Nepal Country Report

State of Migrants Health
2005

NIDS

Empower Migrants
Against HIV / AIDS

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Preface

This publication is an outcome of almost one and half years of work of NIDS (Nepal Institute of Development Studies) and CARAM-Asia (Co-ordination of Action Research on AIDS and Mobility-Asia). CARAM-Asia has programme in eleven countries in South and Southeast Asia and has broad national networks of organizations concerned with HIV/AIDS and mobility. NIDS is the focal point of CARAM-Asia in Nepal.

This is an era of migration. Statistics available from Department of Labour Nepal shows that more than five hundred people go for foreign employment to different parts of the world everyday. Similarly, equivalent number or more go to India everyday and there are large numbers who travel to government banned countries, like Iraq which contribute in giving rise to the number of undocumented Migrant Workers. The increase in foreign employment has significant contribution to national economy. According to Nepal Living Standard Survey (Central Bureau of Statistics 2005), poverty level has reduced from 42 percent to 31 percent during the last eight years (1995/96 to 2003/04) mainly because of remittances. Despite this contribution of Migrant Workers, very little has been done to safeguard their health vulnerability.

The aims of this report are: to visualize the impact of migration on the health and HIV vulnerability of Nepalese Migrant Workers by monitoring the state of health of these workers in Nepal and in different destination countries; and, to report remarkable change in their health status.

This report opens the issues of 'health' and 'health rights' of Migrant Workers. I hope the research findings could be an eye opener for policy makers and could contribute in influencing them to integrate health as an important instrument in the relevant policy for the benefit of the Migrant Workers.

We are very grateful to the respondents - Migrant Workers, Recruiting Agencies, Pre-departure Orientation Centres, Foreign Employment Associations, medical professionals and government officials - who showed willingness and patience, and provided their valuable time and information.

We highly appreciate the role of CARAM-Asia, and the facilitators Dr. Ivan Wolffers and Ms. Sharuna Verghis, Ms. Dilruba Karim (who also did the content editing of the report), Ms. Coreneleike Keizer, Ms. Mara Quesada, and Ms. Michelle Rogers for their continuous support.

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Last but not the least; we are also grateful to all our staff at NIDS, who contributed in conducting this research.

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Foreword

CARAM-Asia (Coordination of Action Research on AIDS and Mobility-Asia) conducted the research on the “State of Migrants Health” in 11 countries to look at the health vulnerability of the Migrants in both the receiving and the sending countries including Nepal.

Migration is generally looked into from the perspectives of volumes of remittances, impact on GDP/GNP and reduction in poverty; however researches have shown that lack of accurate and in-adequate information; the Migrants are at high risk of HIV and other health related vulnerabilities during the pre-departure, post arrival and reintegration phases. This report gives a portrait of the realities faced by the Migrants in terms of accessibility, affordability, availability and quality of health information and services provided to the Migrants at the origin and the destination countries.

I am glad that the Nepal country report “State of Migrants Health 2005” is in the stage of publication. I wish success for NIDS and hope Migrants will have better access to health in the future.

Ganesh Gurung
Chair - CARAM-Asia
Kuala Lumpur, Malaysia.

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List of Abbreviations

AIDS : Acquired Immune Deficiency Syndrome

B.S. : Bikram Sambat (Nepali Calendar)

CBS : Central Bureau of Statistics

CEDAW : The Convention on the Elimination of All Forms of Discrimination Against Women

CERD : The International Convention on the Elimination of All forms of Racial Discrimination

CRC : Convention on the Rights of Children

DoL : Department of Labour

FEA : Foreign Employment Act

FER : Foreign Employment Regulation

FGD : Focus Group Discussion

GAMCA : Gulf Approved Medical Center Association

GDP : Gross Domestic Product

GNP : Gross National Product

GoN : Government of Nepal

HIV : Human Immunodeficiency Virus

ICCPR : The International Convention on Civil and Political Rights

ICESCR : The International Covenant on Economics, Social and Cultural Rights

ILO : International Labour Organization

IMWC : International Migrant Workers Convention

MAMCA : Malaysia Approved Medical Center Association

MoF : Ministry of Finance

MoU : Memorandum of Understanding

MW : Migrant Worker

NCASC : National Centre for AIDS and STD Control

NGO : Non-Governmental Organization

NIDS : Nepal Institute of Development Studies

PDC : Pre-departure Orientation Centre

PLA : Participatory Learning Appraisal

RA : Recruiting Agency

STD : Sexually Transmitted Diseases

TB : Tuberculosis

UNGASS : United Nations General Assembly Special Session on HIV/AIDS

UNIFEM : United Nations Development Fund for Women

WCAR : World Convention against Racism

WHO : World Health Organization

1. INTRODUCTION

1.1 Background

Health is a fundamental human right, indispensable for the exercise of other human rights. The right to health is not to be understood as just a right to be healthy; rather, the right to health entails both freedom and entitlements. The freedom include the right to control one's health and body, including sexual and reproductive health, and the right to be free from interference such as torture, non-consensual medical treatment and experimentation. Every human being is also entitled to enjoy the highest attainable standards of health conducive to living life with dignity. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services." But does everyone have access to these facilities, especially the MWs who leave their country for jobs best described by the 3 D's: Dangerous, Dirty and Difficult? The question remains to be answered.

In the burgeoning economies of Asia, labour moves according to demand from rural areas to cities and from poorer countries to wealthier ones. Experience shows that migrants are mostly considered as a commodity rather than human beings with basic rights. They are generally among the least privileged members of their societies, and their health often falls between the gaps with country programmes, particularly where prevention is concerned. This makes them more vulnerable to potential health risks.

Coordination of Action Research on AIDS and Mobility Asia (CARAM Asia) takes the position that; when the rights of MWs are not protected, they become vulnerable to a number of health risks.

Migrant Workers' health rights are not addressed by agencies or constitutions. Therefore, this is a major issue that needs to be addressed with interventions in both the countries that send MWs as well as those that receive them. Advocacy is needed at the regional as well as the national level to have an impact on the policies that affect the health of MWs, and to promote actions for the protection of migrant/mobile populations' health, especially from HIV/AIDS. Therefore, CARAM Asia has been working on health, HIV/AIDS, and migration issues along with partners from 13 different countries in the South Asian and the Pacific Regions, and has initiated participatory research to assess the 'State of Health of Migrant Workers' on a regular basis, with focus on a new aspect of the topic each year. In the year 2005, the research theme 'Access to Health' was selected through a joint participatory process by networking partners from Bangladesh, Cambodia, Hong Kong, SAR of China, India, Indonesia, Japan, Nepal, Pakistan, Philippines, Malaysia, Thailand, Sri Lanka, and Vietnam. As part of the regional initiative, Nepal Institute of Development Studies (NIDS) conducted research to contribute to the monitoring of migrant's rights and health in Nepal.

1.2 Goals and objectives

The goal of this research is to promote and ensure the fundamental health rights of MWs. With this broader goal, this research aims to fulfil the following objectives:

1. To visualise the impact of migration on the health and HIV vulnerability of Nepalese MWs by monitoring the state of their health in Nepal and in different destination countries and reporting remarkable changes;

2. To identify whether existing laws and policies are ensuring MWs' access to health information and care services and the gaps in policy and practice;
3. To determine the level of accessibility and health information and healthcare services available at an affordable cost for Nepalese MWs;
4. To generate a set of recommendations based on common views of different stakeholders and the migrant community, to be used as an advocacy tool to facilitate the accessibility, affordability, and quality of information regarding prevention and care services for MWs.

1.3 Scope and limitations of research

- This research is the very first of its kind, conducted specifically on Nepalese MWs' access to healthcare. Therefore, this could be the baseline research for future study on the health status of MWs. On one hand, it could give a preview of the existing structure and concerns of MWs' healthcare and services; and on the other, it could provide information that can be incorporated into health aspects in future policy development initiatives.
- The report has only incorporated existing and available secondary data until December 2005.
- This research was conducted on the basis of qualitative information from specific groups of migrant populations and various stakeholders, and not on quantitative data.
- It represents prospective and returnee MWs, both female and male, documented and undocumented, who have experienced health problems related to access to information and care in home and destination countries.

- The study has not been able to incorporate the views of HIV+ MWs from destination countries other than India.
- The primary data collection process was limited to within the Kathmandu valley, where there are a high number of potential MWs. Most of the returnee MWs were residing in Kathmandu or visiting on businesses, and were contacted through NGOs, trade unions, or recruiting agencies.

1.4 Methodology

CARAM Asia organised a total of four regional workshops for State of Health (SoH) participants on conceptualising and shaping research work, and NIDS was a regular and active participant. The participants jointly developed the three pillars of SoH, namely structural indicators, impact indicators, and process indicators. For the structural indicators, international instruments were reviewed to determine whether provisions were in place to protect, promote and ensure MWs' access to heath. This was followed by a check to see if they were ratified by respective national governments, and supporting laws or policies were in place. For the impact indicators, the demographic, labour migration, and related health indices were examined. The process indicators linked the structural and impact indicators by focusing on how national laws, policies and programmes are actually implemented and utilised. This reality was uncovered through MWs' actual experiences of accessing or attempting to access health information and services. Also, the perspectives of relevant stakeholders were explored.

The first workshop, which took place in November 2004 in Chennai, facilitated a deeper understanding of MWs' right to healthcare and progressed towards jointly developing the research framework, guidelines and a plan for assessing the migrants' state of health.

In May 2005, the second workshop took place in Jakarta and focused on reporting on structural indicators, i.e. legislation and policy framework for migrants' access to health. Participatory methods and tools were also developed, as well as skill-building exercises for data collection techniques to be used for process indicators. In December 2005, the first Analysis Workshop took place in Kuala Lumpur, where partners helped each other analyse and compare data. In February 2006, the second analysis workshop in Kuala Lumpur took place, which helped shape the country analysis and focused on a broader regional analysis on MWs' access to health.

Both primary and secondary sources of information were used for this research. The information on policies, acts and other legal documents on migration, health and HIV/AIDS were obtained from secondary sources. First of all the relevant documents on Labour Policy, Labour Act, Health Policy, Health Act, and journals were collected and massive research was conducted on the basis of the indicators developed by the CARAM partners. Facts and figures relating to heath and migration were also collected from secondary sources.

In the field research, based on participatory empowerment philosophy, NIDS adopted a combination of different participatory methods that helped the research participants carry out their own analysis and appraise their own situation. Focus group discussions (FGD), in-depth interviews (IDI) as well as participatory learning and action (PLA) methods were used, where the emphasis was on allowing people to feel free to identify and explore their concerns. The PLA methods used included balloon opinion exercises, mobility mapping, priority ranking, etc. These participatory and visual methods enabled the MWs to express their thoughts, perceptions, and life experiences on access to health information and services, leading to a greater depth of

understanding of the migrants' experiences with the research topics and issues. The research participants included potential MWs, and both documented and undocumented returnee MWs, including those who returned with physical disability, illness, or were forcefully deported because of health problems. Specific focus was put on female MWs. Moreover, the perspectives of various relevant stakeholders were sought through the use of IDIs, covering recruiting agencies, pre-departure orientation centres, training officers, doctors and administrators at testing centres, officials from MAMCA, personnel from the Department of Labour, Ministry of Health, National Centre for AIDS and STD control, NGOs, experts on legal and migration issues, etc.

Unlike most research, there were no pre-determined questions; rather guidelines and checklists were used. The process was left open-ended and flexible in order to follow concerns and issues brought up during the research process. To increase accuracy and understanding; triangulation was made following the use of various tools, different migrant groups and stakeholders. Once the country analysis and report writing was completed, validation of the same was conducted by organising a meeting with representatives of returnee MWs, where the participants discussed the analysis results and confirmed that the research findings reflected the MWs' real-life experiences.

1.5 Research participants

The MWs who participated in the FGDs and PLAs were prospective migrants preparing to travel to Malaysia, Qatar, and Saudi Arabia. Two FGDs were conducted with the groups going to Qatar, one group going to Saudi Arabia and one FGD and two balloon opinions with the groups going to Malaysia. These were complemented with the use of mobility mapping and priority

ranking with regard to access to information and care. The majority of the prospective MWs were going for foreign employment as unskilled labourers, with others going to be carpenters, drivers, masons, or security guards. Each discussion group comprised of 6-8 persons, aged between 18 to 39, with the majority being in their twenties. The respondents were mostly illiterate, literate, or under School Leaving Certificate levels; very few had passed SLC.

Ten in-depth interviews, including two with HIV+ persons, and one FGD were conducted with returnee MWs. The returnees, both male and female, were from India, Hong Kong, SAR of China, Saudi Arabia, Malaysia, Japan, and Korea. They had worked as domestic helpers or as labours in glove, textile, leather, and automobile factories. The education level was mostly under high school, although some were college graduates. Only two female returnee undocumented MWs were interviewed; both had gone to Korea and Japan on tourist visas but stayed on after their visas expired. These in-depth interviews were often conducted in combination of PLA methods,which provided a complete picture of access to care issues in various destination countries.

In-depth interviews were conducted with training officers of the pre-departure orientation centres, medical professionals, recruiting agents, personnel from the Department of Labour, NCASC/MoH, and NGOs working on HIV/AIDS and/or migration.

2. COUNTRY SITUATION

2.1 Background

Nepal is a developing country in South Asia with a population of 23,151,423.[1] The total per capita expenditure on healthcare, as of 2002, is US$ 64. Though government expenditure on healthcare was 5.2% of GDP in 2002, indicators demonstrate that people still have poor health conditions. The infant mortality rate is 64/1000 live births and the maternal mortality rate is 539/1,00,000 population.[2] The adult mortality rate for males is 290/100,000 and for females is 284/100,000. The average life expectancy, according to 2004 estimates, is 62.20.[3]

The Department of Health was established in 1933 under the Ministry of Health to provide health services to the Nepali population. Now there are 19,618 primary healthcare centres, 153 secondary health care centres, and 12 tertiary health care centres.[4] According to the Medical Council, the Nursing Council, and the Nepal Health Professional Council, there are 5,217 doctors (as of May 31st, 2005), 12,133 nurses (as of June 2nd, 2005), and 21,603 paramedical staff (as of March 20th, 2005). There are private, international, and non-government organisations providing healthcare services as well.

It has been remittances sent home by MWs that have sustained the Nepalese economy over Nepal's recent period of political upheaval. Estimates of remittances for (2004-2005) is NRs. 65.54 billion contributing to 15.34% of Nepal's GDP[5]**.** However the

government of Nepal has not implemented or adopted any specific health policy for MWs going for foreign employment; neither have they allocated budget specifically for the MWs and their families, but MWs have been identified as vulnerable groups to HIV/AIDS in Nepal.

2.2 Migration in Nepal

At present Nepal is one of the major labour sending countries fulfilling the demand of rapid industrializing countries in Asia like Malaysia and the Gulf, where there is a growing demand of cheap and low skilled labor. The recent census of Central Bureau of Statistics of Nepal has revealed that a total of 7,62,181 Nepalese are absentee (2001) and they are working and living abroad (CBS 2001). An estimated number of 1.1 million Nepalese are living and working abroad today, whereas the fact sheets from Department of Labor, the figure stands at 622,528 (1993 to 2004/2005).

Lately, the economic hardship in the country is driving the Nepalese to migrate in search of work even to countries like Iraq, which is prohibited for foreign employment by the government. Thus, the number of undocumented workers is increasing rapidly, giving rise to the prospects of various vulnerabilities including health. Researches have shown that MWs are always in high risk of health hazards both in the source and the destination country. It is estimated that there are 30,000-40,000 females and 500,000 male Nepalese undocumented workers[6] living abroad. An unofficial

[1] Population Census 2001 - GoN, Kathmandu, Nepal

[2] Website: Ministrty of Health

[3] CBS (2004) Statistical Pocket Book 2004 Government of Nepal.Kahtmandu. Nepal

[4] Note: These figures represents the total amount and not per 1000

source states that there are around 10 million Nepalese working and living in different cities of India alone.

The history of migration is very long however the Foreign Employment Act was commenced only in 1985 to regulate the foreign MWs. In 1815/16 Nepalese were recruited in the British army and were well known as the brave "Gurkhas" which continues till today but slowly with globalization the foreign employment migration paradigm has shifted towards destinations like Malaysia, Qatar, Saudi Arab, UAE, Kuwait, Israel, Hong Kong, SAR of China, Afghanistan, Bahrain, Macau, Cyprus, Jordan, Oman, South Korea, Europe and USA.

Foreign Employment Act that was implemented to 'control' and 'manage' the foreign employment in 1985 has set provision of age restrictions for the migrant workers. According to Section (12) Foreign Employment should not be provided: "Notwithstanding anything contained elsewhere in this Act, the licence-holder shall not have the authority to provide the foreign employment to the minors and women. 11. Amendment to Section 12 of the Principal Act: Provided that the foreign employment may be provided to women by obtaining the permission of Government of Nepal and guardians." Clarification: (1) For the purpose of this Section, "minor" means the person who has not attained the age of eighteen years. (2) For the purpose of this Section, "guardian" means the following relative of the woman who is desirous of going in foreign employment: -

a) *Father or mother in respect of an unmarried woman and husband in respect of a married woman,*

[5] (Economic Survey 2005) GoN/Ministry of Finance, Kathmandu

b) *(b) In cases where the relative as referred to in clause (a) above is not available, the elder brother or younger brother of the same home and joint family, who has attained the age of twenty-one years, in respect of an unmarried woman and the father-in-law or mother-in-law living in the same joint family in respect of a married woman,*

c) *(c) In respect of a woman who does not have even the relatives mentioned in clause (b) above, the person recommended by the concerned Village Development Committee or Municipality stating him or her as her nearest relative.*

There are policies that discriminate against female MWs, but during the time that this research was conducted, the Supreme Court decreed that women should be issued passports without having to get permission from guardians. There were also other amendments on the discriminatory laws from the new democratic government. Since the Foreign Employment Act is old and was enacted to control rather than promote and protect MWs, a new draft Bill on Foreign Employment which will be more protective of MWs is under consideration.

The government of Nepal has formally approved 108 countries as destination for Nepalese MWs, but there are no bilateral agreements signed to ensure safety and well being of the MWs in these receiving countries. Although there has been one bilateral agreement, signed with Qatar, the details of the agreement have not been made public.

[6] These figurese are estimated after consulting with the Association of Recruiting agency

2.3 HIV/AIDS and STIs in Nepal

Studies have shown a close co-relation between migration and HIV/AIDS. Research indicates that the prevalence of HIV among the migrant population in Nepal may be as high as 4-10%. Research also indicates a higher HIV prevalence among international migrants, compared to 3% in internal migrants and 0.7% in non-migrants.[7] The first case of HIV/AIDS in Nepal was detected in July 1988, and since then the number of persons with HIV/AIDS has been increasing gradually. According to UNAIDS, the estimated number of adults and children living with HIV in Nepal in 2005 was 75,000, with a prevalence rate of 0.5%. Estimated AIDS deaths figure stood at 5100.[8] Almost every district in Nepal now has people that are HIV positive.

3. RESEARCH FINDINGS – HOME COUNTRY

3.1 Pre-departure orientation

The Labour and Transport Department of the Government of Nepal, decided to implement pre-departure orientation as a mandatory component for MWs travelling for foreign employment in 2004. Permission to leave Nepal for foreign employment is granted only after an orientation certificate is submitted to the Labour Department. The orientation serves to inform workers travelling for foreign employment about the countries they are going to, including social, cultural, and political overview. However, there is no specific law that ensures MWs receive information on health or HIV/AIDS.

> *As for the pre-departure program, Rule 27 of the Foreign Employment Regulation 2060 B.S states pre-departure training is to be imparted to foreign employees.*
>
> 1. *It is mandatory to give pre-departure training to every worker going for foreign employment before they leave; and the curriculum of the training, its duration, fees and qualification of trainers are decided by the government;*

[7] Poudel et al., 2001 New Era and SACTS, 2002
[8] 2006 Report on the Global AIDS Epidemic, UNAIDS.

> 2. *The company or institution who wish to conduct such training must fulfil the norms set by the government and department of labour shall issue licence to them within 15 days of their application;*
> 3. *As per the sub-rule (1), the department shall monitor and evaluate periodically;*
> 4. *If, company and institution does not follow the norms set by the government, department can issue directive to revise the curriculum.*

Under the regulation, 113 private companies received permission to conduct pre-departure orientations. Not all existing orientation centres are active. In order to survive, these pre-departure orientation centres link themselves with recruiting agencies. On the basis of the government guideline, the New Horizon (training centre) has developed the curriculum. Each trainer receives Training of Trainers (TOT) for seven days for pre-departure orientations and a two-days induction course. There are 8 chapters in the pre-departure training manual and the last chapter, which focuses on reproductive health issues, is designed only for female MWs.

Key issues

- The majority of MWs do not attend the pre-departure orientation classes.
- Preventive health messages are not provided during orientation.
- Pre-departure curriculum does not cover HIV/AIDS information.
- The pre-departure programme is not implemented effectively.

- There is a lack of information about the pre-departure orientation among the MWs.
- The business of buying and selling fake orientation certificates has flourished.
- Migrant Workers are under extra financial burdens, leading them to ignore health risks for profit.
- There is no mechanism to provide information regarding MWs' rights.
- A language barrier that prevents effective communication with employers and medical personnel.

Quality of pre-departure orientation

The Government of Nepal introduced the mandatory pre-departure orientation to protect migrant workers from fraud cases and to increase their awareness levels. However, in practice these pre-departure trainings are carried out, if at all, in perfunctory manner to fulfil requirements rather than actually educate the workers. Migrant Workers are not informed about the pre-departure programme, so most perspective MWs are not aware these classes exist. It was observed that most of the MWs do not attend the class, since in FGDs conducted just few hours before many were scheduled to fly, were found that almost none seemed to have attended the classes.

> *I do not know about the orientation. No, nobody has told us about the training. No, we do not have the certificates. (FGD:* MWs *leaving for Qatar)*

Only a few recruitment agencies send MWs to attend the pre-departure orientation centres, usually simply as a formality just before they depart for their flights, when they pay little or no attention

to the content of the classes. It is hard to find MWs who have attended the full two-day sessions. Some participants only stay for two or three hours at best. The trainers who conduct the pre-departure classes say it is hard to convince people to stay for the whole session. There is no factor to motivate the training institutions to make the participants attend the entire training programme.

> *Migrant Workers don't realise how important this orientation is. I request them to come to the training, at least to utilise the amount they pay for it. (Pre-departure orientation teacher in the pre-departure orientation centre)*

> *We thought there was no need to go as we already have some knowledge, because four of us had gone there before. They called us on the second day, but we did not go. We still got the certificates. (FGD: MWs leaving for Malaysia)*

> *I felt lazy and did not complete the training. In my opinion, skills are the most essential thing for anyone trying to work abroad. You should possess at least one skill and should have knowledge of the language of the country you are going to. (A deported MW from Malaysia)*

However, the few who do attend the orientation session find the orientation very important. Prospective migrants who do attend say some of the programme content is very useful.

> *Yesterday, I went to the alliance. I found one or two things important, which I did not know even though I had gone to Saudi Arabia before. The information and advice from the classes are good for those who have never been abroad before. (Returnee Migrant Worker)*

The information provided by the pre-departure orientation sessions tends to focus on "do's and don'ts" at destination countries, such as restrictions and reasons for job dismissal abroad. The information also covers discipline at airports, the climate of destination countries, and admonitions not to get involved with activities that may be illegal, like drinking or participating in labour strikes.

> *We learned about how to go to Malaysia, about the discipline, rules, religion, and living style there. We were told not to be involved in vandalism, and not to do contract marriage. We were told things like not to drink alcohol or play cards. But we have heard that people secretly drink alcohol. We should not protest against lodging, food, and religion, we were also told not to eat outside. Actually we should have been given the book they taught us from, because we had paid NRs. 700, but they only let us look at it. (FGD: MWs going to Malaysia)*

On a whole, it seems that recruiting agencies and agents have not been placing enough emphasis or importance on attending the classes. Partly this is because the issues discussed in these classes may give the workers a more informed idea of their situation, which in turn can hamper business for agents who have been dishonest or counting on the workers' native. As one teacher at the pre-departure orientation centre says:

> *They feel threatened because of some of the content we explain to the MWs, like the role of the recruiting agency and about contract letters. The participants may ask about different things, including prices. If the MWs are aware, agents are affected, because in practice if recruiting agencies ask NRs. 70,000, the agent will take NRs. 80,000 from the MWs. The agents act as the sole mediators between recruiting agencies and MWs.*

Despite the sensible, necessary goals that the mandatory pre-departure orientation was started with, in reality this has turned into a business involving the buying and selling of certificates. Some of the training institutes provide certificates without the MWs completing the training, or without even attending the orientation session at all. The government-set price is NRs. 700 for the certificate, in practice it ranges from NRs. 300 to 700 in the market. Some centres are even making a profit by providing certificates at NRs. 100 and not holding the classes at all.

> *We stayed at the orientation for one-and-a-half hours, and got certificates. I paid NRs. 600 for it. This is all a moneymaking policy. My friends have certificates, but no training. (A migrant displaying his certificates as he was leaving for Malaysia)*

However, recruiting agencies claim that this is not the standard procedure, and that the certificates are only given out without the proper training in cases; where there are practical difficulties.

> *Sometimes in cases of immediate flights, we provide the certificates. (The head of the training institution)*

> *This is a business. We have to do it. (A teacher at the pre-departure orientation centre)*

The pre-departure orientation classes do not include information on HIV/AIDS, despite training instructors asserting that there is a need for this information to be included. However, often the trainers themselves are not well informed about HIV/AIDS, and are therefore incapable of providing proper information. One trainer shared:

Malaysia is a free country where you can gamble and where you can enjoy. You can find girls with whom you can have relationships. I myself do not know much about HIV/AIDS since I am not well trained about it. HIV is not mentioned in the curriculum. I have watched some telefilms made on this issue. I have not explained about HIV/AIDS, but give them the clues to be safe from the sexual diseases.

There is a lack of regular monitoring and evaluation mechanisms for the pre-departure training.

Orientation training programmes are conducted by different private agencies, which are monitored by DoLEP. Monitoring activities are carried out when and where they are needed, and on the basis of complaints. (Personnel from the Department of Labour)

The trainers also face difficulties in conducting classes. Sometimes they have a hard time discussing climate and weather or other conditions, as there are MWs going to several different destinations in the same class.

It is difficult to explain things with a group that includes people going to different countries. So I have to explain about each country, one by one. (Teacher in a pre-departure orientation centre)

With MWs coming from all over Nepal, sometimes there are language barriers in the training centres as well. Differences in language or dialect between the teachers and the MWs become a problem, and bilingual teachers are not been appointed in the training intuitions.

Some of the MWs are from Terai areas of Nepal. They are Thakur and Chaudhary. For them, we explain slowly and ask if they understand. I do not know their language. Hill people also do not understand Nepali language properly. (Trainer in the pre-departure orientation centre)

The information, education, and communication (IEC) material could be a good means of educating people rather than verbal classes. One of the orientation centres had produced audio and visual material for the pre-departure training sessions, but unfortunately these were destroyed during the 1st September incident in 2004[9].

Unfortunately, the pre-departure classes are gaining a reputation of imposing extra financial burdens upon MWs. The pre-departure orientation centres are located in Kathmandu. Most MWs are from rural areas of Nepal and often have to take loans to support their migration process; travelling all the way to Kathmandu, and then paying for food and lodging while they attend the pre-departure classes is an added expense.

Orientation is very important but you have to pay extra money and people come from various places, and so have to spend money on transportation. So that is the main problem. (A returnee MW from Malaysia)

It should be noted that MWs often get cheated and face difficulties in the rural areas before they even arrive in Kathmandu. There is a huge information gap between the pre-departure programme and the MWs. The media and NGOs could help lessen this gap. Some NGOs are conducting awareness programmes, using information booths, peer groups, and radio programmes, but there still does not seem to be enough being done to make MWs sufficiently aware about these issues.

3.2 Access to preventive messages

According to the Constitution of the Kingdom of Nepal 2047 B.S; *11. Rights to Equality: All citizens shall be equal by the law. No person shall be denied the equal protection of the laws. (3) The state shall not discriminate citizens among citizens on basis of religion, race, sex, caste, tribe or ideological conviction or any of these.*

The pre-departure programme involves only the occupational safety messages. In most cases, MWs receive information about health from relatives or friends who have worked abroad. In most cases, returnees are the only source of whatever limited information is available on the weather, climate and healthcare. Migrants also get information on first aid treatment and precautions at working place and health from their fellow returnees.

> *Returnee friends have told us about the weather and healthcare. They say if you have a headache or feel dizzy, drink lukewarm water with some salt. If you sweat a lot, then drink a lot of water. (FGD: migrants going to Qatar)*

> *Our friends who had returned from Qatar have said it is hot outside so we should not bathe immediately after coming back from work. We need to rest first, and then bathe. They also said there are some liquids available for cleaning the toilets, and some people drink it since it quenches your thirst for alcohol. They say don't drink that, it is not good for your heath, and also do not eat outside after 7 o'clock. (FDG: migrants going to Qatar)*

Some MWs learn about HIV from the print and electronic media like radio, but still lack correct information.

> *I have heard about HIV/AIDS from the radio, TV, and billboards. It is transmitted while talking with family and friends and one another. It also transmits through injection. (Balloon opinion: potential migrants going to Malaysia.)*

Most prospective migrants have no knowledge about healthcare facilities in their destination countries. They just assume that they should contact the supervisor of the factory in order to be taken care of.

Knowledge of insurance

Insurance could provide a good protective means of securing healthcare for MWs, but there are problems in providing them with information about it. According to the Foreign Employment Regulations, MWs have to be insured. The insurance premiums are NRs. 500[10] on the insured amount of NRs. 100,000.

> *As per Rule 9 and 14 of FER, 2004;*
> *n. Provision of insurance of the worker and health facility.*
> *j. Certificate of insurance*.

Most MWs are not aware about insurance. The recruiting agencies who take care of the documents do not inform the MWs of whether they are insured or not, how much they are paying, and how to make an insurance claim if the need arises.

> *I do not know. I have to see the agreement for insurance. It should be a policy that we should not be able to fly before getting insurance. (FGD: migrants going to Saudi Arabia)*

[9] 12 Nepalese were slain in Iraq by Muslim Terroists Iraq

We keep the documents because they might lose them. If something happens while they are abroad, then the message comes to us first. Therefore, we keep these documents and after 2 years the files are slowly closed down. (Personnel from the recruiting agency)

The lack of information about insurance provisions affects the claims process, and many migrants do not receive or find it difficult to receive the insurance claims.

Knowledge of migrants' health rights

Rule 13 of FER, 2004: Content of the foreign employment contract, (f) Provision of healthcare of sick MW. Rule 13 of FER, 2004: Foreign Employment contract document should contain the following; (b) Provision of salary and facility, working hours and overtime remuneration. The contract agreement between worker and the employer company should contain the following; The designation of the worker and the job description, salary structure, facilities, working hours, overtime remuneration and other facilities, probation period, condition of breach of contract, remuneration in case of accidental and death cases, medical facilities, arrangement to bring the corpse in case of death, process of settlement of dispute with the worker and employer agency, holidays and insurance schemes.

Though the contract document has to have all the elements mentioned as per the Rule 13; such as medical facilities and proper hours of work, as per the contract, but the migrants do not get so in practice. They still lack the preventive messages that promote safe health and knowledge of migrant health rights in the destination country. As the MWs are ignorant about their rights, they keep silent.

Employers do not pay much attention to the environment for the MWs, and as a result they often work in hazardous situations that make them physically vulnerable to harm.

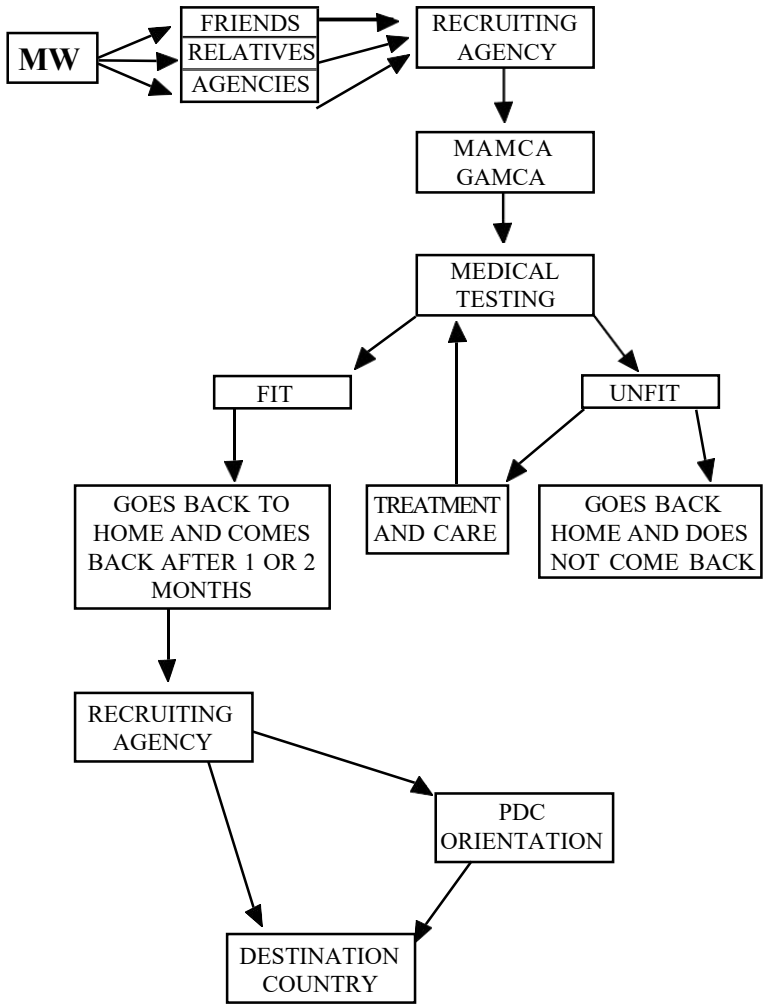
No one told us what should we do or what we should not do in Malaysia if we fall sick there. (A prospective migrant, ready to fly for Malaysia).

At the same time, the migrants are well informed they should not form unions and or participate in strikes. As a result, they are not in a position to demand their health rights. They feel that if they fall sick in the destination country, they should deal with it through other channels.

They have said nothing but we think we should send the message to the in-charge through friends and he will give us the medicine. (FGD: migrants leaving for Qatar)

[10] Local Currency $ 1 = 70 NRs

Chart 1: Pre-departure and medical testing flow chart



3.3 Medical testing

The Foreign Employment Act includes stipulations ensuring that MWs are ensured good health before being sent for foreign employment.

> *In Section (9) Prior permission to be obtained and clause (d) of Sub-section (2) Government of Nepal shall not provide permission for selecting workers if the particulars submitted pursuant to Sub-section (1), when scrutinised show the following; (d) "If the proposed foreign employment is against the value, dignity or health of the worker"*

With the increase in foreign employment in the recent years, medical tests has been made mandatory by several receiving countries, and the Nepalese national policy supports a mandatory health test before approving foreign employment. The selection criterion clearly states.

> *Rule 11: Selection Criteria of Workers*
> - *Healthy State of worker*
>
> *As per Rule 11 of FER, 2004 Selection Criteria of Workers and Rule 12 Health Test*
> Rule 12: Health Test
>
> *In case of the individual applicant selected under the Rule 11 or under the Article 23, she/he has to submit the health certificate certified from the personal recognized by the GoN.*

The tests are conducted as per the demand of the receiving country:

- Vision
- Hearing
- Systemic examination
- Venereal disease
- Chest x-ray
- Psychiatric and neurological disorders
- Urine tests
- Stool samples
- HIV test
- Pregnancy test (for females)

The policy clearly states that HIV/AIDS testing is not mandatory; however, this can be seen to contradict the statement under the Infectious Disease Control Act:

> Section 2 of the Infectious Diseases Control Act, 2020 B.S (1963): *GoN Nepal may issue order on people or group of people in order to prevent the spread of infectious diseases.*
>
> *3. Policy for HIV Testing and Counselling*
>
> - *Mandatory Testing for HIV is not allowed in Nepal.*
> - *Compulsory testing for HIV is prohibited, unless required by law. e.g. recruits to 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.]*

Here the clause, says it can be tested for visa employment purpose.

For testing, the Malaysia Approved Medical Centre Association (MAMCA) and the Gulf Approved Medical Centre Association (GAMCA) are secretariat bodies of the medical testing. An official from MAMCA says that there are nine testing centres under its umbrella. Although healthcare facilities are available in different parts of Nepal, the medical testing procedures for MWs are all in the capital, Kathmandu. Hence the workers have to travel from different parts of Nepal to Kathmandu for their medical tests. Recruiting agencies send MWs to the MAMCA and GAMCA, which then send them to the respective testing centres on a rotation basis. Sometimes recruiting agencies send MWs directly to the testing centre.

> *We will be sent by GAMCA to the medical test centres. (FGD: migrants going to Saudi Arabia)*

A staff member from the Ministry of Health said they had formed a body and selected a few medical testing centres that are qualified to conduct the tests, and given the list to the Ministry of Foreign Affairs. However, he did not know if this recommendation has been followed.

Test procedure

Potential migrants arrive at recruiting agencies from rural areas, often referred through friends, agents (brokers), or relatives. The recruiting agencies then send them to the testing centres. Doctors at these centres say that MWs who come usually have no problem locating the testing centre, as they are almost always accompanied by staff from the recruiting agency or broker who are called agents by the MWs.

We came with the agents. (FGD: migrants going to Malaysia)

The medical check up process takes two days. Once the migrant reaches the centre on the first day, a series of test is taken, along with photocopies of their passport, one photograph, and NRs. 1500 to 2000. Then urine and blood are taken, and the migrant's weight, height, vision, blood pressure, and heart condition are assessed, and x-rays are taken. During the physical check up the workers are required to be naked. After completing these, the MWs leave for the day; often agents are seen waiting outside the testing centres to collect them when the tests are over. All the reports are collected and studied by the panel of the doctors, to produce test results for the second day.

Though the standard procedure is only two days, sometimes the MWs have to return for more tests. Respondents said that once the medical test is complete, they go back to their villages and come back again in one or two months after being summoned by recruiting agencies, their agents, relatives, or friends. The medical report remains valid only for two months.

> *We did the medical exam twice. The agency had sent us when we first came to Kathmandu, but the manpower then sent us to the nearby medical centre for blood grouping again. (FGD: migrants going to Qatar)*

Most potential MWs have heard about the medical test before they begin the migration process. Unlike the pre-departure training, they are aware of the fact that they are required to have the medical exam, and that they will also undergo one in the destination country as well.

> *The medical is the most important; we cannot go without it. There will be another medical test in Malaysia; if we fail there we will be sent back. The test is done because we may be infected with fatal diseases. If any disease is found we will be deported. (FGD: migrants going to Malaysia)*

Migrant Workers say it is important to be 'fit' to go for foreign employment. The terms 'fit' and 'unfit' carry a lot of weight for them, and it's the final verdict of the medical tests rather than the procedure that interests them. They rarely feel the need to ask about the tests, and the doctors do not make the effort to explain the processes to them. There is no pre or post-test counselling or other information provided.

> *We are happy to find out that we are fit, we do not ask about the test and they do not explain. Nobody asks about the tests. (FGD: migrant leaving for Qatar)*
> *We do not explain about the tests, which are required for the concerned country. But they know about it. They know about HIV, but instead refer to it as "something wrong in the blood". Even if they do not know about STDs, they will know about HIV. They sometimes lie, but we give counselling. (Medical professional from a testing centre)*

> *Since the MWs come from rural areas, their interest is concentrated in getting a visa to Malaysia and not on the different tests they are undergoing. They do whatever their agents tell them to do. (Doctor at a testing centre)*

Recruiting agency personnel say that they do not brief MWs about the medical tests because that is the medical centre's job.

> *If we start explaining, it will take another three to four days. (Recruiting agency staff member)*

The respondents find the treatments "*satisfying"*. The MWs are not able to assess the quality of the treatment they are provided with, responding that "*Hospital and everything is fine".* While undergoing the physical check up, the workers have to be naked, and they comply even though they are uncomfortable, for the sake of going abroad. At some places MWs are tested in groups, and in others they are tested one by one. There are mixed responses on the comfort level:

> *It is fine. We are compelled to do what they say. (Balloon opinion: migrants leaving for Malaysia)*
>
> *Everyone goes through the same thing, so I did not feel uncomfortable. (FGD: MW leaving for Saudi Arabia)*
>
> *Many come from village so they do not feel comfortable, that's natural. The doctors don't differentiate between males or females, but when young females come through we allow their parents to be present if they wish. (Doctor at a testing centre)*

The doctor claimed that they do not compromise results, as there are penalties if the migrant returns with health problems. In some cases the doctors are personally held responsible, and in others the organisation receives the penalty. Medical auditing and laboratories are maintained. All the medical professionals interviewed claimed that their testing centre maintain quality standards.

One member of recruiting agency personnel said that rather than a monopoly where only a few testing centres are approved; there should be a free market, which creates competition and promotes quality.

Costs for the medical testing requirement

The cost of the tests varies, ranging from NRs. 1,500 to 2,200 for Malaysia, Qatar and Saudi Arabia. The respondents have to bear all the cost of the medical examination, as well as the expenses of travelling to and staying in Kathmandu while the tests are conducted. Only one of the respondents said he had paid NRs. 5,000 for pre-departure and medical test, which also covered his stay in Kathmandu. Otherwise, the medical test bills are exclusive of the amount MWs already pay to recruiting agencies, which varies from NRs. 45,000 to 70,000 or even 85,000 and more, depending upon the agency.

> *Saudi NRs. 2,200, Qatar NRs. 1,500, we have to pay on our own. First we have to be interviewed, and if we pass we go to GAMCA, and they send us to particular medical centres. (FGD: migrants going to Saudi Arabia)*

The MWs meet these costs by borrowing money at a very high interest rate. Often they are unaware of the medical fees until they are sent to the training centres, but do not have the time to go and explore the issue.

But the professionals involved in the testing centres and recruiting agencies say the cost is reasonable, since the testing centres provide a package deal , which is cheaper than government hospitals.

Handling unfit cases

Migrant Workers do not receive pre-test counselling. However, there are provisions for post-test counselling in cases where somebody is found unfit due to HIV or other diseases. In such cases, the candidate is called to the testing centre for counselling.

In cases of mild illnesses, the candidates are given medicine, and after they are cured they become eligible to try for foreign employment again. Migrants infected with HIV, STIs, or heart diseases are referred to the concerned hospitals.

> *If somebody is found unfit, they do not send the report to us. They call the candidate themselves. (Recruiting agency personnel)*

> *If it can be cured, we give them medicine, and once they are fit we give them the certificate. (Doctor at a testing centre)*

The National Policy on AIDS and STD Control 2052 B.S (1995), policy no. 7: records kept confidential; provides that the results of tests carried out for HIV or STDs shall be kept confidential.

However, despite this policy, most MWs do not collect their own medical reports; usually the agents collect it for them or it is send directly to the recruiting agency. This is a breach of the MWs' right to confidentiality, as their medical information is shared with the agents, and potentially even other migrants. Without proper medical counselling, there is also a chance that MWs found to be unfit due to HIV do not come for a follow up, which increases the risk to their families.

> *Some people want to go for foreign employment even if they are HIV positive. HIV patients are a bit shy. I try to tell them what to do next, and give them good counselling, but they do not come for follow-ups, they run away. (Doctor at a testing centre)*

Female MWs also get a pregnancy test as part of the physical examination. Even if they are otherwise medically fit, pregnant women are not eligible for foreign employment.

The recruiting agencies show very little concern for what happens to unfit candidates, since they can only profit from medically fit workers. It is too much of a risk to try to send the unfit candidates, as they are usually deported back after few months.

One of the medical tests which bar migrants from going for foreign employment is the chest x-ray. Doctors say that most Nepalese suffer from pneumonia during childhood, which is not cured well and leaves a permanent scar on the chest. This scar is visible on the chest x-ray, which means the potential candidate is declared 'unfit'. However these scars are not a bar from joining any other kind of job, even including Nepalese army and police. Doctors who do not know about the medical tests for foreign employment often declare MWs with these signs medically fit. Therefore, the doctors at the testing centres have a difficult time telling the MWs why they are found unfit. The worker still looks healthy even if they have the scars, and can work without difficulty.

Some recruiting agents explained that there are ways to avoid the scars being detected:

> *When a lot of banana and yoghurt or milk is consumed just before the medical test the scar on the chest is not visible and the worker is declared medically fit.*

However, there is no medical basis for this belief. In Malaysia, if somebody is strong enough to work but has spots on the chest, they are immediately sent back to Nepal, says the head of one recruiting agency.

Migrant Workers' insurance only covers health issues caused in the workplace, and so if they are found to have any other problems once they reach their destination, they are sent back immediately. Generally, if this happens the recruitment agency gives the MWs money back, and then is reimbursed by the testing centres, which are held responsible for not identifying the problem prior to the MWs departure.

4. RESEARCH FINDINGS – ONSITE IN DESTINATION COUNTRIES

There is no policy or law to ensure that the MWs receive information on health in their destination countries. However, creating safe health and safe working environment for MWs abroad needs to include very necessary facilities, especially physical accessibility to affordable healthcare services, and availability of quality, appropriate health information and services, a healthy lifestyle and nutrition, and respect for their health rights. But these facilities are not provided to the MWs; instead, more time is spent on mandatory health testing and documentation status.

4.1 Access to preventive messages

Access to preventive message is one of the most important components for the health and well being of MWs in their destination countries. Research has indicated that while MWs are vulnerable to different diseases, they are not provided with preventive health messages, or information on STIs and HIV/AIDS in both source and destination countries. Often MWs who are blamed for bringing diseases into destination country actually tested fit and healthy when they leave their country of origin. However, in absence of formal sources of health information and preventative messages, MWs' only sources of information are their friends and co-workers, who are often not properly, informed themselves. All MWs, both documented and undocumented said that they get information through friends during social gatherings. However, this depends greatly upon the country of destination. In

country like Hong Kong, SAR of China, for example, a domestic helper has the freedom to explore and access information. In contrast, the domestic workers in Saudi Arabia or the Gulf countries may not have the same opportunities, as they are given restricted freedom; any communication with outside world is usually not possible.

> *Every Sunday we have time off and Nepalese gather at Kowloon Park. Likewise the Filipinos and Indonesians also gather together on off days. During that time we share information. For most of our questions, we can get lots of information through friends. (Returnee migrant domestic worker from Hong Kong, SAR of China)*

> *We were not allowed to go out of the house, so did not know anything. I could only see a hospital when I was taken for a medical test. (Returnee migrant domestic worker from Saudi Arabia)*

In India, similarities in language and culture make it a lot easier for Nepalese MWs to get information. Still, even in India the major sources of information are the friends and co-workers.

4.2 Living conditions

Living condition factors, such as food, sanitation, working hours, and working environment affect both the health of MWs and the productivity of the company. A lack of basic facilities in destination countries often ruins the health of MWs. However, the situation differs from one country to another. Female MWs who had worked in Korea said they had a rented apartment and the company where they worked provided lunch. These women's salary was lucrative compared to a male migrant worker in the Gulf countries or Malaysia. They were also provided with adequate drinking water. They believed that the 'tap water was clean and safe for drinking'.

In contrast, MWs from Malaysia reported that they had to share a big room with a large number of fellow workers. Besides the health hazards of such cramped conditions, they also found it impossible to sleep soundly and get proper rest. On top of this, they also had to queue for up to four hours to freshen up since the bathrooms were always packed.

> *There are four thousand workers in our factory. 150 of us shared the same room, provided by the company. In the factory, we always had to clean the machines before leaving, but cleaning our living quarters with large numbers of workers living together was almost impossible. Unhealthy and congested living quarters causes health problems, but once workers fall sick because of the living environment, they are not treated. Eleven people fell sick and they were sent home. Employers are happy if we work even when we are sick, otherwise they say to go back home. There are problems living together like this. A friend from Butwal died in his bed. We collected money to send the dead body back to Nepal. (A deported MW from Malaysia)*

4.3 Working conditions

Poor working conditions also contribute to health problems for MWs. Often they do not have enough time to cook as they work for 12 hours everyday. They depend upon the canteen food, which is more expensive than the agreed rate in their contract papers.

> *The agreement says that the cost will be 160 ringet, but we pay 220 ringet. (A Migrant Worker from Malaysia)*

Even MWs that are healthy on departure from Nepal have chances of falling sick due to high pressure, poor working environments with no supplementary preventive health measures.

I had kidney problem. I had no sugar or blood pressure problems, but I think sweating and a lack of adequate water caused the kidney problem. (Documented returnee textile worker from Korea)

Undocumented MWs always use social networks to find jobs. However, because they are there illegally, they face problems such as employers refusing to pay, or firing them for unjust reasons. Migrant Workers, especially women, are often harassed by the local people. Sometimes undocumented workers have to work in extremely poor working conditions. To escape these situations, they keep changing jobs, but are often repeatedly victimised. One female returnee said she had changed three jobs during her two-year working period.

I managed to find work in leather factory with the help from Nepali people in Korea. The working place was very dirty, but I worked there for 9 months. It was very hard to work being a woman. I slipped away to Seoul where I worked in Iron Company. (Undocumented returnee Migrant Worker from Korea)

4.4 Access to health care and services

Access to health facilities

Issues:
Accessibility is limited by cost
Lack of provisions for sick leave
Restricted freedom of movement
Legal status

GoN introduced; Regarding the treatment and care, Rule 13 of Foreign Employment Regulation, 2060 B.S (2004): Foreign Employment contract document should contain the following; (between employer and employee)
e. In case of accident and death of the MW, list of compensation to be received by the heir.
f. Provision of medical treatment if the Migrant Worker has any health problem.

Although most companies provide MWs with healthcare facilities, there are still many that fail to do so. Often workers are not given healthcare as per their contract agreements. It is particularly difficult for undocumented female MWs to get healthcare, due to social and cultural barriers, and a lack of knowledge of the local language. Female migrant workers feel compelled to keep silent about their diseases and suffering. They try to hide the illness, especially if it is related to reproductive health.

Access to healthcare and services varies from country to country, along with the individual capacity to explore and available networks. In spite of knowledge about where healthcare centres are located, accessibility could be limited due to high cost, or the fear of job termination. The fear of getting arrested while seeking treatment is an additional factor for the undocumented MWs. Undocumented MWs try to avoid contact with official or government personnel, including health workers, unless their lives are in danger.

Late one night my husband had a severe pain in his stomach. He requested his Nepalese roommate to call the local ambulance. He refused, since we were all undocumented MWs. When the pain was too much to bear, my husband shouted, "I would rather give myself up to the police than die like this, please go and bring the ambulance." When both of us started crying, his friend

had no choice; he brought the ambulance. Since it was emergency service it was very fast. Luckily the police in the hospital did not do anything to us. He just asked us where we were from. We told him we were from Nepal. He did not check our visas. He just looked at our passport to make sure of our identities, and that was all. (Undocumented female returnee from Japan)

Workers also face problems in accessing healthcare due to fears of losing their jobs, and because of employers' negligence when the sickness is not caused at the work place. They try to suffer silently and only go to the doctor when the pain is unbearable. This applies to both for undocumented and documented workers.

If we mention that we have illnesses or diseases, then there is a high chance of our jobs being terminated, so we do not mention it even if we have headaches, stomach problems, etc. We go to the nearby Indian medical store to buy medicines and take those until we have chronic illness. (Documented returnee from Hong Kong, SAR of China)

When my husband had a summer boil on his left leg, we were scared that if we told them we might lose our jobs. When pain was too much, we lied to our boss; the infection was caused by an accident while working in the factory. (Female undocumented returnee from Japan aged 45)

Migrant Workers' access to healthcare is also affected by their freedom of movement, particularly domestic workers who do not have access to a doctor as they are not allowed to go out when they fall sick. Therefore, there are chances of not getting proper treatment or not receiving any treatment at all.

One day I had a stomach-ache and fever, and I vomited blood. My owner's young son saw that and told his mother. I told her that I do not want to stay there, I wanted to go home. I did not have any medicine. They started treating me badly, (chi! chi! dur dur!) and gave me food in a different plate. They did not give me medicine. I was not allowed to go out by myself. I had not seen the hospital and they did not take me. (Female returnee from Saudi Arabia, aged 26)

Health seeking behaviour

Even when MWs are aware about the availability of hospitals, private clinics etc, they still may not get access to these facilities. They often resort to self-medication, with drugs they bring with them from their home country, or which they buy from cheaper medicine stores.

I took Citamol, Aspro, and Acilog. When ill, I did not go anywhere and took medicine myself. I was afraid to tell madam as my job might be terminated. After that, I went to my brother's place in Jordan and bought medicine from the Indian shop. If we mention that we have some illness or diseases, then there is high chance of termination so we do not say even if we have headache, stomach problems, etc. We go to the Indian medical store to buy medicines and take those until we have chronic illness. (Female documented returnee MW from Hong Kong, SAR of China).

The nature of the work may be same for the domestic workers in various destination countries, but seeking treatment is more of a problem in the Gulf countries as they

are not allowed to go out. They carry on living with the pain and suffering from various untreated illnesses. Even if they inform employers about their illness, often they are not treated as domestic workers as seen as a mere commodity, without the need for any compassion or care.

> *My employer said, "No, you cannot go. We bought you for one lakh rupees." She did not give me medicine. (Domestic worker in Saudi Arabia)*

It is only in extreme emergency cases that migrants go directly to the hospital despite their undocumented status, risking arrest and detention. However, in cases where the companies have a doctor on staff, even documented MWs are scared to go to the doctor or ask for sick leave because they fear being sent back home, since employers do not like their MWs taking leave.

> *Actually, it was not easy to approach a doctor even if we are sick. In Japan, factory owners and our bosses do not like workers taking sick leave. We MWs usually did not take sick leave until the illness was intolerable, for fear of our jobs being terminated. (Undocumented worker from Japan)*

Cost of treatment

Cost is one of the major factors that hinder access to treatment in all the major destination countries, including Japan, Korea, Hong Kong, SAR of China, and Malaysia. Treatment is very expensive compared to Nepal, so MWs prefer to come home for treatment instead. Migrants have to pay for healthcare if they get hurt or sick when they are not working in the factory, and sometimes they have to go to the factory owner back for the treatment. Payment methods depend on the company and the workers' contracts. The research

participants say that in Korea there are organisations that help raise money for the treatment of MWs.

> *Doctor's fees are expensive, so no doctor. The pain remained same, I came home to Nepal. (Documented female domestic worker returnee from Hong Kong, SAR of China)*

> *Our factory owner paid for the summer boil since we had lied to him about having an accident in the factory. Otherwise, it would have been expensive. (Undocumented female returnee from Japan)*

> *While working in the factory my hands were crushed and I was taken to the hospital. My fingers were cut off and the bill was for NRs. 40 lakh, so instead of working 9 hours he told me to work from morning 8'o clock till 1'oclock in night to pay it off. I had to work continuously even as blood oozed out of my hand. After a month, he didn't pay me, and when I asked for my money he said that I had to work for free for a year because he had paid 40 lakh for me. (Undocumented female MW from Korea)*

Medical costs are very high in Malaysia, and the MWs have to pay for it themselves. Sometimes they have relatives who support them, but otherwise it is difficult to pay for the medical costs. When one of the migrants fell ill in Malaysia with malaria, his friends and relatives had to help him pay the bills.

> *I had brothers there to support me; otherwise I would not have been able to pay that amount. The big companies sometimes do not pay much attention on the workers' health. They ignore health facilities, medical treatment, and regular health check-ups. Some of the companies send their workers for health check up, but charge extra money*

for this. Workers are not told about these charges before, and the workers find out after getting their salary as the money is deducted from their pay. (Returnee Migrant Worker from Malaysia)

Conditions also depend upon the company. For example:

It all depends on the company and the contract; good companies may even pay for the treatment, bad ones may not even give workers their salaries.

Once the company told us to take injections, we thought it was of free. So all of us went, but later the company deducted 98 ringets from our salary. (Migrant Worker from Malaysia)

Insurance

Health insurance can be a means in accessing treatment, but usually the migrants do not know if they are insured or not, as they don't read their contracts. The contract papers should include:

Rule 13: The list of contents of the contract document
The contract agreement between worker and the employer company should contain the following;

The designation of the worker and the job description, salary structure, facilities, working hours, overtime remuneration and other facilities, probation period, condition of breach of contract, remuneration in case of accidental and death cases, medical facilities, arrangement to bring the corpse in case of death, process of settlement of dispute with the worker and employer agency, holidays and insurance schemes.

Legal MWs are insured in their home country; however undocumented workers are not insured. Even the insured migrants find it difficult to access treatment in the destination country, since they are only insured for accidents at the workplace and not for general health problems.

I went legally but they said they would only pay if an accident occurred while working. We had to pay NRs. 1000 as medical insurance. (Male documented Migrant Worker from Korea)

Language barrier

Language barriers are a big problem in accessing proper treatment. Language difficulties mean that MWs often do not get proper information, and have to resort to sign language or speak broken English. In Korea, though there was a company interpreter, one was not available in the hospital. One of the research participants says his illness got worse because of the language barrier:

They must have said something, I must have done something, again they tried to tell me something, and I might have understood something else. Yes, if I had understood the language then maybe my kidneys would not have failed. (Documented Migrant Worker from Korea).

I could not understand their language properly. So I could not tell them about my problem. (Returnee from Saudi Arabia)
Those who speak neither Malay nor English communicate through signs. The migrants understand the language, but just cannot speak it. (Returnee from Malaysia)

Quality of health services

Though there are company doctors available in Malaysia, Nepalese migrants do not trust these doctors, as they feel they are discriminated against and given expired medicine.

> *The company also keeps a doctor. He gave me an injection once, which still hurts. They respect workers from the Philippines, China, and Vietnam. They do not treat us well. They do not take much care of the Nepalese patients and give us expired medicines. We are foreigners to them, and they do not consider our life to be life. (Male documented deported Migrant Worker from Malaysia)*

While MWs in Malaysia have reported discrimination, there are examples of migrants being treated well in countries like Japan and Korea, especially in cases where doctors have visited Nepal. The treatment also depends on the personal behaviour.

> *In the company they used to give us less salary and dominate us, but in public places people used to treat us nicely. (Male documented returnee from Korea)*

> *Their job is to give services to the people; they do not care if you are Korean or Nepali. (Undocumented Migrant Worker from Korea)*
> *He was given medicine and discharged in the morning. Yes, the doctor was very good to us since he had visited Nepal several times and most of the Nepalese MWs in our area went to his place for treatment. (Female undocumented Migrant Worker from Japan)*

Health problems experienced

According to medical professionals from the medical testing centre in Nepal, dead bodies of Nepalese MWs coming back from different countries everyday. Deaths of MWs in Malaysia are increasing. They are reported as natural deaths. Research participants report cases of stomach pain, fever, malaria, jaundice, blood pressure, obesity, physical disability, summer boil, kidney failure, and mental trauma in various destination countries. The research found that domestic maids often undergo various psychological traumas. The confined and isolated house environment, along with the ill treatment of the maids creates problems in both physical and mental health.

Case study: Saudi Arabian domestic worker who did not receive pre-departure orientation

Sita, a 26-year-old widow, went to Saudi Arabia as a domestic helper. She did not receive any pre-departure training or go through medical testing as a relative completed all her foreign employment documents for her. As a result, she arrived without knowing anything about Saudi Arabian religion and culture. She did not know that the owners' ate cow's meat, which is forbidden in Nepal. She could not stand the smell and she started eating less, which led to gastric problems. During a gathering of relatives during the Eid festival, she also learnt that the previous maid working in the same house was burnt to death. *"I was very scared. I heard that a housemaid was burnt and killed in the same place where I was working. I was sick and wanted to come back home. The inner fear fuelled my worsening health condition".* She eventually came back to Nepal with the help of another Nepali.

Medical testing and deportation

Contract provisions for medical testing in the destination country forces many MWs to come home without completing the contract period. Deportation occurs due to lack of sensitivity, responsibility and respect for MWs' rights by the employer and the host government. Employers often see MWs as a tool for production, and not as human beings. They use them until they can no longer work, and then basically throw them away. Such irresponsible attitudes from employers lead to MWs facing various health vulnerabilities, even after they are deported. Sometimes health issues are actually covered for other reasons for deportation. An official at the medical testing centre says that *when MWs fail to cooperate with their bosses, they are sent back under the pretext of being 'medically unfit'*.

One MW from Malaysia was deported because he was suffering from malaria and could not work for a week. Sometimes the MWs are not informed about their diseases or the cause of their illness, and deported even with curable diseases. In doing so, the receiving countries are ignoring even the basic human and the migrant rights.

> *I was sent back without any information. I did not know why I was sent back. I had malaria, so I did not go to work for one week. The boss came and asked me why I was not working. I told him I had fever, so I could not. He told me to go back to Nepal. I then said I could not because I had no money. He told me to rest, and after four days I was taken to the airport. I was a documented worker. I just had fever. I do not know why they sent me back. One of my friends got mad and was sent back, another was sent back because he had high blood pressure. If we continue to work even when we are sick then they do not send us*

> *back, but if the doctor's bill increases then they send us home. (Migrant Worker deported from Malaysia)*

Receiving countries do not recognise the specific needs and rights of HIV positive MWs. Instead, they detain and deport them without any counselling, treatment or referral to care or support organisations back home. Even though India and Nepal share an open border, once the Nepalese MWs are found HIV positive, they are sent back.

> *I had loose motion. I have a friend in Madras, he told me to come with him to the market, and then he took me to a hospital. The doctor took blood and told me to stay outside for an hour. I stayed there, and my friend took the report. After coming back home to our room, the boss and my friend told me to go back to my home in Nepal. (Migrant Worker returned from India)*

5. RESEARCH FINDINGS - REINTEGRATION IN HOME COUNTRY

There are no policies for a migrant reintegration programme so far. The Government of Nepal does not have specific programmes for the sick returnee migrants. In the absence of any formal sources; friends, relatives, and other former MWs provide information, care, and support to returnee MWs. A migrant returning with a serious illness comes and goes straight to the hospital on his or her own or family's initiative. Usually, they go to the nearest hospital that is available. It is found that simple cases that could have been cured with simple medication have also been deported back home. There are no reintegration programmes to help assist such returnees who are deported due to health problems. As a consequence, migrants have to come home before the contract expiry date and are left with the debts for the loans that they had taken to go abroad, and have to resort to internal migration—usually to Kathmandu.

Healthcare costs are a major factor in healthcare access both in host and home country. If costs could be managed, it is not that difficult to access treatment in Nepal using available medical facilities. However, MWs, especially those who return prematurely with illness and injuries, or are deported back home due to the health problem; find it difficult to manage expenses for their treatment, as they are already heavily in debt.

One male MW, who was deported due to kidney problems, found that kidney treatment is very expensive in Nepal. He says, "*I am*

going to a private clinic. It is quite expensive. It is cheaper in (the public) Bir hospital, but I cannot go there. We have no good networking. In Nepal people having low income will die". The returnee migrants usually cannot afford much, and though government hospitals are cheaper, they are overcrowded and hard to get into, without a network of connections with high officials.

Some migrants deported from India after being found to be HIV positive are not informed of why they are being sent back. They come to know about their status only if they undergo another check up in Nepal. People with HIV face immense social stigma.

> *It is a harsh reality to face the negligence and hate of the society where one lives. (A returnee Worker infected with HIV)*

Often, an HIV infected person will try to hide his/her status even from their spouses because of fear of social exclusion. In Nepal, many of them die without being diagnosed with HIV/AIDS, and the family come to know about it only after their death. In the western and far western regions of Nepal, people know the disease as "*Bombaiya*" (a term which signifies that it was initially brought back from Mumbai in India). Some of the people who are aware that they are HIV positive go into shelter homes.

> *Finally, I came to Nava Kiran Plus. My wife hates me. I have not told my wife about my HIV status. (An HIV positive returnee)*

Returnees who are HIV positive status are often excluded by their families and society, although there are some positive examples of those who are loved and cared for by family and friends. There is still a great need for proper awareness to reduce stigma against HIV/AIDS patients.

6. CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Although MWs make such an enormous contribution to our economy in the form of remittances, the country still lacks protective, care and support measures to ensure their health is cared for. The Government of Nepal has not developed appropriate mechanisms that guarantee MWs access to preventive measures and care facilities. There are also gaps in existing policies and implementation processes.

- The health policy does not cover MWs going for foreign employment, though the HIV policy covers mobile population. There are no programmes to inform MWs about their health and their health rights in destination countries, and there is no separate budget allocated for this purpose.
- Though the pre-departure orientation programme started in the year 2004, most MWs do not attend these classes or does not even know it exists. The pre-departure classes are not effective and most of the migrants leave without taking these class, which increases their vulnerability to occupational and health hazards. The curriculum does not include HIV/AIDS and STIs information.
- Agents/brokers are an integral part of the migration process in Nepal, which has added to trends of overcharging MWs and debt bondage.

- The migrants have to pass a medical test to be eligible for foreign employment; the exam includes tests for the following: vision, hearing, systemic examination, venereal disease, chest x-ray, psychiatric and neurological disorders, urine, stool, HIV, and pregnancy.

The HIV testing policy and foreign employment regulations support mandatory testing of MWs for HIV/AIDS. It can be concluded that the MWs are well aware of the medical test, but see it as an iron gate that has to be passed to be able to go abroad. As a result, they are more interested in passing the test so they can go, rather than actually hearing the test process.

Since the health test reports are collected by recruiting agencies, there is a chance that the confidentiality of the HIV tests is breached.

While testing centres provide an ideal opportunity to provide MWs with health-related information, including HIV/AIDS, in practice this is not being used.

- All the pre-departure orientation centres and the medical testing centres are located in Kathmandu; this adds to MWs financial burden, as many are from rural areas and must pay for expenses including travel, food, and lodging to come to these centres, in addition to the amount they pay to the recruiting agencies.

Potential migrants are mostly from rural areas and so lack the ability to assess the quality of the medical tests they are given. Some make their first trip to Kathmandu to come to these centres.

- The policy or law does not include post-arrival programmes for MWs. After the screening through medical tests, all the migrants are assumed to be healthy. There are no

programmes run by host or home countries to provide preventive messages and healthcare information to the MWs.

- Having inadequate information on healthcare facilities; limits the MWs from finding treatment in their destination countries. Sometimes they even face discrimination while accessing treatment.
- Health-seeking behaviour depends on the migrants' social network, individual level of freedom, and legal status in their destination countries.
- Migrants coming from rural areas are generally ignorant about the insurance scheme, which limits their access to treatment.
- Due to lack of reintegration programmes, there is no safe and dignified repatriation for MWs with health problems after their contracts are terminated or they are deported.
- Even in cases where MWs are aware of how to access healthcare, they are still limited by financial constraints.

6.2 Recommendations

Law, policy, and programmes

1. Nepal should ratify the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990), which sets human rights standards to be respected for both the documented and undocumented MWs and their families, to get recognition of the right to health for MWs in national, political and legal systems.
2. Bilateral agreements should be signed between Nepal and the receiving countries to ensure a standard, affordable and

accessible healthcare services and working conditions for MWs. This should be implemented and monitored strictly, with necessary corrective measures undertaken as and when required.

3. The policy, legislation, and the bilateral agreements should also cover undocumented MWs, who are the key contributors to the national economy.
4. Healthcare initiatives for MWs and their families must be embedded within national healthcare strategies and policies, with participation of MWs in the policy-making process.
5. As migrants landing in the destination country are healthy, they should be assured safe and healthy workplace and living environment in the destination country. Companies and recruitment centres are responsible for MWs basic needs, and they must be legally required to meet a minimum set of standards, including a provision that MWs have access to adequate, available, and affordable healthcare.
6. The government should develop specific programmes for MWs, initiate welfare programmes for the sick and returnees, and preventive health programmes for prospective MWs. Life skill development programmes need to be introduced at the community level. The government should also allocate a separate budget for the MWs programmes.
7. The government should establish a database and resource centre on MWs, with up-to-date information (e.g. statistics, laws, policies, programmes, codes of conduct, and information on health insurance, rights for ill, injured, deceased, detained, jailed, and/or deported MWs) to guide policy and programme development.

8. Regional advocacy should be undertaken to bridge the gaps between existing and felt needs for MWs access to healthcare. Since migration and HIV/AIDS are global issues, there should be a collective effort to address these from the government, civil society, private companies, international organisations and networks.

Access to health information

1. Mechanisms to pre-inform migrants about health issues need to be developed and implemented at every stage of migration. Ensuring access to health and STI/HIV/AIDS information and education to all MWs and their family via pamphlets, brochures, and posters is essential. These should include updated information on treatment, care, and support services for MWs, including those with HIV/AIDS. It is also important to use existing mass media to reach and educate people.
2. Pre-departure training should be decentralised at the community level. The pre-departure orientation should teach basic language skills, and incorporate information on health rights and preventive healthcare. Migrant Workers must be informed about HIV/AIDS and STI prevention and care, sexual and reproductive health issues, mental and occupational health hazards, nutrition, basic medication, and medical testing.
3. Standardised, correct, and up-to-date training modules should be developed and the pre-departure trainers should receive specific training of trainers.
4. Government and donor agencies need to support MWs associations, companies, training centres and other groups to help integrate HIV/AIDS and other health-related material into their programmes and projects.

5. Medical testing should be decentralised at the district level, reducing costs for MWs, and testing should be voluntary rather than mandatory. Programmes need to be established where medical testing can be used as a platform to educate MWs on preventative health information.

Access to healthcare

1. A standard set of healthcare provisions should be agreed upon, implemented and monitored regularly, with special focus on female MWs. Sexual and reproductive health services should be made available. Information and awareness on such provisions should be widely available for the MWs in both the home and host country.
2. Migrant Workers who test positive for curable infectious diseases must have proper referrals and access to affordable treatment immediately and upon recovery should be allowed to proceed with migration processes in Nepal, or continue their work in the destination country.
3. Medical conditions, including HIV/AIDS, should not be the ground for MWs to be deported. When an employer desires to repatriate a person with HIV/AIDS, relevant authorities should provide proper counselling, support, and referrals to care back home.
4. Confidentiality and privacy must be ensured at hospitals and other health institutions, as this will increase MWs comfort and confidence in seeking treatment and follow-up visits.
5. Government officers, lawyers, police, and embassy personnel need to be educated on MWs realities and health issues, and

be able to direct MWs to appropriate channels to receive treatment and care in both home and destination countries.

6. The policy should provide adequate protection and compensation for MWs. Health insurance schemes for MWs need to be introduced in Nepal. Arrangements for adequate health compensation for injuries sustained both in and out of the workplace need to be made. Insurance claim processes should be made easier. The information on insurance has to be made widely and appropriately available for all MWs.

7. Post-arrival and reintegration programmes with special focus on health should be mandatory.

8. Embassies and consulates would be a good place to provide MWs with information. Therefore, embassies should have links with relevant NGOs, CBOs, law groups, and government agencies in order to provide MWs with their healthcare needs and information. Embassy personnel's capacity should be expanded to include HIV/AIDS, STIs, and other health issues in context of international labour migration.

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