others eat salt to hide amphetamines in urine. Others dilute their urine with water, simply because they are unable to urinate at the time. The concern is that as test conditions become more restrictive and migrants remain desperate to work abroad, these strategies may eventually move from being innocent to actually endangering migrants' health.

ACCESS TO TREATMENT AND SUPPORT

As long as they are in the origin countries, prospective and returned migrant workers fall under the same policies and laws as their fellow nationals regarding access to treatment and support. It is while they are in destination countries that migrant workers find that they are being discriminated against, as destination countries do not take any action on behalf of HIV infected migrant workers. There are no amnesty procedures for HIV infected people in place and no destination country legally recognises the specific needs of HIV infected migrant workers. There are no specific clauses within guidelines for ARV provision for either documented or undocumented migrant workers. In Bahrain, ARV is only available to its nationals supposedly due to the costs of the treatment. Even Thailand finds the costs of providing ART to migrants prohibitive at this point in time.

On the other hand, regarding treatment and support for migrants with infections and diseases other than HIV and AIDS, Thailand probably has the most lenient policies. Treatment is provided for workers who are detected with conditions that are still at a treatable level, and are put on probation until the doctor gives approval for them to resume work. Even those who fail their health exam for advanced conditions will receive some treatment even though they will not be given a work permit.

> "One of our friends got TB and the employer asked her to take a rest for one month. She took medicine and has to go to the hospital three more times. She has to get another test. When the hospital gives approval she can get her job back." (Female migrant from Burma, in Thailand)

In Bahrain, in cases of non-communicable diseases which are grounds for deportation, migrant workers will be referred to hospitals and clinics. However, depending upon the sponsor, employer or the company's policy, the costs of treatment might be borne by migrant workers themselves. With only a few having health insurance, combined with the fear of being found unfit and facing deportation, only a few migrant workers are willing to seek treatment on their own behalf.

Since there is no proper regulation on treatment in case of illness under terms of work for migrants, it largely depends on the goodwill of the employer whether a migrant worker receives care. A woman in Malaysia stated that her employer took her to the hospital once every three months and she received excellent care for her high blood pressure. However, this seems to be an anomaly, as other migrants in Malaysia have reported receiving 'treatment' that consisted of painkillers and vitamins.

In Hong Kong Special Administrative Region of China, about one third of the migrant workers believed their employers would at least consider a re-test in case of a failed health test, while in reality only 8% of the employers polled said that they would consider doing so; the majority of employers reported that they would opt for immediate deportation instead.

DEPORTATION

'Public health legislation should ensure
that people not be subjected to coercive measures such as isolation,
detention or quarantine on the basis of their HIV status.'

(Consolidated guidelines on HIV/AIDS and human rights, p.27)

In destination countries where medical testing is linked to the Immigration Department, such as Bahrain, the Republic of Korea and Malaysia, migrant workers face immediate deportation when testing positive for HIV, hepatitis or TB. Bahrain has particularly stringent rules: migrant workers are declared unfit and immediately deported when HIV or AIDS, hepatitis B, malaria, leprosy, tuberculosis or an STI is detected. If migrants are infected with TB, the patient is provided basic treatment for a period of two weeks and then deported. In the Republic of Korea and Malaysia, comparable rules are employed, even if they are rather arbitrary:

> "Mostly, initial diagnoses are found to be wrong. But if confirmed to be HIV positive, agents from the Immigration Bureau in the Ministry of Justice and a local health centre visit the centre, take the HIV positive person to a temporary shelter and deport the person within a week.(…) In addition to HIV/AIDS, tuberculosis and certain STIs, including syphilis, are also subject to the same deportation policy." (Official from the Human Resources Development Service of Korea, Republic of Korea)

> "We do short test VDRL [veneral disease research laboratory test for syphilis], then we do hepatitis. VDRL is actually reactive you know. We give them medication and tell them [migrant workers] to appeal. But sometimes, FOMEMA says no, and sends them back. It is up to the discretion of FOMEMA." (Doctor with a panel clinic of FOMEMA, Malaysia)

Studies have shown that mandatory testing as well as policies designed to deny entry or deport non-nationals are counterproductive to halt the spread of HIV or STIs. Irregardless, many destination countries require migrant workers to undergo annual health testing as a preventative measure. Having more experience with health tests (even when they may not know what they are tested for) migrants are generally well aware of the consequences of a failed health test: deportation to their home country. Under such circumstances if a migrant knows or suspects that they may have an exclusionary condition, a migrant will make efforts to hide his or her health status and to avoid contact with the health authorities. In Bahrain and the Republic of Korea, it is known that people choose to become undocumented in order to avoid health tests. This has profound consequences, as undocumented migrants are often out of reach of the health care system. In addition, undocumented migrants usually end up in even more deplorable working conditions, potentially exacerbating their health condition and leaving them vulnerable to exploitation and abuse.

> " If a foreigner knows that he will be deported, then he will just disappear.That is even more dangerous." (NGO representative, Republic of Korea)

> "And what happens [if they fail their medical test] they sometimes escape and we do not know where the man is.They are going to stay here illegally". (Medical doctor (GP) and a migrant, in Bahrain)

Not only are these measures ineffective, deportation of HIV infected individuals is often accompanied by flagrant human rights violations, marked by the lack of due process of law, discrimination and disregard of confidentiality. Nowhere is that more evident than in these migrants' accounts of being deported:

> "While working in [the Republic of] Korea, I developed some ulcer and had to get a medical test done.At this test I think they discovered my HIV. I did not know that I had HIV.A few days later some Korean people came to my cabin.They verified my name and asked me to pack my belongings. I asked them why.They told me not to ask questions. I was then put into a vehicle and handcuffed. I demanded and wanted to know why.Then one man shouted in Korean and in English:' Shut up, we are deporting you now'. They took me to the Immigration Office and one Korean said something in a loud voice. I knew he said I have AIDS. I asked for some water.They refused. Later I asked them to go to the toilet. They refused. All this while I was handcuffed. All of this took about seven hours. They embarrassed me so much. I felt like I was a convict for no reason.The only thing was that it was all in front of their people. But my friends saw them handcuffing me. That was my biggest fear and embarrassment. I was very worried because my friends saw everything and also a relative was working with me. I was very disturbed and did not know how to face my family.Anyway, I told them I fell ill and that is why I had to come home. Until this date nobody in my family knows about my illness." (Deported migrant worker from Sri Lanka)

> "No reason was given.The whole process finished in five days. I spent those five days in jail and then I was taken directly to the airport. No chance was given to talk to anyone or even to take my luggage." (Pakistani migrant worker in one of the GCC States)

In some destination countries, although there is no direct linkage between immigration and testing centres, an unfit result either leaves migrants at the mercy of their employer or in limbo. In Thailand for example, migrant workers who are fired as a result of a failed health test lose their employment status and are therefore vulnerable to arrest and consequently deportation. An NGO in Hong Kong, SAR of China testified that employers have the right to send the migrant worker who is declared unfit back to the country of origin immediately and without compensation.

If you are unfit, for example because of hepatitis or any kind of diseases, meningitis, jaundice, TB, cancer, AIDS, if detected you are deported. Sometimes immediately deported. For example we had a food & beverage girl from the Philippines. She had hepatitis. It is a disease that is infectious and transmittable. So the hotel got her room checked and got all her roommates vaccinated.The government of UAE said cancel her visa and send her back immediately. It is contagious if you take a glass of water from the same person, if you spit. So we vaccinated the closest persons only. No need to vaccinate the others. That is why she is immediately deported. Actually she should have tested before coming to Dubai in her country. But it is not a rule in Dubai.They ask only upon arrival.They should actually test before coming. After 3 days we sent her back. Because it takes time to cancel the visa. But she was stopped coming to work from the next day. The HR people told her. No, they don't give her the result. Never. No matter what the disease is, that is also in the good interest of the girl. Other staff also did not know. I was with her and she was literally wrecked. She hugged me and cried and I cried too.The poor girl (sad nod). She was a very good worker and very joyous and very happy to work in our hotel. She liked working here. The poor girl had no idea what the disease is. She was doubting it was something very dreadful of course to send her back like this. I know because I am near the inside management. We knew but she didn't. It is for her interest we did not tell her till end. I felt so bad. The hotel gave her ticket and salary dues also and we told her if she is cured back home she can come again and join work in the hotel. No, the treatment back home she has to bear herself. She resigned from her job. So we can't give her treatment. Yes, the Philippines embassy was informed. They have to be informed. No, nobody came. They did not help at all. They can't help, it is the Dubai rule. Embassies can't do anything. The Philippine embassy is good and takes good care of its people. So if they can't help, no one can. Here in Dubai everything is good. But the law is very strict.You have to swim with the current. If you swim against it you will drown.You can't tell them to give the result or to give information. It is not the rule. Here you can't argue or ask anything opposed to the rules.You must follow rule. All the staff were very caring and loving and they took money and gave her gifts, dinner out and she left in a happy mood. (Secretary to GM, Hotel, Dubai)

IMPACT OF RESULTS

As mentioned, those who decide to go abroad as a migrant worker in unskilled jobs often do so in order to sustain their families or for the family to have better future prospects. Prospective migrant workers are the hope of whole families, as they will provide the means to buy food, build a house, and send children to school. As this is an investment for these people, a considerable amount of money is needed to apply for a better paying job abroad. In anticipation of great returns, often land or property is sold, or money is borrowed from family, friends, sponsors or agents, the latter charging steep interest rates. Thus, failing a health test has severe financial consequences for the individual and his or her family:

> "See we have to spend money to come here…So it's lost then. There are men, they borrow money from people [to go abroad and work] so how will they get it back? Maybe they are begging by now." (Male Bengali migrant worker, Bahrain)

> "When a person goes to Malaysia, he has to spend around one Lakh to one and a half Lakh, whereas a person going to countries like Japan and Korea spends around four to five Lakhs. Depending on the destination country, the person bears financial risks. When the person returns back within one or two months his entire money gets wasted. Most of the people take a loan or sell their land to be able to work abroad. When he returns early it becomes difficult to pay back their debts." (Health official, India)

> "Some people put their land for sale and then they want money because they want to go to Bahrain or whatever and then they go back and don't have their land. No house, nothing." (Filipina domestic worker)

> "There is nothing they can do but die if they go back to Thailand.They already spent a lot of money to come to Korea so they don't have much. It is also very hard to tell the fact that they are infected with HIV." (Thai migrant worker in the Republic of Korea)

People who fail their health test in the origin country are confronted with a certain financial loss, as well as the emotional distress of finding out they have a serious health condition. Then they must also face the disappointment of family and community. When a migrant fails a health test in the destination country, however, the financial losses are even greater as they also must pay the costs of air travel. But, it is the humiliation or sense of helplessness they must face before their family that perhaps hurts the most.

> 'The person who has gone for foreign employment will come back and his or her family status will improve. But in contrast, when a person returns empty-handed, the family perspective towards this person changes and the trust level decreases." (Male returnee migrant worker and staff of Trade Union, Nepal)

> "As soon as I reached Bombay, I tore away all my documents including my passport. I didn't want anyone to see that I was 'deported'. I couldn't bear that stamp on my passport. One good thing was that my sponsor had passed on some money for me through the policemen. It was this money that helped me for the bus fare home." (Deported migrant worker, Kerala, India)

While the international donor, scientific and NGO communities consider factors of vulnerability in HIV infection, rather than focusing on "risk behaviours," traditional communities in many countries regard HIV as a punishment for one's own promiscuity. In cultures that value marital fidelity and virginity highly, while the discussion of issues of sexuality remains taboo, a migrant worker who is declared unfit and deported because of a HIV positive test often experiences a double stigma:

> "But this man actually who came here with this amount of money and is declared unfit here [because of HIV], he is, I mean he is a dead person in his country. In can say this, I saw so many people like this." (Doctor at a private health centre, Bahrain)

CONCLUDING THOUGHTS

If a migrant is responsible for the well-being of his/her whole family, his/her own well-being often becomes negligible and secondary to the goal of providing money. Only when confronted with an unexpected health condition does a migrant or potential migrant become aware that health is priceless.

Unfortunately, although health is a public good and migrants contribute greatly to the economies of destination countries, bilateral agreements between origin and destination countries fail to address health-related issues of migrant workers and generally disregard human rights standards. Nowhere is this more obvious than in the double standards used regarding HIV testing. When mandatory or compulsory testing is conducted for employment purposes among migrants or potential migrants, a separate set of standards are used apart from those established and available to the rest of the country's citizens, even when in their country of origin. General standards of consent, pre-test and post-test counselling, confidentiality, referral and treatment are disregarded for the sake of convenience on the part of the implementers, with the interests of third parties such as the Ministries of Health and Immigration, recruitment agencies and private for-profit health centres taking priority over migrants' needs. In the end, it becomes clear that the standards used in mandatory testing for migrant workers generally disregard all the rights that have been established as best practices in voluntary heath testing, and reduce migrant workers to expendable units of production.

References

1 International Guidelines on HIVAIDS and Human Rights 2006 Consolidated Version. Geneva. UNAIDS and OHCHR.

2 Khoja, T.A. (ed.) (2005), Rules and Regulations for Medical Examination of Expatriates for Work in Cooperation Council States. Saudi Arabia: King Fhad National Library.

3 See Article 2 of the International Covenant on Civil and Political Rights. See also Article 26 of the International Covenant on Civil and Political Rights, which enshrines customary principle of non-discrimination without limiting to the rights set forth in the Covenant in: UNAIDS/IOM Statement on HIV/AIDS-related travel restrictions (2004)

4 Centre for Disease Control and Prevention (CDC), 2006, Revised guidelines for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. Vol. 55, No RR14;1

5 International Guidelines on HIVAIDS and Human Rights 2006 Consolidated Version. Geneva. UNAIDS and OHCHR.

C

RECOMMENDATIONS

Migrant workers
often signing consent
without understanding
testing procedures

CHAPTER SIX:

RECOMMENDATIONS

MIGRANT-FRIENDLY TESTING

Mandatory medical testing is now being used to restrict the movement of migrant workers in the name of public health. The very idea of required testing connotes and reinforces the judgment that migrant workers are carriers of disease and are vectors for the spread of infections like HIV. Under this paradigm, current mandatory medical testing practices are conducted without respect for the rights of migrant workers and are punitive by nature, since failing the tests leads to loss of the right to travel to or stay in a destination country and thus denies them the right to employment.

Although CARAM Asia does not, in any way, support mandatory testing of migrant workers, the reality is that there is currently no political will to abolish testing requirements, which widely includes HIV. As such, CARAM proposes a more humane manner of conducting medical tests among migrant workers: a "migrant-friendly" medical testing that assures the protection of the rights of migrant workers and ensures that their health and well-being is safeguarded.

This framework for "migrant-friendly testing" is characterised as being based on the principles of *non-discrimination*; is *responsive to the contexts of migrants*; and is *conducted in an enabling environment* that provides migrants the ability to make choices that support their health and well-being. In addition and ideally, CARAM believes that, in line with UNAIDS guidelines, testing of migrants should be accompanied by full access to antiretroviral therapy for those who are found to be HIV positive.

The principle of **non-discrimination** stipulates that migrants are treated in the same way as the general public under prevailing laws and policies regarding HIV testing, and are treated as human beings with full exercise of their human rights no matter which country they are in. Under the context of medical testing, this principle can be manifested in the following conditions:

Informed consent

Full informed consent is obtained from the migrant worker being tested. This means that all information about the health test is communicated to migrants in a way that they understand, considering language and literacy before providing formal consent. Information includes: the process of testing, the risks and benefits of health testing, consequences and implications of the results, and the treatment services available. Other elements of informed consent include how the test results will be communicated and the opportunity for the migrant to ask questions.

Pre-test and post-test counselling

In the conduct of HIV testing, proper pre-test and post-test counselling is provided in a way that migrants understand, taking into consideration their language and literacy level. Pre-test counselling includes basic information regarding HIV transmission, prevention, and the specific vulnerability of migrant workers; the process of testing, and the meaning of HIV test results.

Post-test counselling is provided individually to all migrant workers, regardless of their HIV test result, or at least to all HIV positive results. Post-test counselling for migrant workers with HIV positive test results is aimed at encouraging positive, healthy lifestyles, and providing information on available support services and treatment options. For migrant workers with negative HIV test results, counselling is directed at promoting safer lifestyles to prevent HIV infection, and can be given in a group setting if necessary.

Confirmatory tests

Government Health Institutions, in the form of centralised reference laboratories, have a mechanism for ensuring verification of all test results that render migrant workers unfit to work. Confirmation of test results is free of charge.

Confidentiality of test results

Full details of test results are given directly and only to the migrant worker on an individual basis, especially for an “unfit” result. An option of having a translator during disclosure of results is available with the assurance that confidentiality is observed by all involved. In the current reality where third parties are also provided with such results, these parties are not provided details on the condition found, but only the determination of whether the individual is fit, temporarily unfit or unfit.

Referral systems for treatment, care and support

Health testing is only ethically acceptable in a context where treatment, care and support are available in all stages of migration. Proper referral systems need to be in place at all testing centres to provide migrants with access to treatment, care and support. This requires facilitating contact with service providers and follow-up efforts to ensure migrant workers’ welfare.

Making medical testing *responsive to the contexts of migrant workers* means that there is acknowledgement of the unique situations migrants face, and that assistance is provided to counteract their vulnerable social position, which is most pronounced when they travel outside their home countries for work. This means fulfilling the following:

Financial and Geographical Accessibility

The location of testing centres in both origin and destination countries is decentralised to allow easier access for migrant workers whose residence or place of work are in geographically remote areas. This minimises transportation and other related costs that migrant workers would otherwise incur if testing centres are all located in the capital.

Testing fees, like all information pertaining to the medical testing process, are presented in a transparent manner to avoid unscrupulous practices by medical testing personnel. This implies a sound monitoring system and an accessible mechanism for redress by relevant regulatory bodies.

In cases where a migrant worker is found "unfit" to work, especially in the destination countries, repatriation costs are provided by employers or sponsors. Upon return to their home countries, repatriated migrant workers receive support or assistance from the Government to ease their reintegration.

Language

Stakeholders involved in the mandatory medical tests are required to explain the process of medical testing to migrant workers in a way that they can understand, considering language and literacy levels. This language requirement is also observed in the provision of counselling services, delivery or disclosure of results and in referring migrant workers to service providers. Although this is particularly important in destination countries where migrant workers may not speak the language of the nationals, the situation in origin countries may also require sensitivity to the language used by migrant workers in relation to ethnicity and terminology. If specific language capacity is not available among the staff of a testing centre, services of skilled independent translators are utilised.

Gender and Cultural Sensitivity

Medical testing centres observe proper gender matching by employing the services of female doctors to conduct examinations for female migrant workers, and male doctors for male migrant workers. In situations where there is a lack of female doctors, other female health personnel – midwives, nurses or others – are present during the course of the examination of female migrant workers.

There is a need to review the requirement of a physical examination that requires migrant workers to fully undress. If this is deemed necessary for medical purposes, then it is conducted with full explanation of every step of the examination process.

Sensitive examination procedures, including those involving the prostate, breast, pelvic or rectal areas, are fully explained to the migrant workers prior to the onset of the whole medical testing process. Such examinations are conducted with respect to privacy and cultural sensitivity.

Medical testing facilities respond to the needs of male and female migrant workers by having separate and sanitary restrooms or toilets, and separate cubicles for physical examinations and the like.

The ultimate goal of creating **an enabling environment for migrants** to access migrant-friendly testing is to ensure that migrants are able to make informed decisions in all matters pertaining to their health and well-being. As such, there is a need to formulate principles and strategies across the range of issues relating to medical testing for migrants. The following points need to be taken into account.

Policy

Medical testing for migrant workers is conducted in a manner that respects and protects their right to health, particularly, the right to information, privacy, bodily integrity and access to health care services. This can be realised if appropriate and sound policies are in place and are properly implemented in both sending and receiving countries. Such policies need to reflect the provisions enshrined in international conventions that promote and protect migrants' rights, such as the Migrant Workers Convention. Furthermore, strict and regular monitoring of the implementation of these policies needs to be set up by Governments, with participation from civil society and migrants' communities.

Health Education

Health education is institutionalised and implemented to improve the health-seeking behaviour of people and to enhance their awareness of their rights as individuals, as migrants and as patients. This way, migrants will be able to proactively seek health-related information and services.

Accessibility

Government-accredited medical testing facilities are accessible to migrants, geographically and financially, and without monopoly. Migrant workers are able to choose the most convenient testing facility s/he can access, without prejudice to quality medical testing facilities and procedures.

Medical testing should not be used simply as a screening mechanism to decide who can work and who cannot. Medical testing is foremost a process to prevent the occurrence of illness; and it is a gateway to access healthcare services, specifically treatment and care. More than a screening process, medical testing should be aimed at benefiting the health and well-being of migrant workers because they have a right to be healthy and they have a right to work productively.

CARAM Asia hereby initiates the campaign **'Migrant-friendly testing in all countries by 2010'** to invite governments to cooperate in developing and implementing migrant-friendly testing.

ACTIONS FOR GOVERNMENTS IN ORIGIN AND DESTINATION COUNTRIES:

- Ratify the UN Migrant Workers Convention.

- Specifically address the health rights of migrant workers through bilateral agreements and MoUs negotiated between origin and destination countries, to include migrant workers' rights with regards to health testing, access to treatment and inclusion under insurance policies. It is urged that bilateral agreements and MoUs specifically define the elements of migrant-friendly health testing in the content of these agreements

- Institute specific laws and policies that are in accordance with the principles of migrant-friendly testing and that explicitly mandate the inclusion of informed consent, confidentiality of testing and test results, pre-test and post-test counselling and a proper referral system as components of health testing for migrants.

- Institute an independent monitoring system that establishes standards and regularly monitors both government and private facilities in their implementation of informed consent, pre-test and post-test counselling, gender and cultural sensitive health staff, confidentiality of test results and a functioning referral system for all migrant workers.

- Decentralise high-quality health testing centres or develop support packages in order to reduce the additional costs that migrant workers pay for transportation and accommodation when seeking health testing for employment abroad, and provide compensation for lost wages for time spent testing in destination countries.

- (for Governments of origin countries) Unite in order to affect changes in the policies and practices of labour recruitment that will benefit and protect migrant workers' rights and health.

- (for Governments of origin countries) Fulfil the inherent responsibility to protect their nationals as human beings, rather than consider migrant workers as purely economic units. This can be done by negotiating for the rights of their migrant workers with destination countries.

- (for Governments of destination countries) Discard HIV status as an exclusionary condition, and cease and desist in the practice of forcibly deporting HIV positive migrants to prevent the further stigmatisation and marginalisation of migrant workers living with HIV.

ACTIONS FOR HEALTH TESTING FACILITIES:

- Strictly enforce confidentiality of test results by not giving out any details on the exact results of the health tests to third parties such as recruitment agencies, employers and others.

- Adhere strictly to the practice of informed consent where a person learns the key facts about the health test, including its risks and benefits, its consequences and implications before deciding whether or not to participate.

- Integrate pre-test and post-test counselling that includes information regarding HIV transmission, prevention of HIV and the meaning of the HIV test results, as well as prevention-counselling by jointly identifying a client's unique circumstances, vulnerabilities and risks when migrant workers have to undergo a HIV test.

- Ensure that pre-test and post-test counselling for migrant workers is provided in a language the migrant worker can understand, and in a cultural and gender-sensitive manner.

- Establish a policy on the provision of post-test counselling for every migrant worker on an individual basis, regardless of their HIV test result. In the meantime, immediately initiate the provision of individual post-test counselling for all HIV positive results in a way that does not stigmatise the individual, and initiate provision of post-test counselling in group settings for those with HIV negative results until health test providers are able to provide post-test counselling individually to every migrant.

- Provide independent translation services when needed or requested by migrant workers.

- Obtain the necessary information (for example, a list of addresses) for referral of migrant workers to treatment, care and support services.

- Ensure that health staff are continuously trained on gender and cultural sensitivity.

- Ensure that both male and female doctors are available and that migrant workers are presented with a choice of either a male or female doctor.

- Make available separate restrooms and separate cubicles for physical examinations.

- Abolish all unnecessary health testing and related practices that are not required standards, such as providing women with Depro-Vera injections or full-naked body-checks.

- Conduct confirmatory tests free of charge, with a new blood sample by an independent hospital.

ACTIONS FOR THE PRIVATE SECTOR:

- Broaden GAMCA's well-established monitoring system on the technical quality aspects of health testing both in origin and destination countries by introducing an equally strict monitoring of the principles of informed consent, pre-test and post-test counselling, the confidentiality of test results, and a proper functioning referral system.

- Specify and standardise the costs for health testing, along with stipulations of costs potentially forfeited or borne by the migrant in the case of an unfit result, in a fully consistent and transparent manner.

- Ensure recruitment agencies provide a full list of the costs involved when a migrant worker applies for work abroad.

ACTIONS FOR EMBASSIES:

- Provide assistance for migrant workers who get repatriated due to health conditions, including providing direct referral to health facilities and treatment in the country of origin.

- Ensure embassy staff are versed in the related migration policies of the destination country and receive sensitivity training on issues of health, especially regarding STIs, HIV and AIDS. In this way, they will be able to assist their countrymen and women with proper health referral and can assist in dignified repatriation.

ACTIONS FOR NGOS AND CBOS:

- Work on sensitising third parties such as employers and recruitment agencies about migrant-friendly testing, and advocate appropriately for changes in current testing standards.

- Challenge stigma and discrimination (including in the media) against migrant workers and advocate for the protection, respect and fulfilment of their health rights with regards to health testing through policy and legal reform.

- Support associations or informal groups of migrant workers and assist them with integrating HIV awareness and related policies into their work.

- Establish culturally and linguistically appropriate HIV outreach programmes targeting both documented and documented migrant workers that can also assist with referral to related health services.

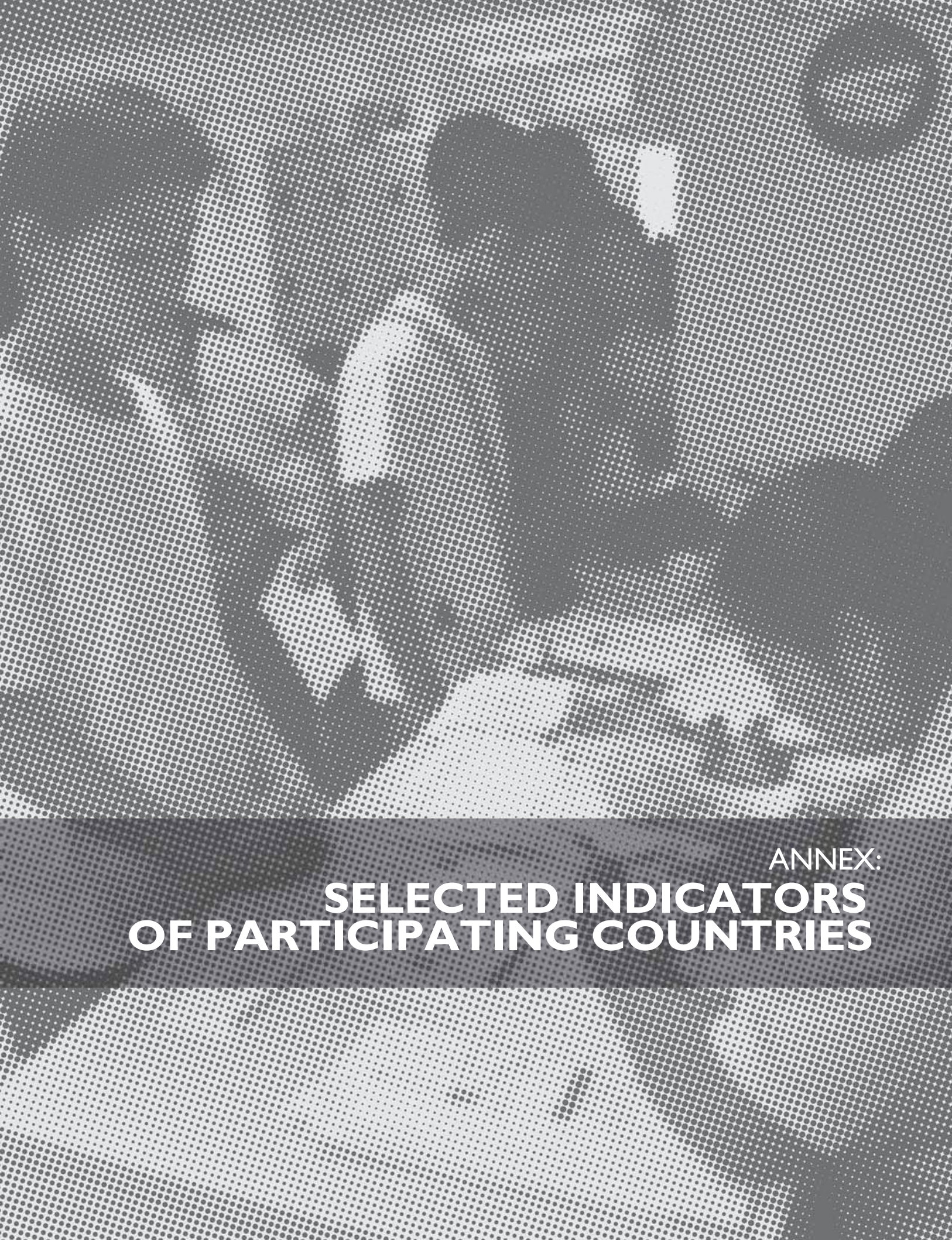
ACTIONS FOR INTERNATIONAL PARTNERS:

- Implement the framework for migrant-friendly testing, which needs to be firmly rooted in bilateral, regional and multilateral mechanisms, in terms of both formal and informal cooperation.

- Ensure meaningful participation of migrant workers in international forums on health testing and HIV issues.

- Stimulate both quantitative and qualitative research on health testing and its effects on the well-being of migrant workers.

- Increase and maintain awareness on issues of migration and HIV, and promote the rights of migrants through formal campaigns, multilateral conferences that bring migrants and policy makers together, and by stimulating donors to support related activities.



ANNEX: SELECTED INDICATORS OF PARTICIPATING COUNTRIES

Demographic, Social, Health and Economic Indicators

Country	Total population (millions) 2005	Avg. 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 expenditures, public (% of GDP)	External population assistance (US$,000)	Access to improved drinking water sources
ORIGIN COUNTRY										
Bangladesh	147.1	1.8	63.7/65.6	380	50	13	2,090	1.1	71,347	74
Cambodia	14.6	2.0	54.2/61.1	450	88	32	2,490	2.1	36,508	41
India	1,135.60	1.4	63.0/66.5	540	60	43	3,460	1.2	99,173	86
Indonesia	228.1	1.1	66.7/70.2	230	35	66	3,720	1.1	52,100	77
Nepal	28.2	1.9	62.8/63.9	740	56	11	1,530	1.5	26,296	90
Pakistan	164.6	2.1	64.4/64.7	500	71	23	2,350	0.7	39,983	91
Philippines	85.9	1.6	69.1/73.4	200	24	60	5,300	1.4	43,596	85
Sri Lanka	21.1	0.8	72.4/77.7	92	15	97	4,520	1.6	14,038	79
Vietnam	86.4	1.3	69.8/73.7	130	26	85	3,010	1.5	31,873	85
DESTINATION COUNTRY										
Hong Kong, SAR of China	7.2	1.0	79.2/85.1		4	100	34,670			
Japan	128.3	0.1	79.1/86.3	10	3	100	31,410	6.4	442,186	100
Republic of Korea	48.1	0.3	74.4/81.8	20	3	100	21,850	2.8		92
Bahrain	751		73.8/76.6	28	12	98	21,290			
United Arab Emirates	4.8	2.3	77.3/82.0	54	8	100		2.5	4	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'.

Purchasing power parity is often called ***absolute*** **purchasing power parity** to distinguish it from a related theory ***relative*** **purchasing power parity**, which predicts the relationship between the two countries' relative inflation rates and the change in the exchange rate of their currencies

External Population Assistance is Overseas Development AID pledged by Developed countries

Migration and Migrant Workers' Indicators

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Insurance for MWs
SENDING COUNTRY						
Bangladesh	Total: **377,591** (2006) January – May 2007: **265,590** *Source: Bureau of Manpower, Employment and Training (BMET)*	Not Available	Officially and unofficially said to be equal to the documented MWs *Source: Estimation BMET*	Remittance (Million): 2006: **USD 5,485.98 Million** Jan-May 2007 **USD 1500.16 Million** *Source: Bangladesh Bank*	Not Available	No
Cambodia	1998 - April 2007: **8,969** Cambodian MWs to Malaysia. Female: **7,042** FDWs: **4,349**	Not available	Undocumented Cambodian MWs in Thailand (2006): **180,000** Registered: **37,142**	Income from female MWs sent to Malaysia: **USD 1,300,000** Income from MWs sent to Republic of Korea: **USD 8,150,000**	Not Available	No
India	**4,74,960** (2004) *Source: 6th report of the Ministry of External Affairs (2004-2005)*	Not Available	Same as documented.	**USD 18,885** Millions (2003-2004) *Source: 6th report of the Ministry of External Affairs (2004-2005)*	Not Available	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.

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Insurance for MWs
Indonesia	Government projection for 2007: **1,000,000** *Source: Jumhur Hidayat t[1], Chairperson of BNP2TKI.* Feb : 52,876 (Asia: 24,041; Middle East: 28,835) Male : 12,238 Female : 40,638 *Source: Processed from Data of the Ministry of Manpower in tki.or.id, updated April 2007.* Total 2006: **680,000** Male: 138,292 (20%) Female: 541,708 (80%)	Reintegrating (through Soekarno Hatta Airport): 2006 : 3**23,585** *Source: Jumhur Hidayat, Chairperson of BNP2TKI.* Deported (estimates): **12,000** from Malaysia (Until April 2007) *Source: http://www.suarakarya-online.com/news.html?id=174829* **2,868** from Singapore (2007) *Source: Jurnalnet.com, 25 May 2007, Migrant Care's Statement on Deportation*	2007: **40,000** in Saudi Arabia *Source: http://www.suarakarya-online.com/news.html?id=174829*	Remittances 2006 : **USD 4.4 Billion** Source: Ministry of Manpower **IDR 5,560,250,451** (8.9 IDR = 1 USD) *Source: Indonesian Bank*	N/A - Depends on the destination country - Based on Decree of General Director of TAX NO KEP - 38/PJ./2001, MWs are excluded from the obligation to pay foreign Fiscal (income tax for peoples who want to go abroad)	**IDR 400,000** (40 USD) per MW collected by insurance companies. <u>Compensation:</u> Pass away due to accident IDR 20,000,000 & due to illness IDR 10,000,000. Total/certain part permanent deformity due to accident IDR 20,000,000 Medical cost due to accident IDR 2,000,000 Medical cost due to illness since the placement phase IDR 20,000,000[2]
Nepal	Total: **177,506** *Source: Department of Labour, Ministry of Labour*	Not available	Not available	Remittance: **NPR 65.54 Billion** (65.1 NPR = 1 USD) Remittance is **15.34%** of the GDP *Source: Economic Survey 2005-06, Ministry of Finance,Government of Nepal.*	**NPR 500** collected from each MW; (no data available of the actual amount of tax and levy collected) total collected revenue: **NPR 98,622,913** *Source: Department of Labour)*	**NPR 505** is collected from each worker as a premium for the insured amounts of **NPR 100,000** for 2 years.

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Insurance for MWs
Pakistan	**3,231,329** (1971-2002) Age: 25-45 years Major Destination Country UAE, Bahrain, Brunei, Hong Kong, SAR of China, Iran, Iraq, Jordan, Kuwait, Libya, Lebanon, Malaysia, Oman, Qatar, Saudi Arabia, Singapore, U.K, USA, Yemen, Japan, Korea etc. *Source: UNFPA. 2006. 'State of World Population 2005'.*	**17%** of total migrant workers came back to Pakistan permanently. *Source: UNFPA. 2006. 'State of World Population 2005'.*	Not Available	Remittance: **USD 3,871 Million** (2003-2004) Remittance is **4.46%** of the GNP *Source: UNFPA. 2006. 'State of World Population 2005'.*	**PKR 100** (60.4 = 1 USD) for stamping agreement in government treasury, fee of **PKR 2,500** for permission from protector of emigrants to proceed. **PKR 1,050** deposited by all persons getting employment abroad as a welfare fund. *Source: Associated Press of Pakistan*	**PKR 650** per MW registered with protector of emigrants for insurance. Compensation: In case of death **PKR 300,000.** Loss of two limbs or two eyes or one limb or one eye **PKR 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 **PKR 150,000.** Stoppage of functioning of any part of body due to paralysis or stroke **PKR 30,000-150,000.** *Source: UNFPA. 2006. 'State of World Population 2005'.*
Philippines	**Est. 3.6 Million** Contract workers *Source: Philippine Overseas Employment Administration (POEA)*	**1,296,972** *Source: Asian Migrant Yearbook 2004*	**1.3 Million** Irregular migrants *Source: Philippine Overseas Employment Administration (POEA)*	**USD 12.8 Billion** (2006)	Not Available	Not Available

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Insurance for MWs
Sri Lanka	**230,973** (2005) Male: 93,965 Female: 137,008 Categories: Male: Skilled (38,833), Unskilled (38,525), Middle level (7,148), Clerical (6,978), Professionals (2,481) Female: Domestic Worker (125,054), Skilled (6,767), Unskilled (3,345), Middle level (892), Clerical (753), Professionals (197) estimated total of Sri Lankans abroad: **1,221,763** *Source: SLBFE, Annual Statistical report of Foreign Employment - 2005*	Not Available (repatriated Stranded workers in 2005: **584**) *Source: SLBFE, Annual Statistical report of Foreign Employment - 2005*	Not Available	**LKR 191,800 Million** (111.6 LKR = 1 USD) (2005) Remittances make **est. 12%** of the GNP. *Source: Central Bank of Ceylon Report (2005)*	No taxes or levies.	Money collected from MWs by insurance companies **LKR 106,726,500** and money paid out to MWs **LKR 101,233,500** (In 2004) *Source: Central Bank of Ceylon Report (2005)*
Vietnam	Total (2006): **78,855** (Female: 27,023) Major Destination Countries (2006) Malaysia: 37,941 Taiwan, Province of China: 14,127 Republic of Korea: 10,577 Laos: 5,731 Japan: 5,360 Qatar: 2,621 United Arab Emirates: 1,743 Others: 755 *Source: Administration Bureau of Overseas Labour, Ministry of Labour, Invalids and Social Affairs, 2006 and 2007.*	Not Available. MWs usually get deported due to 2 main reasons: (1) lack of health and (2) lack of skill. Taiwan, Province of China returned most MWs due to the lack of necessary skill.	Not Available	Remittances: **USD 1.6 Billion** *Source: Estimation of the Bureau for Administration of Overseas Labour* *Source: Estimation of the Information Office of the Administrative Department of Overseas Labour, Ministry of Labour, Invalids and Social Affairs.* % of GNP: **3%** *Source: Ministry of Foreign Affairs*	The Vietnamese government does not levy any tax on migrant workers.	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	Insurance for MWs
DESTINATION COUNTRY						
Hong Kong SAR of China	**225,846** FDWs, **987** other foreign labours, **21,000** professionals, *Source: http;//www.immd.gov.hk/ehtml/facts_3.htm*	Not Available	Not Available	**HKD 1,279,230,220 Billion** (total income of all documented MWs) GNP: **1,479 Billion**	Around **one billion Hong Kong, SAR of China dollar** (estimated from that the levy for a foreign domestic worker for two years is HKD 9,600 which is less than 0.5% of the Total Government revenue *Source: http://www.immd.gov.hk/ehtml/faq_fdh.htm#5, access on 10/7/2007)) which is less than 0.5% of the Total Government revenue (Ref: http://www.censtatd.gov.hk/hong_kong_statistics/statistical_tables/index.jsp?htmlTableID=192&excelID=&chartID=&tableID=192&ID=&subjectID=9, access on 10/7/2007).*	The employment law in Hong Kong, SAR of China requires all employers to buy insurance for their employees, regardless the employees are local or migrant workers. As the employers of FDWs are required to pay for the workers' medical expenses; some employers also buy insurance for this, but it is not mandatory.
Japan	**2,084,919** (2006) *Number of registered aliens *Source: Immigration Bureau of Ministry of Justice*	Number of deported foreigners **56,410** (2006) *Source: Immigration Bureau of Ministry of Justice*	**17,0329** Number of overstayed foreigners as of 1st January 2007 *Source: Immigration Bureau of Ministry of Justice*	Not available	Not available	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 enroll their employees in the Employee's Health Insurance. In this case, nationality and documentation status are not questioned.

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Insurance for MWs
Republic of Korea	Total: **468,326** (2005) Male: 327,785 (70%) Female: 140,541 (30%) Countries of Origin: China (Han and Korean): 213,144 Philippines: 38,347 Vietnam: 30,792 Thailand: 30,719 Indonesia: 27,434 Bangladesh: 21,746 Mongolia: 21,406 Uzbekistan: 15,657 *Source: Ministry of Justice. Annual Report on Emigration and Immigration.*	Not available	**180,792** (38.6%) 2005 *Source: Ministry of Justice. Annual Report on |Emigration and Immigration.*	N/A	Special Taxation on Foreign Workers (1st Jan. 2004) Whichever the smaller between (1) General income tax rate applied to total annual income after basic deduction of 30% (inclusive of other deductions & tax credits) (2) A flat rate of 17% applied to total annual income (not inclusive of other deductions & tax credits)	Documented MWs are required to join National Health Insurance and Industrial Accident Compensation Insurance. MWs have to insure themselves with a casualty insurance against diseases and death. MWs take benefits from other insurances like accident, returning expenses. *Source: Act on Employment of Foreign Workers*
Bahrain	**235,108** (July 2007 est.) Equivalent to 33.2% of the total population *Source: The World Factbook 2007* Percent that are female: 30.9% *Source: Worldbank: Migration and Remittances Factbook* <u>Origin countries:</u> India, Saudi Arabia, Egypt, Iran, Sudan, Algeria, Morocco Iraq, Yemen, Syria *Source: Development Research Centre on Migration, Globalisation and Poverty: Global Migrant Origin Database*	Not available	The number of runaway and free-visa workers is estimated between **30,000 - 40,000.** *Source: Suad Hamada: Amnesty 'to draw wide response' ahead of reforms, Gulf News, July 2007* A six month worker's amnesty will start in August 2007 *Source: Bahrain Tribune, June 24 2007*	Remittances: USD **1,531** Million (2006) The remittances in 2005 (USD 1,223 Million) constituted **9.4%** of the GDP. *Source: Worldbank: Migration and Remittances Factbook*	From 25th June 2007 onwards citizens and non-citizens alike must pay an annual income tax of 1%. *Source: Khaleej Times : Bahrain's income tax, first in Gulf, sparks opposition, 26th June 2007*	No data available for overall insurance. From May 2nd 2007 onwards, all contracts that go through the Philippine Embassy would be required to include the new insurance scheme for Filipino expatriates which pays an employee's next of kin up to BHD 3,000 (BHD 0.37 = USD 1) in the case of death due to accident. *Sources: "New insurance cover deal for Filipinos," Gulf Daily News, 1st May 2007*

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Insurance for MWs
United Arab Emirates	Total foreign-born population of UAE: **2,738,000** (accounts for 95% of the total population) Thereof construction workers: **500,000** (2004) *Source: Human Rights Watch: Building Towers, Cheating Workers, Nov. 2006* Total foreign-born population of Dubai: **1,272,000** (2004 est.) (accounts for **83.0%** of the total population) *Source: Ministry of Labour* Thereof construction workers: **304,983** (2005) *Source: Human Rights Watch: Building Towers, Cheating Workers, Nov. 2006* <u>Countries of origin:</u> India (51%), Pakistan (16%), Arab countries (11%), Bangladesh (9%), Other Countries (7%), Philippines (3%), Sri Lanka (2%), Europe (1%) *Source: MPI Data Hub*	No data available for overall deportation. Annual deportation of foreign women found in prostitution: **5,000 - 6,000** *Source: Embassy of the United States of America (UAE) 2006 Trafficking in Persons Report*	Not available	Remittances: **USD 80 Billion** (2002) *Source: Human Rights Watch: Dubai: Migrant Workers at Risk, Sep. 2003*	Recruiting agencies unlawfully force workers to pay USD 2,000-3,000 for employment contract, travel, visas and government fees.	The labour law does not require employers to maintain insurance for compensation or medical care. The law does require the employer to: - "provide appropriate safety measures." - provide medical professionals "at regular intervals of not more than 6 months." - report instances of work-related injuries and occupational diseases to the police and to the Ministry of Labor. *Source: Federal Law No. 8 for 1980, On Regulation of Labor Relations.*
Malaysia	Total: **1,812,631** (nearly 12% of entire population) Categories: Domestic Work: 310,661 Construction: 266,809 Manufacturing: 645,524 Services: 166,829 Agriculture: 123,373 *Source: Ministry of Home Affairs, Malaysia, 2006 obtained from the Indonesian Embassy in Kuala Lumpur* <u>Countries of origin:</u> Indonesia, India, Nepal, Vietnam, Pakistan, Bangladesh, Philippines, Cambodia, Myanmar, Laos	Not Available	Estimated equal or higher than documented migrant workers.	Not available.	Annual payment of levy for each MW: **RM 1,800** (USD 523)	

Country	Documented MW	MWs Reintegrating & Deported	Estimates of Undocumented MWs	Remittances & % GNP	Taxes/levies Paid by MWs	Insurance for MWs
Thailand	Number of documented migrant workers (unskilled labour from neighboring countries only) in 2004: Total: **1,284,920** migrants and dependents registered with the general ID card (known as the Tor Ror 38/1); **849,552** registered with a work permit. Nationalities registering for a work permit in 2004: **Burma – 633,692** (75%); **Laos - 105,259** (12%); and **Cambodia – 110,601** (13%). Number of migrants who re-registered with a work permit (2006): **668,000** - The general proportion of migrants has remained the same, with groups from Burma the vast majority. *Source: Ministry of Labour, Thailand, 2004, 2006*	Annual deportation of migrants: **est. over 100,000** Monthly deportation to Burma: 10,000. *Source: The Nation, Oct. 5, 2003* In 2003 - 228,062 persons from the three neighboring countries were arrested for illegal entry or overstaying visas. Many of these deportations are done informally, where migrants are simply sent back to the border and expected to cross on their own. Many simply turn right back around and re-enter the country. Number of Thais deployed overseas – **148,600.** (p.27, IOM) *Source: IOM: International Migration in Thailand*	Total number of migrants estimated to be in Thailand (from three neighboring countries, including dependents): **2.5 Million.** Only 1/3 of those who are working are believed to be registered. *Source: General estimate acknowledged by government and NGOs.*	It is not known how much is remitted by migrant workers living in Thailand as there are no official channels for remittance, but the amount is believed to be substantial. Thais are believed to have remitted **USD 1.5 Billion** in 2004 through official channels. *Source: IOM: International Migration in Thailand*	When registering, migrants have to pay a total of **THB 3,800** (34 THB = USD 1): THB 1,800 for one full year's work permit, THB 600 for the health exam, and THB 1,300 for health insurance plus administration costs of THB 100 Baht. Migrants are often paid informally, so no taxes are collected from them directly.	Upon passing the health exam, MWs are included under the national health insurance scheme, which allows migrants to receive a subsidized rate for health services at an assigned provider - the same as local Thais. When registering, migrants pay THB 1,300 for health insurance (included in THB 3,800 for registration) (THB 34 = USD 1): Those without a work permit do not have health insurance. The fee may be paid up front by the employer but is then deducted from the migrant's wages.

HIV and AIDS Indicators, 2005

Country	Adults (15+) with HIV	Women (15+) with HIV (and percentage of total)	HIV prevalence (%) in most-at-risk groups in capital city	AIDS deaths (in 2005)
ORIGIN COUNTRY				
Bangladesh	11,000	1,400 (12.7%)	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 (45.4%)	Female Sex Workers – 26.3 (2000)	16,000
India	5,600,000	1,600,000 (28.6%)	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 (17.1%)	Injecting Drug Users – 65.5 (2000) Female Sex Workers – 0.0 (2000)	5,500
Nepal	74,000	16,000 (21.6%)	Injecting Drug Users – 50.0 (2000) Female Sex Workers – 2.0 Men who have sex with men – 3.9	5,100
Pakistan	84,000	14,000 (16.7%)	Injecting Drug Users – 22.9	3,000
Philippines	12,000	3,400 (28.3%)	Injecting Drug Users – 1.0	<1,000
Sri Lanka	5,000	<1,000 (20%)	Female Sex Workers – 0.0 (2000)	<500
Vietnam	250,000	84,000 (33.6%)	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 (No separate info on Hong Kong)	650,000	180,000 (27.7%)	Injecting Drug Users – 8.3 Female Sex Workers – 0.5 Men who have sex with men – 1.5	31,000
Japan	17,000	9,900 (58.2%)	Men who have sex with men – 2.9 (in 2000)	1,400
Republic of Korea	13,000	7,400 (56.9%)		<500
Bahrain	No data available	No data available	No data available	No data available
United Arab Emirates	No data available	No data available	No data available	No data available
Malaysia	67,000	17,000 (25.4%)	Female Sex Workers – 6.9 (2000)	4,000
Thailand	560,000	220,000 (39.3%)	Injecting Drug Users – 38.0 (2004) Female Sex Workers – 4.3 (2004)	21,000

Source: UNAIDS, 2006. '2006 Report on the Global AIDS Epidemic'.

Status of Ratifications of the Principal International Human Rights Treaties (as of 04 June 2004)

Country	CESCR	CCPR	CCPR-OP1	CCPR-OP2DP	CERD	CEDAW	CEDAW-OP	CAT	CRC	CRC-OP-AC	CRC-OP-SC	CMW
ORIGIN COUNTRY												
Bangladesh	5-Jan-99	6-Dec-00			11-Jul-79[a]	6-Dec-84[a]	22-Dec-98	4-Nov-98[a]	2-Sep-90	18-Jan-02	18-Jan-02	s:7-Oct-98
Cambodia	26-Aug-92[a]	26-Aug-92[a]			28-Dec-83	14-Nov-92[a]	s:11-Nov-01	14-Nov-92[a]	14-Nov-92[a]	30-Jun-02	30-Jun-02	
India	10-Jul-79 [a]	10-Jul-79[a]			4-Jan-69	8-Aug-93		s:14-Oct-97	11-Jan-93[a]			
Indonesia					25-Jul-99[a]	13-Oct-84	s: 28-Feb-00	27-Nov-98	5-Oct-90	s:24-Sep-01	s:24-Sep-01	
Nepal	14-Aug-91[a]	14-Aug-91[a]	14-Aug-91[a]	4-Jun-98[a]	1-Mar-71[a]	22-May-91	s:18-Dec-01	13-Jun-91[a]	14-Oct-90	s:8-Sep-00	s:8-Sep-00	
Pakistan					4-Jan-69	11-Apr-96[a]			12-Dec-90	s:26-Sep-01	s:26-Sep-01	
Philippines	3-Jan-76	28-Jan-87	22-Nov-89[a]		4-Jan-69	4-Sep-81	12-Feb-04	26-Jun-87[a]	20-Sep-90	26-Sep-03	28-Jun-02	1-Jul-03
Sri Lanka	11-Sep-80[a]	11-Sep-80[a]	3-Jan-98[a]		20-Mar-82[a]	4-Nov-81	15-Jan-03[a]	2-Feb-94[a]	11-Aug-91	12-Feb-02		1-Jul-03[a]
Vietnam	24-Dec-82[a]	24-Dec-82[a]			9-Jul-82[a]	19-Mar-82			2-Sep-90	12-Feb-02	18-Jan-02	
DESTINATION COUNTRY												
Hong Kong SAR, China	27-Jun-01	s:5-Oct-98			28-Jan-82[a]	3-Sep-81		3-Nov-88	1-Apr-92		3-Jan-03	
Japan	21-Sep-79	21-Sep-79			14-Jan-96[a]	25-Jul-85		29-Jul-99[a]	22-May-94	s:10-May-02	s:10-May-02	
Republic of Korea	10-Jul-90[a]	10-Jul-90[a]	10-Jul-90[a]		4-Jan-79*	26-Jan-85		8-Feb-95[a]	20-Dec-91	s:6-Sep-00	s:6-Sep-00	
Bahrain					26-Apr-90[a]	18-Jul-02[a]		5-Apr-98[a]	14-Mar-92[a]			
United Arab Emirates					20-Jul-74[a]				2-Feb-97[a]			
Malaysia						4-Aug-95			19-Mar-95[a]			
Thailand	5-Dec-99[a]	29-Jan-97[a]			27-Feb-03[a]	8-Sep-85[a]	22-Dec-00		26-Apr-92[a]			

Source: Office of the United Nations High Commissioner for Human Rights

Notes: The dates listed refer to the date of ratification, unless followed by:
a: signifies accession
s: signifies signature only
* indicates that the state party has recognised the competence to receive and process individual communications of the Committee of Racial Discrimination under article 14 of the CERD (total 42 state parties) or of the Committee against Torture under article 22 of CAT (total 53 state parties)

Acronyms:

CESCR	International Covenant on Economic, Social and Cultural Rights
CCPR	International Covenant on Civil and Political Rights
CCPR-OP1	Optional Protocol to the International Covenant on Civil and Political Rights
CCPR-OP2-DP	Second Optional Protocol to the International Covenant on Civil and Political Rights, aimed at the abolition of the death penalty
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEDAW-OP	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women
CAT	Convention against Torture and Other Cruel, Inhuman or degrading Treatment or Punishment
CRC	Convention on the Rights of the Child
CRC-OP-AC	Optional Protocol to the Convention on the Rights of the Child, on the involvement of children in armed conflict
CRC-OP-SC	Second Optional Protocol to the Convention on the Rights of the Child, on the sale of children, child prostitution and child pornography
MWC	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families

References

1 ''Pre Departure Orientation Seminar Concept" a paper by Jumhur Hidayat, Chairperson of BNP2TKI.

2 Decree of Ministry of Manpower and Transmigration of the Republic of Indonesia, No: Kep 157/MEN/2003

GLOSSARY

Compulsory testing

Also known as involuntary testing, is defined as testing without a voluntary element – i.e., without informed consent, at the behest of someone or some institution other than the person tested and, sometimes, with neither the fact of having been tested nor the result communicated to the person tested (Canadian HIV/AIDS Legal Network, Center for Health and Gender Equity, Gay Men's Health Crisis, 2006).

Confidentiality

The ethical principle or legal right that a physician or other health professional will hold secret all information relating to a patient, unless the patient gives consent permitting disclosure. Confidential antibody testing means that the patient and the health care provider know the results, which may be recorded in the patient's medical file. Those who are tested confidentially and are found to be infected with HIV are reported to local public health officials so that the government can better track the extent of the disease in the population as a whole.

Confirmatory testing (new sample for testing)

A highly specific test designed to confirm the results of an earlier (screening) test. It is recommended retesting any positive (reactive) ELISA twice; if either retest is positive (reactive), then a confirmatory test is performed. For HIV testing, a Western blot or, less commonly, an immunofluorescence assay (IFA) is used as a confirmatory test. Only when the confirmatory test is also reactive is the result reported as HIV positive.

ELISA

Stands for Enzyme-linked immunosorbent assay and is a type of enzyme immunoassay to determine the presence of antibodies to HIV in the blood or oral fluids. ELISA tests are generally highly sensitive and specific and compare favorably with radioimmune assay (RIA) tests. They have the added advantages of not needing radioisotopes or a radiation-counting apparatus. Repeatedly (i.e. two or more) reactive ELISA test results should be confirmed with a second test such as the Western blot test, a rapid HIV test, or a DNA or RNA PCR.

"Fit to work"

A potential migrant worker is "fit" to travel/to work when he/she has passed the health test either at the sending or the receiving country.

Formal consent

In order to underline their consent to a surgical or medical procedure or participation in a clinical study the patient signs a written consent form, thus satisfying all legal requirements.

Informed consent

Consent by a patient to a surgical or medical procedure or participation in a clinical study after achieving an understanding of the relevant medical facts and the risks involved so that he or she can make an informed decision to proceed or to refuse a particular course of medical intervention.

Irregular (undocumented) migration

Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries it is illegal entry, stay or work in a country, meaning that the migrant does not have the necessary authorisation or documents required under immigration regulations to enter, reside or work in a given country. From the perspective of the sending country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfill the administrative requirements for leaving the country. There is, however, a tendency to restrict the use of the term "illegal migration" to cases of smuggling of migrants and trafficking in persons. (International Migration Law: Glossary on Migration. Geneva, 2004.)

Mandatory testing

Testing that would occur as a condition for some other benefit, such as donating blood, immigrating to certain countries, getting married, joining the military or as a pre-condition of other kinds of employment.

Migrant-friendly testing

There are, as yet, no standards for migrant-friendly testing. But migrant-friendly testing complies with the guiding principles of Voluntary Counselling and Testing (VCT). According to those principles, HIV testing should be voluntary, confidential and accompanied by counselling sessions. Ideally, the test should be conducted in a one-on-one situation. In this way, the potential migrant worker should be able to exercise their right not to take the test. Migrant-friendly testing should ensure that HIV does not affect a person's employment status and is not a determining factor in their employment and testing is free from discrimination and accommodates migrant workers' needs, with a priority on improving their health and welfare.

On site (annual checks)

Refers to annual health tests conducted in the destination country in order to renew the work permit.

Provider-initiated testing and counseling (PITC)

Refers to HIV testing and counseling that is initiated by health care providers for persons attending health care facilities. According to the recent WHO/UNAIDS draft guidance on PITC in health facilities, "the major purpose of such testing is to make specific clinical decisions and/or offer specific medical services that could not be done without knowledge of the person's HIV status. Guidance from health care providers is not neutral but recommends HIV testing and counselling"
(WHO/UNAIDS, 2006).

Provider-initiated testing can be done using either an "opt-out" approach or an "opt-in" approach.
With an "opt-out approach", testing is initiated by the provider of some (health) service and people are tested unless they clearly opt out and refuse to be tested. Some add other elements to the definition, saying that in opt-out testing regimes clients or patients receive only essential information about HIV, and there is greater emphasis on post-test, rather than pre-test, counseling. This is consistent with what is proposed in the WHO/UNAIDS draft guidance on PITC in health facilities, which recommends an "opt-out approach … including simplified pre-test information" (WHO/UNAIDS, 2006, at 4). What taking an opt-out approach to testing means in practice will vary widely. WHO and UNAIDS stress that people need to

be given “sufficient information to make an informed and voluntary decision to be tested, including an opportunity to decline the test”.
With an “opt-in approach”, testing is initiated by the provider, but the client must specifically agree to the test, rather than having to decline.
(Source: OSI background paper on “Routinizing” HIV testing in low- and middle-income countries, 2006)

Pre-test counseling

Done to assess the risks and the adequacy of the timing of taking the test (to avoid testing in the window period), inform the client of the benefits of taking the test and of the implications of both positive and negative results, and assure him/her of the right to refuse taking the test. This information is critical to obtain the informed consent of the patient. Moreover, during pre-test counselling the client is encouraged to anticipate the possibility of beneficial disclosure of sero-status status (e.g. sexual partner, family member, etc.), and is provided with preventive information and material.

Post-test counseling

Both HIV positive and HIV negative test results should be delivered by a counsellor, in order to manage the shock and ensure proper understanding of the meaning and implications of the result. HIV positive individuals should be informed of their options and advised and referred for further care, treatment and support services as needed. In addition, beneficial disclosure of positive sero-status is discussed and encouraged, along with the provision of prevention information and material. HIV negative individuals should be counselled and provided with information and material that help them remain HIV negative. Individuals with special conditions exposing them to high risk of HIV can be referred to care and support services relevant to their situation (e.g. injecting drug users can be referred to harm reduction services or drug treatment facilities).

Rapid testing

A test to detect antibodies to HIV that can be collected and processed within a short interval of time with greater than 99% sensitivity and specificity.
Advantages of rapid testing are:

- Produces results in a short period of time (10-30 minutes).
- Allows testing, counseling and referrals to be done within 1 day; return visits are not necessary, more people will get their results..
- Easier to use than the traditional ELISA test, while providing the same accuracy.
- Less costly for testing agencies due to fewer outreach visits to give results.
- By learning of infections earlier, potential exposures that would have occurred between traditional testing and receiving results is reduced.

A positive rapid test result should be confirmed by an HIV Western blot test, which can be a second rapid test made by a different manufacturer.

Reconfirmatory testing

See Western blot.

Regular (documented) migration

Migration that occurs through recognised, legal channels.

Sponsor

Refers to the sponsorship laws of GCC countries. Every non-GCC citizen who comes to work in these countries must have a sponsor (individual or company). This fully dependence on the employer can also result in late payment of wages, the substitution of the original employment contract with one containing fewer safeguards for the migrant worker, restrictions on freedom of movement, and, in some cases, physical or sexual intimidation.

"Temporarily unfit"

A potential migrant worker is "temporarily unfit" to travel/to work when he/she has failed the health test either at the sending or the receiving country but was not diagnosed with an infectious disease. In some cases (i.e. GAMCA) the testing centres would administer a course of medication or refer to external consultations for further treatment. However, there is no set definition of what exactly is counted as " temporarily unfit".

"Unfit"

A potential migrant worker is "unfit" to travel/to work when he/she has failed the health test either at the sending or the receiving country. As a consequence the potential migrant worker is not allowed to leave the country of origin or gets departed when the test was conducted in the receiving country. There is no set definition of what exactly is counted as "unfit" but HIV, Hepatitis, TB and Malaria are the findings that will lead to a "permanently unfit" status.

Voluntary testing

An individual is usually counseled regarding HIV prevention and how HIV infection occurs. Participants make an informed choice about whether to accept or refuse HIV testing.
Voluntary testing may be undertaken at the request and with the written informed consent of a worker, with advice from the worker's representative if so requested. It should be performed by suitably qualified personnel with adherence to strict confidentiality and disclosure requirements. Gender-sensitive pre- and post-test counselling, which facilitates an understanding of the nature and purpose of the HIV tests, the advantages and disadvantages of the tests and the effects of the result upon the worker, should form an essential part of any testing procedure.

Western blot (WB)

The Western blot is one type of confirmatory tests (see confirmatory testing). It is a laboratory test for specific antibodies to confirm repeatedly reactive results on the HIV ELISA or EIA tests.
A positive western blot confirms HIV infection.

Window period

The "window period" is the time it takes for a person who has been infected with HIV to react to the virus by creating HIV antibodies. This is called seroconversion. During the window period, people infected with HIV have no antibodies in their blood that can be detected by an HIV test, even though the person may already have high levels of HIV in their blood, sexual fluids, or breast milk. Although HIV may not be detected by a test during the window period, HIV can be transmitted during that time. In fact, individuals are often most infectious during this time (shortly after they have been exposed to HIV).

ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral
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	GCC Approved Medical Centres' Association
GCC	Gulf Cooperation Council
GDP	gross domestic product
HIPTEK	Association of Medical Clinics for Indonesian Overseas Migrant Workers
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-governmental organization
OFW	overseas Filipino worker
OPF	overseas Pakistanis Foundation
PDOS	pre-departure orientation seminar
POE	Protectorates of Emigration
PPIMFC	Placement and Protection of Indonesian Manpower in Foreign Countries
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 (for tubercle bacillus)
UAE	United Arab Emirates
UN	United Nations
UNAIDS	Joint United Nations Programme on 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 State of Health of Migrants (SoH) taskforce has completed a second round of action research, this time focused on the issue of Mandatory Testing. The research was completed in sixteen countries spanning across Asia, including both origin Hong Kong, SAR of China and destination countries: Bahrain, Bangladesh, Cambodia, Dubai, Hong Kong, SAR of China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, Philippines, Sri Lanka, Thailand and Vietnam. In this report, using participatory research methods, migrants' direct experiences with mandatory health testing were collected at all ends of the migration continuum - prospective migrants at their country of origin, migrants working at destination countries, and returnee migrants including those living with HIV and those who were deported as a result of testing. Through analysis of the results by CARAM partner organisations and migrants, a "Migrant-Friendly" Testing Framework was developed. CARAM Asia calls on all actors involved, including governments and third parties, to adopt this framework and uphold human rights standards on health and HIV testing for migrant workers as recognized under countries' own laws and policies, and which are enshrined in international conventions.

Vrije Universiteit Medical Centre, Health Care and Culture Section (Netherlands) provided invaluable technical support for this action research. The key features and strengths of this type of research include the role it plays in promoting change through organizational learning and knowledge generation, the participatory nature of the research that allows those directly impacted to have their voices heard, and the resultant social action that can affect real change.

CARAM-ASIA

CARAM Asia, an open and dynamic regional network was set up in 1997 to address special interventions for mobile populations at all stages of migration to reduce their vulnerabilities to HIV and improve health outcomes. Its overall objective is to empower migrants, their families and communities throughout the migration process and build capacities of CBOs/NGOs through utilising Participatory Action Research to ensure inclusion of migrant voices and perspectives on HIV vulnerabilities, migrant health status and recommend potential policy prescriptions for effective national and regional advocacy. For more information please go to www.caramasia.org

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