This Section Of The Manual Focuses On:

Health of the migrant worker is a holistic concept. Health and human rights within the public health framework are interlinked and can empower communities to protect themselves against HIV/AIDS.

Health of the migrant worker is not recognised as a right by both, sending and receiving countries. In most cases neither of them bears the responsibility of providing an enabling healthy environment and access to services for health and welfare of migrants.

Sexual health, reproductive health and mental health are key elements that define health needs and concerns of migrants.

The following factors put the migrant worker at the risk of infections, including HIV/AIDS:

- *Working and living condition and policies*
- *Health care financing*
- *Single entry into receiving country*
- *Health Notification and deportation*
- *Policies related to mandatory testing of HIV/AIDS and its negative impact on both sending and receiving countries*
- *Policies related to access to health information and care & support services*

Strategies and interventions should focus on reducing the conditions of vulnerability. Empowerment of migrant workers and facilitating enabling environment are crucial for maintaining good health of the workers while acknowledging human rights in migration.

An enabling environment should address conditions that enhance the migrant workers' ability to protect themselves through information and making informed choices; through access to migrant friendly preventive and curative services; and by addressing policy issues related to employment and mandatory testing.

Interventions should address key factors such as risks, vulnerability and human rights while being gender sensitive.

Intervention strategies need to be implemented simultaneously at all sites including the stages of Pre Departure, Transit, Post Arrival including initial adaptation and successful adaptation, and Return and Reintegration.

BACKGROUND

The relationship between population mobility and the spread of diseases has been noted by epidemiologists, public health workers and social scientists. Since 1980s, this relationship has received increased attention as a factor in the spread of HIV/AIDS in different parts of the world.

However, health is a holistic concept and it involves many aspects of the migrants' well being. It goes beyond dealing with STDs and HIV/AIDS. It includes a potential to defend oneself against threats of biological, psychological and social integrity of the individual. The spread of diseases and vulnerability of migrant workers needs to be understood in the context of the conditions of the communities and the environment, which the migrant worker leaves, enters and then re-enters.

Health and human rights are powerful concepts that must be recognised and understood in a holistic manner as both contribute to the total well being of an individual.

Health rights of a person refers to accessibility to health care and treatment, which include affordability, being part of a process of enabling people to increase control over and improve their health; and finally attain and enjoy the highest standard of health.

In order to understand health rights and human rights and the linkage between the two to ensure health for all, one needs to highlight the relationship between the two, and how interconnected they are as each can bring about significant consequences. The first linkage is the impact of health policies, programs and practices on human rights.

Protection of individual human rights is consistent with national aspirations for growth and progress especially for public health as it relates to development. Public health is an important component of development activity, as improved health contributes to sustainable development. Considering national resource levels, the sustainability of development directly relates to an effective balance of preventive and active public health policies and strategies.

The three central functions of public health include assessing health needs and problems; developing policies to address key health concerns; and assuring programs to meet carved out goals. However, one has to be careful about misusing information and strategies. For example, assessment of health needs may need collecting data on HIV/AIDS. Mandatory testing accompanied by deportation, tests and data collection on migrant workers who are HIV+ve can present a skewed picture of migrant workers as being the 'carriers' of HIV/AIDS. This leads the migrant workers into being

further marginalized and exposes them to further discrimination and stigmatisation. Thus, the misuse of information on HIV infection status may lead to a point where strategies for action compromise on human rights for public health goals without reducing the vulnerability. Also, focusing on migrant workers as 'carriers' of infection is not the solution for a public health goal of an HIV free society. It facilitates a false sense of security in the country while focussing interventions solely on migrant workers and not conditions or environment in the country that contributes to vulnerability.

Thus, close adherence to principles of human rights is critical. However, it is often believed that human rights and public health are inevitably conflicting, which may not be the case. Public health and human rights are complementary and inter-linked. Integration of both is crucial for the promotion of health, in harmony with sustained development.

The traditional public health paradigm and strategies developed for diseases are now less relevant. It is clear that the strategy for preventing HIV infection through quarantine and isolation does not work. The conflict arises because health policy makers and practitioners are ignorant about the concepts of health and human rights. Protection of human rights within the context of HIV/AIDS, creates an enabling environment to empower the population against HIV infection.

Health Of Migrant Workers: Whose Responsibility?

As described earlier in the manual, an analysis of health conditions and the increasing lists of tests that the potential migrant workers have to go through to get their fitness certificates indicates that the receiving country wants the best and the fittest citizen as workers.

These tests may include general physical examination, urine and stool analysis, X-ray and blood tests for HbsAg, Hepatitis A&B, VDRL, HIV, Tuberculosis, Malaria, Leprosy. Some countries also include tests for Cancer and Psychiatric illnesses etc. Pregnancy test is, in any case, mandatory for all women migrant workers.


Accident & Abuse

This means that almost all migrant workers enter the host country as 'healthy' individuals.

While defining responsibilities, one observes that most host countries which require healthy workers, do not take responsibility to provide an environment for healthy living or provide supportive policies for accessing health information or services, leaving the migrants with little choice for treatment of illnesses for remaining healthy. In fact, most countries do not recognise health care as a human right for migrant workers. Migrants are often portrayed as draining the receiving country's resources including burdening the health care systems. However, migrant workers contribute significantly to the receiving country's economy, which benefits a lot by importing cheap labour for advancing their own country's production and trade. Migrant workers also pay heavy taxes for earning their income.

The sending country, on the other hand, while viewing migrant workers as 'economic tools' for debt repayment and contribution to national income, also bears no responsibility to ensure health and welfare of the migrant workers. Discriminatory policies related to mandatory testing and health; working conditions and exploitation exist. Not enough information is provided to the migrant worker prior to departure. The migrant worker is usually not covered under any insurance scheme. No vaccinations are provided to them, prior to departure.

We thus find migrants being exposed to malaria, TB, STDs and HIV and a number of other infectious diseases. (source: Ron Keller, in his paper

In the year 2000 alone, Overseas Filipino Workers contributed US$ 7.2 billion to the Philippines economy, making up almost 25% of the country's GNP.

"The Impact of HIV/AIDS, Policy and Program Implications: Case Studies of Filipino Migrant Workers living with HIV/AIDS": Presented by Malu S. Maria Marin at 6th ICAAP, October 2000.

The remittances of migrant workers in Sri Lanka, have become the highest net foreign exchange earning source wherein the country has earned Rs. 79 billion in foreign exchange in 1999.

National Position Paper on Migration and HIV by Nimalka Fernando, 2000

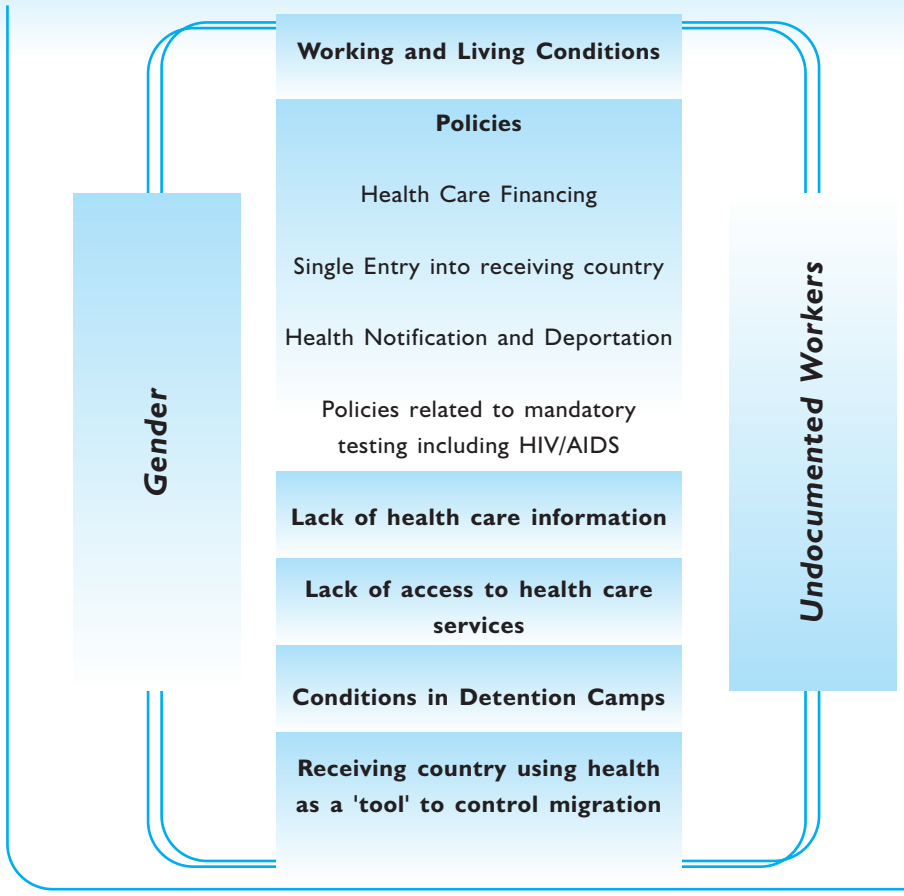
However, some countries such as Bangladesh who have established policies of labour export, do mention programs related to HIV/AIDS for the migrant workers in their National Plan. It states that " Peer education and peer outreach works best for certain communities. Strategically located drop-in centres that provide STD services, information and counselling services should be accessible, convenient and sensitive to the needs and particular requirements of the particular targeted group.

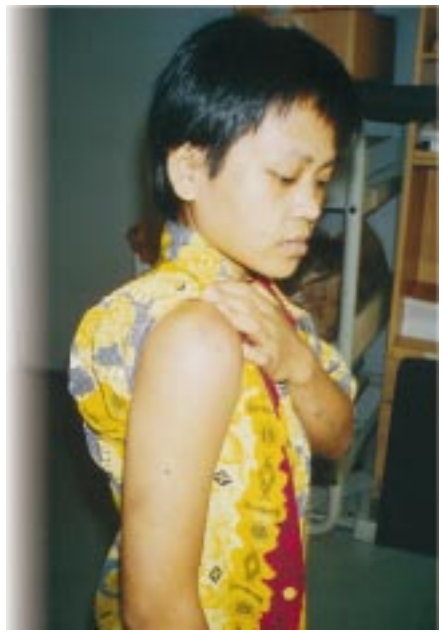
"Migration and Health" presented at the Migration and Health Symposium, Amsterdam)

Where does a migrant worker go in the alien country if he/she is sick, since he/she cannot speak the language, does not know where to go, and fears deportation due to various discriminatory policies? Or they cannot visit a doctor because they have no time off work?

1. Working and Living Conditions: A migrant worker who is undertaking a typical but dangerous, dirty and demanding job, has long hours of working in

What makes the migrant worker vulnerable to health risks?





Abused Indonesian domestic worker (Tenagainta)

unhygienic conditions, with very little rest or respite. Wages are often low. This affects the workers' health as well as access to health care with no time and high treatment costs. These working conditions also expose migrant workers to a lot of occupational hazards which can leave them incapacitated for life, with meagre compensation.

Working Conditions: Health and Occupational Hazards

Migrant workers are hardly prepared for the kind of work they would be involved in when they leave their countries. But even in the host country, there is little or no orientation or training for the kind of jobs they have to do. They are expected to know the job and be highly productive. In Malaysia, at the extreme, many migrant workers have even lost their lives or injured themselves while at

work. Migrant workers who have stayed for four to five years are beginning to experience long term impact of hazards at work as well.

Many workers who face accidents at work have difficulties in gettings treatment in a proper hospital. If they do, all expenses are deducted from the compensation. Quite often, they return with nothing. Many workers who go home after a serious accident find it difficult to continue their treatment at home. This deportation does not facilitate investigation on the worksite and thus the company has no accountability for the regards.

According to Tenaganita, many migrant workers in Malaysia who began their work in the plantation sector, especially in harvesting of oil palm fruits, did not understand the skill in harvesting. There have been cases where migrants after cutting the oil palm bunch that weighed 40-60 kg. caught it and were seriously injured. Some even died. In fact, hazardous jobs are given to migrants only. In the plantations, local labour realizing the hazards at work, have rejected spraying of pesticides with the result that spraying of pesticides is being done by migrant workers with lower pay. Unorganized, not unionized, sub-contracted and unable to move to another job due to stringent policies, the migrant workers surrender their health to keep themselves and their family alive.

Countries with intensive development have short deadlines for completion of construction projects. Migrant workers work very long hours without rest. This has led to an increase in accidents. In Malaysia, many migrants lost their lives building the twin towers which are the tallest buildings in the world and the pride of Malaysia. Many migrant workers were unable to receive compensation owing to their undocumented status. This type of development with its dependency on cheap foreign labour and the concomitant irregular conditions under which it plays out needs review.

In the manufacturing sector, especially in the small and medium enterprises, there is no or little training to equip the worker to understand the work and deal with the machines safely. In a plywood company, the workers are provided with woolen gloves as a safety measure. However the workers have found it hazardous. Strips of wood stick to the gloves, injure their hands that cause bleeding and tend to develop into sores. Workers rejecting the gloves get exposed and face other forms of hazards.

Living conditions in the host country are often inhuman with provision for little and nutrition less meals. These conditions are far worse for women migrant workers as discussed in the earlier chapters.

Symptoms of Recurring Health Problems : 'Vulnerable' Research conducted by Tenaganita with Bangladeshi migrant workers in Malaysia,2000

Recurring Health Problems	Total % who said YES	Distribution of Symptomatic Respondents by Sector (%)				p Value
		Plantation	Services	Construction	Manufacturing	
Fever	77.9	64.3	7.1	---	28.6	0.001
Sleeping problems	62.3	22.4	23.7	14.5	39.5	n s
Headache	68.9	19.2	26	16.4	38.4	n s
Urinating problems	55.6	21.5	10.8	9.2	58.5	0.076
Stomach ache	43.4	22.2	36.1	11.1	30.6	n s
Dizziness	42.5	24.3	24.3	8.1	43.2	n s
Back ache	28.9	22.7	40.9	27.3	9.1	0.020
Skin diseases	20.9	21.4	14.3	35.7	28.6	n s
Chest pain	18.2	41.7	--	16.7	41.7	n s

n s = not significant

Case Study by Tenaganita of an undocumented migrant worker and the issue of compensation and repatriation

Abdul Sattar came on a tourist visa in 1999 to Malaysia. He paid a sum of RM 6,000 (USD 1667) to the agent. Upon arrival at the Kuala Lumpur International Airport, the agent took his passport and took him to a factory for work. The agent left and never returned. The employer forced Sattar to leave the factory.

Cheated, lied and robbed of his documents and money, Abdul Sattar was forced to work illegally in a furniture factory, since he had to repay the RM 6,000 and also support his family back home.

Sattar's job was to bend steel according in a machine mould. In May 2001, Sattar was at work bending the steel, when the machine hit his hand. His left hand fingers were severely damaged, to the extent that the doctors had to amputate his fingers. The company had to use another worker's passport to get him treated.

Sattar's hand is still not healed. He is without a job and unable to continue with his treatment. As he is undocumented, there is no insurance coverage. He is not able to return as he does not have the money to pay. The company is not willing to assist him or repatriate him. Upon investigations by Tenaganita, at the time of accident, Sattar had been working very long hours and as he was tired, lost his concentration.

2. *Policies:*

a. Health Care Costs in Receiving Countries

Most host country government's attitude towards migrant workers as 'burden' on the system including health care, results in restrictions in accessing health care, and high cost of treatment including high doctors fees. The high cost of treatment has also been a result of globalisation induced privatisation policies. Not only does it increase the costs of health care, it also makes the overseas agencies look for profits from migrant workers while conducting the pre-departure program.

In a research conducted by Tenaganita with Bangladeshi migrant workers in Malaysia, it was observed that 61.9% went to government hospitals when they were ill, an additional 7.4% used both public hospitals as well as private clinics (either company or non company sponsored clinics). With regard to those who used public hospitals, it was found that 87.5% of plantation workers, 65.7% of service sector workers, 42.9% of construction sector workers and 44.4% of manufacturing sector workers used sate owned hospitals. It is, because of this that the impact of corporatization and privatisation of hospitals and health care services is going to have a negative impact on the health care accessibility of migrant workers.

In Malaysia. all foreigners are required to pay first-class fees although they are only entitled to third-class treatment. This has a significant impact on migrant workers and a limited impact on expatriate professionals who enjoy other medical benefits. In addition, restricting migrant workers' use of public health care services, resulting from immediate cost considerations, have other implications.

Payment of first-class medical fees for third-class medical facilities is inequitable.

It is noted that often the migrant worker falls within the highest tax bracket of a country. On an average, migrant workers in all sectors except for those working in the domestic sector pay an annual levy of a minimum of M$ 1,000. On this basis, subsidized health care should be the right of the migrant workers who are contributing to national growth and productivity and paying higher taxes than most nationals.

In addition to the fee paid by the workers in Malaysia, they also contribute towards Employees Provident Fund (EPF), where they once again suffer discrimination. While employers contribute 12% to the contribution of local workers, in the case of migrant workers they are required to pay only RM 5/-. This is notwithstanding numerous problems they encounter in withdrawing their EPF contribution.

The Foreign Workers Compensation Scheme also exists in Malaysia which migrant workers are required to contribute to, only covers treatment for accidents and work-related injuries but excludes invalidity pensions for work-related disabilities.

In all, migrant workers pay a total of RM 1,646 per annum as per the following breakup:

Levy	:	*RM 1,200*
Pass	:	*RM 50*
Processing Fee	:	*RM 60*
Insurance	:	*RM 156*
Medical Test	:	*RM 180*
Total	:	*RM 1,646*

Source : 'Vulnerable' Research conducted by Tenaganita with Bangladeshi migrant workers in Malaysia

b. Single Entry Policy of Receiving Country

The receiving country often does not acknowledge the social and sexual identities of migrant workers. The migrant workers are often young, in the reproductive age group, and, hence, are sexually active or sexually curious. In addition, they have to deal with adjustments in the alien culture all alone. To add to this are the discriminatory policies prohibiting marriages and relationships between locals and the migrant workers. These conditions of loneliness, conflicts, multiple identities, leave migrants with very little choice but to develop social networks and sexual relationships in order to meet their human needs. These conditions may lead to unsafe multipartner sex.

c. Health Notification and Deportation Policies*

Most receiving countries require migrant workers to undergo pre-employment as well as periodic health tests. If, during these mandatory tests or during any regular medical check, the migrant is diagnosed with any infectious disease such as TB, STD, HIV, the migrant worker is deported to the country of origin. This is often done without informing the worker, without his or her consent or pre or post test counselling. For women migrant workers, over and above the health risk, if she is found to be pregnant, she can be deported back immediately. This leads her to practice unsafe abortions or deliveries, putting her at higher risk of infections. These policies force migrant workers to avoid accessing health care for fear of notification and deportation.

d. Policies Related to Mandatory Testing of HIV/AIDS**

Mandatory testing for HIV/AIDS is discriminatory and violates the human rights while reinforcing stigma and discrimination. Also these tests are conducted for assessing the 'fitness' of the migrant worker to perform a job. As discussed earlier, if a migrant worker is found to be HIV+, he or she is immediately deported to the country of origin. This is also a direct violation of employment/ labour policies. Being HIV+ does not mean that the worker cannot perform his or her duties or is 'unfit' to work. Mandatory testing also creates a false sense of security for the local population who believe that they are free from HIV infection.

If we analyse the national policies of some of the countries, it becomes apparent that most sending countries such as Bangladesh and India do

**See SRO Guidelines on Medical Examinations - Annexure-I*
**See Procedural guidelines on referral of GPB hires to POEA retained clinics - Annexure-III*
***See Medical tests required for Filipino overseas workers - Annexure-II*

not have a policy for mandatory testing but give in to the requirements of the receiving country for the same. At the same time, most of the host countries also do not have a policy of mandatory testing for their own populations but demand the same for migrant workers. This reflects a discriminatory attitude towards the migrant workers.

*The **infringement of human rights** of **migrant workers** and the **associated aspects of mandatory testing** and **deportation include:***

- *Mandatory HIV testing of migrant workers is discriminatory, as an HIV status does not preclude the capability to function at various levels. Such tests restrict the right to travel and when used in conjunction with deportation it denies the right to work.*
- *Selection of migrant workers as a category for mandatory testing appears to arise from their marginalized status as other expatriate workers are excluded from testing. Inconsistency of selecting migrant workers for mandatory HIV testing is based on the perception that they are transmitters of the HIV virus, when all persons are at risk. With the exception of Singapore, most host countries require only migrant workers to undergo mandatory HIV testing.*
- *Conduct of mandatory HIV testing of migrant workers without their knowledge and not providing pre- and post-test counseling violates the right to information, privacy and confidentiality.*
- *When a migrant is deported following an HIV test in the host country, based on a false positive result, then discrimination becomes more severe.*
- *The significance of HIV testing as an epidemiological tool or as a necessary medical intervention for treatment is not challenged. However, a focus on migrant workers for the conduct of mandatory HIV testing that subsequently restricts employment is an unfair practice and is not an effective way of managing the HIV epidemic.*
- *Testing is also unfair to host populations as it places the responsibility for handling the HIV epidemic on the migrant worker. Research and actions undertaken with migrant workers indicate that migration places them at the risk of acquiring HIV. A false sense of security also occurs in the local population of the host country who consider that they are free of HIV when*

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mandatory testing and deportation of migrant workers is undertaken.

- *The social responsibility of governments, companies, and other such institutions that test migrant workers for HIV and deport them is also questionable. Many migrant workers enter the host country with a clean bill of health but subsequently became HIV positive. It is noted that the period and forged medical certificates may be misleading at the time of entry. It is noted that detection in post arrival medical tests is possible. Also, a possibility exists that a person was not infected after entering the host country.*
- *Currently, host countries that impose pre-employment medical tests so as to employ only healthy workers contribute to the imbalance of regional health. When standards are controlled by a right to employ healthy persons for continued productivity, the responsibility to ensure continued health during employment and to provide for medical care and treatment is apparent. The responsibility is, therefore, to develop supportive and protective mechanisms to ensure that the migrant worker departs as healthy as on arrival.*

(Source : "Protecting & promoting human rights to reduce HIV vulnerability of Migrant Workers - Sharuna Varghese 1999)

The above mentioned policies of mandatory testing and deportation harms both, sending as well as receiving countries.

Most host countries believe that by mandatory testing, notification and deportation they are protecting public health. However, if one was to see this policy in the light of infectious disease control and public health, it does not hold any meaning. Migrant workers will move around and form their own social and sexual networks while interacting with other groups and individuals.

Does the policy of notification and deportation protect the public health of the host country? In fact, as mentioned above, notification and deportation can give a wrong and false sense of security to the nation. The traditional public health paradigm and strategies developed for diseases are now less relevant.

Regarding the sending country, it faces major health problems, adverse economic impact and use of resources since it sends out fit and healthy persons and later receives them as sick persons.

e. *Lack of Information and Health Care Services:*

Access to Health Information and Education Programs

Migrant workers in most cases do not have access to preventive health care information. Neither are they familiar with the language of the

Pre departure training by CARAM Cambodia

receiving country and thus cannot be communicated with informative messages developed for the local population. Most host countries do not include migrant workers in national health and HIV information campaigns. Accessing health (especially sexual health) information for women is furthermore difficult and stigmatising. Within the given cultural and gender social constructs of most South Asian countries, women who seek information on sexual or reproductive health are often looked upon as 'immoral' or 'loose' women. They are encouraged not to talk about these issues openly.

The receiving countries often fail to implement effective AIDS prevention programs for migrant workers, because it lacks the understanding of this group and hence migrants with their conditions and needs are not a priority. There is no policy to provide effective information through workplace interventions at the sites.

Although migrant workers were included in the national AIDS action plan of Malaysia in 1996, migrant workers have yet to receive information relating to HIV and STIs in their respective languages during post-arrival orientation programs or education programs at the place of work.

Most sending countries also fail to provide adequate and effective health care and prevention information during the pre-departure programs where the pre-leaving training programs focus on skills building and protecting the reputation of the country. If such health information is provided through these trainings, it is given at a time when the migrant worker is most anxious about the new destination and hence, mentally not receptive to the messages on health.

Access To Health Care

Access to health care is limited because of

- the above mentioned policies
- requirement of 'healthy individual'
- deportation
- low wages
- high cost of treatment

Language abilities also inhibit the accessing of health care, which impacts on the quality of medical attention received that may have significant repercussions when the problem is serious.

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Many employers may even provide for health care services to the migrant work-force through company doctors. However, the 'appearance' of health care accessibility may not necessarily be equivalent to the 'reality'. For example, migrant workers fear that if they have an STD and visit the company doctor who is legally assigned to them, their health status might be revealed and they may be immediately fired or deported. Accessibility is therefore undermined. Thus, many infections remain untreated and get treated through self-medication and local medicines.

Generally, the migrants do not approach a doctor until they are convinced that the disease is serious. The tendency is to consult family members, endure the pain, and to resort to self-medication. Also spending money on health care is not seen as a

In one instance, Tenaganita reported that a migrant worker from Bangladesh lost sight in one eye as the doctor advising surgery misunderstood the worker's request not to proceed with the surgery.

Excerpts from interviews with domestic workers by CARAM Asia:

"There was a time when my private part pained. I was crying. I want my employer to care, but I was ignored. My employer saw but did not take me to the doctor, that is why I felt humiliated. I was treated as if I was not a human being. My female employer saw my private part and gave me a crème. She wanted to take a closer look but I was embarrassed. I tried to control it, so when she asks me, I will say there is no pain. I will bear the pain until night and then it will heal naturally, on its own."

" When we feel dizzy or have headaches, we krok (scratch) our bodies with coins, oil, vicks or balm until the body turns red and the wind in our body comes out."

"When I had eye problems, itchiness, redness etc, my employer asked me to wash with salt water. My eyes are always paining, itchy and then the nose is also itchy every morning."

Excerpts from an interview with a doctor, a dermatologist & VD specialist, by CARAM Asia

"Domestic workers do not come to see me on their own. They are brought in by the employer for various reasons. But most of them come as a result of certain skin problems, a lot of which arises due to daily contact with strong fluids such as detergents. They also have problems like rash, to the extent that they are unable to work sometimes. Other problems are fungal infection that gets worse due to scratching. Some domestic workers are brought because the employer suspects that their maid is having a sexual relationship outside their work place. Sometimes they are brought in for tests to make sure the family is safe, especially when they are in contact with the children."

"My mother's domestic worker once had herpes, which I suspect she got from her boy friend. She did not tell my mother until she could not actually work anymore and it was starting to smell. They keep it to themselves hoping that the symptoms will go away. Sometimes symptoms go away and the person thinks that she is cured, whereas in fact the illness is still there. One problem is that many of the domestic workers are not aware of STDs. They think that as long as they are not pregnant, they are okay. Very often they do not think of STDs. They have no idea that they can get infected. Their knowledge is very poor."

priority by many migrant workers, since they would rather remit the money back home or spend it on other things.

Untreated infection further increases their vulnerability to HIV/AIDS (for example, STDs being untreated). It also decreases their health status with continuing ailments with no proper treatment or care and nutrition.

In addition to the lack of access to quality and adequate health care, is the issue of nutrition and food intake. Most migrants cannot adapt to the cultural differences in the food habits of the host country. Thus, they tend to eat small amounts of food and that too at infrequent intervals. The food that they get or eat is often low in nutrition content. Food intake is worse for domestic workers who are many a times at the mercy of their employers to provide meals, which are small in quantity, untimely and low on nutrition. This contributes to the deterioration of their health status, and also affects the recovery from any ailment.

With regard to HIV/AIDS and access to treatment, most individuals living with HIV are denied this rights, coupled with stigma and discrimination. Doctors and hospitals often refuse treatment to people with HIV/AIDS. STD prevention is not a priority in many countries and thus is not reflected in their health policies. In most poor and developing countries such as the Philippines, India etc, many people are left untreated after being diagnosed, because no appropriate drugs are available, and purchasing them at a pharmacy is unaffordable to many.

'Social Hygiene Clinics' have been established since 1989, throughout the Philippines, mainly to reach the 'high risk groups'. With this focus and strategy, many STDs of the so-called 'non-risk' groups may go unnoticed. Simultaneously, people who are at increased vulnerability level are reluctant to go to specific STD clinics out of fear of being identified as 'bad women' or 'bad boys'.

Compounding the misconceptions regarding HIV/AIDS is the low incidence of condom use among migrant workers. Many migrants do not use condoms prior to departure and this trend does not change when they move abroad. Low condom usage could be due to myths about condom usage, reluctance to use condom in intimate or steady relationships, and uncertainty about the protection that condoms can provide against diseases or pregnancy.

f. Detention Camps and Health

In detention camps in Taiwan, the physical needs of detainees are adequately addressed and access to people and external support is freely available. However, in most regional camps, migrant detainees face poor nutrition and sanitation, and minimal medical attention. Rape, sexual and physical abuse of female migrant workers has been known to occur in these camps. Such violations may cause direct infection with HIV and severely compromise the health of detainees and increase vulnerability to infection.

A former detainee of an illegal immigrant camp in Malaysia told the Magistrates' Court (in the trial of Irene Fernandez) that he had to strip off in front of other inmates despite being an Imam in the camp, six years ago. Abdul Alim said that he suffered emotional pain, and had refused to continue leading prayers in the Machap Umbu Camp in Melaka after the incident. He said that he and other inmates were told to strip naked as a punishment meted out by the Police.

"After this incident I had refused to remain as Imam, because I felt that I had been shamed and had lost my self respect. However, the other inmates kept saying that they were all stripped together with me and I should no put any connection between the incident and the prayers. I then led the Zohor prayers with a lot of emotional pain." Abdul Alim added that after the prayers, he recited some doa together with other inmates, and asked for forgiveness.

Abdul Alim also testified that he suffered sores on his skin which were sometimes filled with blood and pus during his stay in the camp from February to July 1995. "My genitals were worst affected. I had problem wearing clothes because it was difficult to scratch over the clothing. I received my medicine only after 20 days but they did not heal completely," he said.

"I screamed in pain due to my tooth ache, at night and a policeman came and kicked me. He told me to shut up but the pain was too much that I still made some sound," he said, "adding that he was only taken to the hospital the next day."

Source: Testimonies by Tenaganita

A memorandum prepared by Tenaganita relating to detention camps in Malaysia indicated that considerable suffering by migrant workers and violation of rights could have been avoided if coherent and comprehensive policy on migration was in place. Also, suitable bilateral agreements between sending and the host countries and strict enforcement of laws meant for errant employers and fraudulent recruitment agents would have alleviated problems.

Further discrimination of undocumented workers and women in accessing health related information and health care services

Undocumented migrant workers have no access to the government health care services because of the need to show their documents in these places. Neither do they have any health insurance nor are they included in public health services. The fear of deportation prevents access to available health services. Apart from their status, many undocumented workers have irregular working hours that make the strict HIV treatment schemes difficult to maintain. Very often, they are subcontracted by the official agency, for example, in the construction sector. The labour is often hired at a cheap rate. Insurance or compensation for occupational hazards in building and construction sector is usually not provided for.

Gender and Health issues: Female migrant workers, as discussed in earlier chapters, have limited access to reproductive health services due to biological and social vulnerability of women in general.

The reproductive health concerns related to migration are an under-researched area. However, the emerging data on migration, especially on women, highlight high health problems in women who have been in sexually exploitative or high risk situations, whether as domestic workers, factory workers or workers in the entertainment industry. These sectors where women are mostly employed are informal and most unsafe and unprotected. Most of the health problems are linked with violence, which includes physical violence, food deprivation (as punishment or torture), inability to be mobile (kept in closed houses, small rooms), psychological trauma (constant threats, verbal abuse etc.) and long hours of work.

A number of Filipino women were punished severely for some supposed crimes that are related to the taboos for women in certain societies, such as in the Middle East (e.g. looking at men, wearing culturally inappropriate clothes or exhibiting culturally unacceptable behaviour.). Other problems related particularly to prostitution among migrant workers including the use of banned drugs, excessive intake of alcohol, eventually leading to a host of health problems that affect a woman's general well being.

However, in the course of their overseas work, some women migrants find themselves either in sexual relationships or in sexually exploitative situations that

give rise to unwanted pregnancies. There is no policy giving the female migrant workers the right to bear a child. While there are women who choose to complete the pregnancy, many others find themselves undergoing abortions for reasons that include the fact of humiliation, condemnation from their families and especially their husbands. Case studies and empirical research indicate a trend in unwanted pregnancies in the migrant women. In cases when the woman decides to continue the pregnancy, the risks of social stigmatisation, not to mention additional economic responsibility and social obligations to keep and raise the child, have enormous impact on the woman.

According to CARAM Malaysia, Indonesian women in Malaysia take pills, use traditional methods to abort the foetus such as herbal drinks called 'jamu', and massage their stomachs to avoid pregnancy.

When migrant women become pregnant or infected with STDs or HIV/AIDS, more often than not, they are not asked whether they have been raped or sexually abused. Instead, they are punished by being deported often with no investigations, medical care, counselling or compensation offered.

The Universal Declaration of Human Rights, the convention on the Elimination of All Forms of Discrimination against Women; and the convention 90 on Migrant Workers all emphasise equality and dignity of each person and that all rights are inherent, inalienable, and universal. But it is with migrant workers that we see the violations taking place. Inability to negotiate safe sex practices and the consequences of violence and physical harm to women in sex work, in the entertainment industry and domestic work, reveal women's condition to the risk of infections. The inability of migrant women to control their partners' sexual behaviour back home again brings about risk.

Thus, there is a need to recognise women's reproductive rights, their right to decision making and their right to the their body. Cultural and religious relativism and interpretations should not undermine these rights.

Mental health issues: Isolated from their traditional support systems, migrant workers are subjected to constant readjustments in their lifestyle. They have to constantly be on the alert psychologically that their behaviour and actions do

not confront or alienate not just their employers but the new community in which they need to build a new system of support. These psychological manoeuvres can be a source of stress, which can lend itself quite easily to severe emotional illnesses. Studies in violence against women point to a host of psychologically related illnesses that, in the past, were either unknown to health service providers or completely ignored.

Some studies have also shown the migrant workers, particularly the women in the informal sector such as domestic work, massage parlours, etc. to be suffering from chronic depression. This situation arises due to their separation from their families, abusive work environment, limited options and choice to earn income for debt payment and savings, verbal and physical abuse etc. Isolated working conditions such as that of domestic workers, including lack of social and peer interaction can also contribute to depression, loneliness and mental trauma. Domestic workers from some countries are elderly women with children back home. While taking care of the employer's house and children especially in the initial adjustment period, she may miss her own family and children which could lead to depression and loneliness.

Excerpts from an interview with a Psychiatrist in Malaysia:

"Domestic workers are usually brought in by the agents or the employer for treatment of psychiatric illnesses, adjustment disorders, and active stress disorders. Undocumented workers are brought in by the Police. In either of the cases, the worker is deported after treatment. For a documented worker, it is also because the employer does not want to take her back into the household as she may become more of a liability and danger to the family. Most cases, especially the undocumented workers, go to private clinics. Many do not seek any treatment or seek traditional treatment for minor problems."

Violations of the rights of the migrant worker happen simultaneously. The violation of the right to life, health, adequate standards of living, and medical treatment have the potential to impact on HIV vulnerability. Though the violation of rights begins in the sending country, thus impacting the protection of rights in the receiving countries, most human rights violations of migrant workers occur in host countries, and are violated in more that one situation. Violators of these rights include both the states and non state actors. Action programs developed in host countries are required to recognize these aspects. However, greater protection of rights require joint responsibility of both sending and receiving countries.

The report on the national consultation in Pakistan on migration and HIV/AIDS organised by the LHRLA, CARAM Asia and UNDP, while highlighting the mental health issues for migrant workers, noted that:

Migration brought on by the quest for a more lucrative livelihood and the stresses associated with adjusting in a new cultural, political, legal, lingual, professional and social environment takes a toll on the mental health of migrant workers. There is also the added pressure of earning enough to remit back to families in country of origin and maintain standards of survival in a foreign country. The mental health aspect of the migrant worker is a very neglected sphere.

In illegal migrants the stress level would escalate to an even higher level as the threat of being found out and deported is a constant fear they have to live with during their stay. Exploitation by overseas employers and a step brotherly attitude add fuel to this burning frustration and the state of powerlessness on which the migrant workers have no control and have to contend with.

If the concern and safety nets for nurturing the physical health of migrant workers are inadequate then it may be safely speculated that those available for the mental well being and psychological health of this uprooted workforce are non existent. There is no provision of counseling, availability of mental health professionals or even awareness amongst the migrant workers themselves of the need for such treatment and medical aids to ease adjustment and make their transition smoother. It is suggested that this particular aspect of mental health, commonly known as depression, should not continue to be ignored and appropriate measures be taken to allow the migrant workers to constitute associations and unions to share and express their concerns and also to protect their rights. Appropriate measures by the employer/employing organizations should also be taken for their counseling if and when required.

Health As A 'Migration Controlling Tool' Used By The Receiving Countries

Receiving countries try to control migration, but have problems to do so effectively. There are two ways to control migration. The first, control at the border, which is becoming more and more difficult. This is true for Asian countries, and also for the United States and European countries. Border control remains an important tool, but an increasing number of ways exist to go around that.

The second way to control migration has become a system of accepting incapability to control borders - to give up the idea that things can be arranged through documented migration - and to place undocumented migrants in a second dimension. They are there, but they are not supposed to make use of facilities. One of the most important one is health care.

Once in a while those undocumented migrants who seem to have settled, found stable jobs and have more or less assimilated, are 'pardoned' and given legal status. In this way, the State on purpose creates an invisible 'underclass' and accepts poverty, high risks and bad health.

When health facilities are linked with migration services, health care completely takes over the role of border control. The person who is in trouble and

has to cross the border as invisible non-complaining cheap foreign worker to the official world to obtain access to health care, can be transported back to his/her country of origin.

CARAM believes that an international effort should be made for the recognition of health care as a right for all.

Approaches, Strategies And Interventions

Due to the very nature of mobility and the virus, it includes components of movement and mobility; dealing and coping with different environments; interaction with members of different communities; formation of social and sexual networks. These, as mentioned earlier, create conditions of vulnerability for migrant workers, thereby increasing their risk to physical, social and mental factors including health.

Thus, the Public Health approach should take into account the migrant perspective that should focus on how migrants' vulnerability can be decreased in co-operation with migrant communities, while preserving the rights of the worker. In order to promote the holistic concept of health and its access to the migrant workers, an enabling environment to improve their health has to be facilitated.

An **Enabling Environment** is defined as an environment in which the migrant workers are able to protect themselves against threats to their health and where access to appropriate preventive and curative services is guaranteed.

This definition contains three components:

- the ability to protect oneself by making informed choices
- preventive programs
- access to curative services

National policies for the improvement of the health of migrant workers should try to focus on all these three components with Human Rights, Migrants' Perspective including gender perspective, and Migrant Participation and Empowerment, being key and central aspects.

What Should The Enabling Environment Address? What Are The Appropriate Strategies?

Enabling environment is a political, policy level issue, but increasingly, its public health advantages are becoming clear. The need to develop such an enabling environment is more and more expressed by different sectors and professionals.

1. Ability to protect oneself by making informed choices

Only well-informed people that have no dependencies towards others are able to make informed choices to protect themselves. This establishes the serious need for access to appropriate information about health risks and sexuality. Experiences and lessons learnt, have demonstrated that language and culture are serious barriers against accessing this information. This could be provided or facilitated through strong national

Ability to protect oneself by making informed choices access to appropriate information about health and risks; culture, context of migration as a culture; context of human, social and survival needs

Implementation of Preventive programs community - based information on occupational health, promotion of sexual health and a thorough understanding of health hazards should begin in the country of origin and through all stages of migration

Access to curative services, which are available, accessible, affordable, appropriate and migrant friendly.

Capacity building and orientation, advocacy

Migrant workers participation, involvement, and formation of groups

Policy review and issues:

- *Coordination of national policies; regional interventions*
- *Health policies in receiving countries to reflect cultural dimension of migrant workers*
- *Shifting away from mandatory testing as a policy*
- *International harmonization and standardization of immigration and migrant health legislation and practices*

policies on information provision, both in sending and receiving countries as well as through regional cooperation.

Use of languages that are understood by migrants, development of information systems that empower people and an understanding of cultural differences should be the key elements for policies in this regard. Most public health messages focus on providing strict norms of behaviour and conduct and do not address the conditions, which can heighten the health risks.

In addition, the policy implementers need to understand migration as a culture by itself. Migration has specific characteristics that will dominate cultural influences of the home country as well as the guest country. The strategies for survival also need to be understood and the respect for migrants as more than one-dimensional people (provision of labour only) will have to be the basis for national policies. This will include the difficult issue of the sex sector on which migrants may be dependent for fulfilment of some basic needs, in the absence of other possibilities to make intimate contacts with others. A national policy should include ways to deal with this in a non-judgmental way, which may lead to national discussions. This can also be done at the regional level.

In some countries, migrant workers are not able to protect themselves against disease because of conditions and factors that hinder their ability to make choices or decisions. It is essential that migrant workers should empower themselves by organising themselves. Examples show that migrants that organise themselves integrate more easily in the dominant society. In addition, the status of undocumented migrants (in some countries called illegal migrants) has to be clarified so that they have access to at least some of the basic things needed to protect themselves against disease.

2. Implementation of Preventive Programs

Preventive and community programs are often seen as not very spectacular because they need high inputs. Coupled with that is the fact that their outputs are difficult to measure, because results are seen only after long periods of time, and influence of confounding factors cannot be stopped. That is why, they are often not very popular with politicians who only stay for a short period of time.

Preventive programs need strong commitment from all stakeholders (policy makers as well as service providers and beneficiaries who often do not understand their benefit).

Preventive programs should include promotion of occupational health, promotion of sexual health and a thorough understanding of health hazards related to migration itself. They need to be integrated in other already existing activities.

Since these programs need to be provided from the very time the migrant workers make a decision, they often should start in the country of origin.

Community-based pre-departure programs are the typical examples and they should concentrate on position of women, advantages and disadvantages of migration, cultural problems that can be foreseen and preparation on how to remain healthy in another country.

Education is an important aspect of preventive programs and it seems important to guarantee continuation of messages in the sending and receiving countries. It is ineffective to have different programs that are conflicting or confusing. Receiving countries need to have preventive information dissemination campaigns for migrant workers.

A regional approach provides the necessary exchange of information and coordination.

3. *Access to Curative Services*

Right to health is an essential human right for all individuals. It should include the elements of access, equality and non-discrimination. The concept of Primary Health Care was designed to address this basic human right of health care and access.

Curative services, such as Primary Health Care (PHC) services, need to be used by the primary

The services have to be available in the first place (near to the places where they work and/or live).

They have to be accessible (open at times that they are free and without the risk of being identified as someone with an infectious disease so that the migrant workers would not avoid visiting the doctor due to fear of being stigmatised or deported).

It has to be affordable (the fact that migrants often have to pay more than the dominant population and that they are forced to use private services makes care often unaffordable).

It has to be appropriate (the service needs to answer the needs that are identified by the migrants themselves).

The services have to be of good quality otherwise migrants will stop making use of it.

The issue of equaliity is also very important. Migrants have specific needs, which should be recognised for extra inputs without increase in cost.

target group. Some of the criteria that are important for PHC are also important for the services for migrants.

Specific health concerns of migrants such as trauma and psychological stress; poverty related illnesses and gender-associated diseases need to be reflected in health care services, while focussing special attention on health care needs of women migrant workers. Strategies and ways to reach the undocumented worker need to be drawn up as well.

4. To fulfil these criteria the services have to be 'migrant friendly'. Thus, migrant friendly health services (MFHS) should be characterised as welcoming, pleasing, comfortable, relaxing and enjoyable. They should provide an environment that is private, confidential, affordable, accessible, and staffed with sensitive service providers. The latter is important because if service providers look down upon migrants, discriminate them or treat them unkindly, one cannot expect migrants to keep making use of them. MFHS should be developed in both migrant sending as well as migrant receiving countries.

5. Capacity building and orientation of medical practitioners and health providers needs to be undertaken on issues related to mobility and health including HIV.

6. In addition, involvement of migrant workers themselves in these services can be an effective policy. They can work as interpreters in the health services and they can be involved in peer education programs.

7. All the above mentioned activities need to be initiated at the Pre Departure Level and continued throughout the migration process i.e. at the transit, Post Arrival and Reintegration stages, with the same set of people being the key player.

Policy issues for an enabling environment for health of migrant workers

8. There needs to be a coordination of national policies in migrant sending countries and migrant receiving countries as well as regional interventions and collaborations. Issues of working conditions, contracts and employment etc need to be addressed jointly for welfare of migrants. Also, suitable bilateral agreements between sending and host countries and strict enforcement of laws and policies on errant employers and fraudulent recruitment agents needs to be undertaken to deal with the issues of detention, irregular migrant workers and issues related to women.

9. Health systems in receiving countries have to modify programs in both preventive and treatment services to reflect the cultural origin of significant number of migrant populations.

10. There needs to be an agreement between all countries about the negative impacts of mandatory testing. Policies need to shift from being migrant unfriendly testing policies to policies that protect the health of migrant workers.

11. Health Policy Planners need to be sufficiently aware of current migration patterns to effectively anticipate and adequately plan for the consequences of migratory flows.

12. One of the important areas that IOM (International Organisation on Migration) in its interventions is trying to develop is that of international harmonization and standardization of immigration and migration health legislation and practices. This is intended to support the desire for less complicated border and travel procedures. This strategy needs to be discussed further and made a reality as it strengthens regional dimensions.

13. Advocacy needs to be undertaken for political mobilisation and involvement of politicians along with NGOs, migrant workers groups, and other civil society organisations.

How To Design Appropriate Interventions For Above Strategies And Issues

While designing interventions to address migration and health including HIV/AIDS, following needs to be considered:

- Key concepts, framework
- Stages of migration and related activities

Key Concepts for Prevention Interventions

During the symposium "Mobile Populations and HIV" at the 12th World AIDS Conference in Geneva, 1998, three linked concepts were identified as key to effective HIV/AIDS prevention and care programs for mobile populations: vulnerability, risk, and human rights.

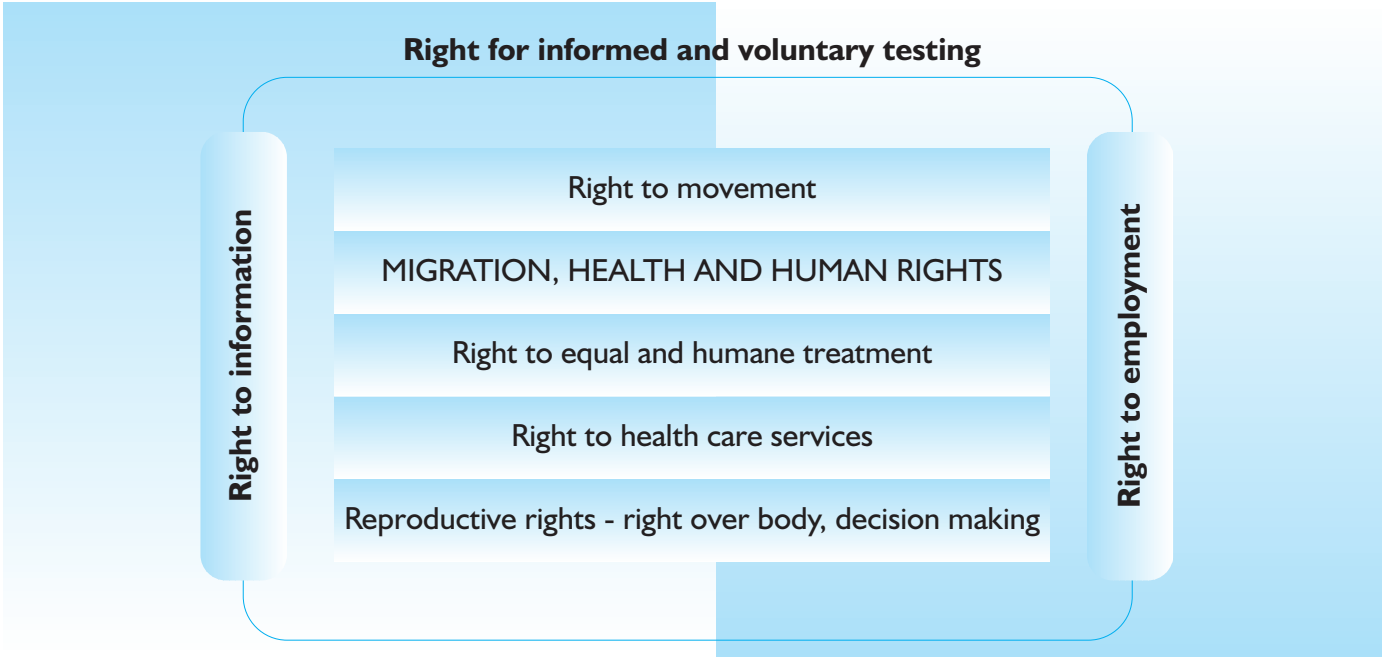
- **Vulnerability** applies to many people on the move and is created by precarious conditions that are typical of livelihood mobility in resource-constrained areas. Community-based interventions are needed to address issues related to migrants' vulnerability.
- **Risk** applies to individual behavior and responsibility, and the opportunities and threats people face as they attempt to satisfy their needs. Interventions that focus on health education and individual behavior change are needed to address risk issues. Taking

responsible action - doing the right thing to prevent HIV/STD infection - requires that people have the right to do so.

- Concern about **human rights** is essential for programs meant specially for mobile populations since they face significant human rights violations. These should include advocacy and a focus on improving pertinent policies.

health etc. which marginalize women. Women's reproductive rights, their right to decision making and their right to their body must be recognised.

- Adapted interventions need to be implemented with specific target group and settings. People engaging in mobile livelihood strategies, described in the aggregate as mobile populations or people on the move, differ not only in terms of the specific types of income-earning activities they



Additional considerations include:

- Gender issues also need more attention since increasing number of people on the move are women. There are several issues, as described earlier in the chapter, related to recruitment issues, working and living conditions, health and departure, mandatory testing, access to

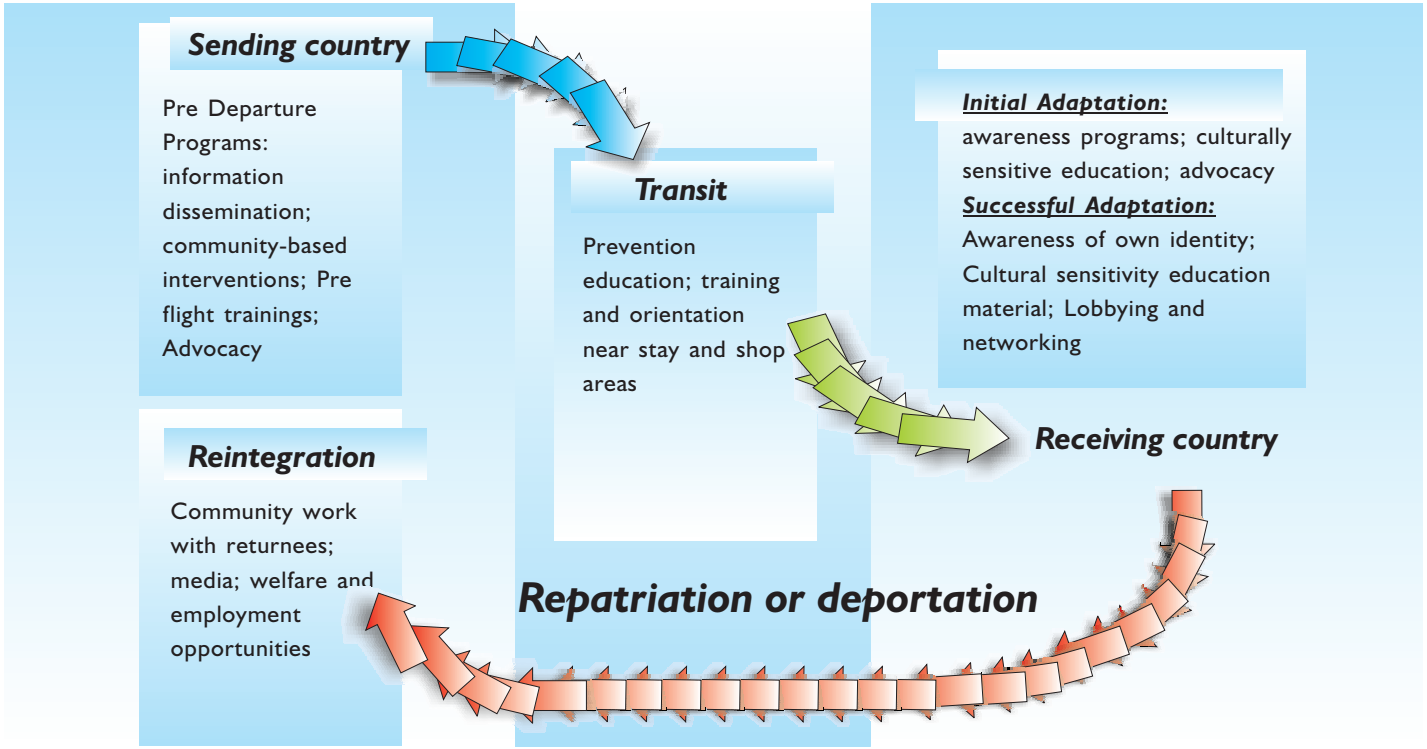
pursue, but also in the degree to which they are mobile. Migrant workers with labor contracts may spend several years in their destination sites, while individuals, particularly undocumented workers engaged in occasional labor or trade, may spend just a few weeks or months before returning home or moving to another location. Trafficked women may be transferred to different brothels every two or three weeks. Differing

levels of mobility among these kinds of target groups affect the feasibility and effectiveness of HIV/AIDS prevention interventions.

The greater the degree of mobility, the more difficult it becomes to implement interventions. Development of satisfactory understanding of the risk situations faced by people on the move may be slowed, particularly when access to needed information or entrée to groups relies on recurrent contacts with the same people, such as key informants or influential members of target groups. High levels of mobility can make it difficult to gain access to a critical mass of target group members and maintain contact with them for follow-up and assessment of intervention impacts. Problems related to limited access include small numbers of people contacted, severe constraints on their time and availability, and limited interest and attention spans. When high levels of mobility affect intervention staff (such as peer educators), the tasks of training, supervising, performance, and providing quality control become particularly difficult.

Interventions need to be implemented simultaneously at different stages of migration

Interventions with mobile populations need to concentrate on settings and the movements in livelihood mobility processes when target groups are physically accessible and reasonably attentive to



well-prepared intervention content. Thus, development of interventions needs to be based on the understanding of specific features of the settings where the mobile populations encounter HIV infection risks. Interventions need to establish contact with mobile populations at key stages in what is described broadly as the migratory process. These stages include pre-departure; transit; post arrival including initial adaptation to new settings to successful adaptation; and return.

Typically, these settings include their home communities prior to departure and following their return, transit areas inside and outside home countries, and destination areas where they work, live and organize their sex lives. Both mobile populations and their spouses and other potential sexual partners should be targeted in each setting. Because so many people on the move travel to distant, often foreign destinations unaccompanied by regular sexual partners, and because the frequent opportunities for sexual networking are relatively free of constraints that operate in their home communities, interventions should give particular attention to destination areas where migrants and others work, live, and seek sexual satisfaction.

Some Current Initiatives

Pre Departure:

Pre-departure interventions for communities of mobile populations should increase awareness about how mobility as a livelihood or survival strategy can create situations of high risk for contracting HIV and STDs. Though Pre-departure programs need to provide information about reproductive health and HIV/AIDS, experience reveals gaps in practice.

In the Philippines, for example, Republic Act 8504 or the Philippine HIV/AIDS Control and Prevention Act of 1998 mandates that HIV/AIDS information must be provided in the mandatory one-day pre-departure orientation seminars (PDOS). However, the implementation of this provision is not being consciously monitored, especially among PDOS providers from the recruitment agencies. Prospective migrants who have signed labor contracts are given information on airport procedures, government and NGO programs and services for migrant workers, and realities in the destination country, but HIV/AIDS prevention information is not regularly included.

The CARAM Cambodia pre-departure program started with classes on reproductive health for female migrants leaving for Malaysia. This contributed to increased awareness of their situation, their vulnerability, and their options. They were given contact information in Malaysia so they could continue these kinds of discussions in their destination areas.

Pre-departure programs should also address the vulnerability and health risk issues of spouses of migrants. Empowerment of the spouses through information provision and mobilization are crucial for reducing their vulnerabilities.

One of the bigger challenges for SHISUK in Bangladesh has been mobilization of the spouse group. According to the representatives of SHISUK, many wives were suffering from STIs and reproductive health problems without knowing that they were suffering from diseases and that there is a treatment for problems like white discharge for long time and some had prolapsed womb that some of the women were suffering from. Consultation on personal healthcare was very useful to raise the awareness of women including wives, mothers, and daughters, about their reproductive health and STI problems. The group members became aware of their HIV vulnerability. Through the health education program they have seen the need to better care for their health.

The response has been overwhelming, as women have organized themselves into groups. The income generating program is facilitating institutionalization of group activities and aims to support their livelihood for economic empowerment. Usually non-working women face a lot of problems if they have to go out or join in a meeting; but if it is an earning opportunity it is easier for them to move out. There is a growing restlessness in them for more organized collective programs and consciousness raising program. These emerging concerns and challenges require leadership development, mobilization and organization.

In the Philippines, ACHIEVE Inc./CARAM Philippines is implementing a community-based education and training program addressing gender, sexuality, reproductive health and migration issues faced by female spouses of migrant workers. The program aims to build and enhance the skills and capacities of female spouses to respond to situations that could put them at risk of being infected with HIV/AIDS. It also aims to enable them to make sound decisions on other matters concerning their health and sexuality. A series of education activities such as workshops, skills training and seminars have been conducted in partnership with local organizations of female spouses in three areas in the Philippines, mainly Families and Loved Ones of OFWs (FLOWS) in Antique Province, and the Seaman's Wives Association of the Philippines (SWAP) in both Davao City and Metro Manila. Contact building and partnership with health service providers in their localities have also been established. The three communities have each formed a core group of trainers who would echo the learnings and information to their fellow spouses.

Transit

This stage involves travel, border crossings during international travel, and arrival at

destinations. Travel can be time consuming because migrants sometimes have to spend long periods at border crossings. Travel can be particularly risky for undocumented (described by some as illegal) travelers, as they can become easy targets for unscrupulous recruiting agents at border locations.

Agents at the Thai-Burmese border, for example, offer very poor deals to women who are repatriated after being caught working illegally in Thailand. Offers of similarly disadvantageous arrangements have been observed among mobile populations elsewhere.

A range of interventions is possible in these settings. Interventions that focus on protecting migrants' human rights are particularly important. Prevention education interventions are also very important. Pharmacists and drug sellers can be trained to provide STD treatment when requested by people on the move who buy medicines.

The Border Area HIV/AIDS Prevention Project (BAHAP) project, implemented by CARE International and funded by USAID, is an example of an intervention in cross-border areas to reduce the spread of HIV/AIDS in Southeast Asia. Using a 'twin city' approach, participatory rapid assessments are first conducted to collect information about communities on either side of the Thai-Burmese, Thai-Cambodian, Cambodian-Vietnamese, and Vietnamese-Laos borders.

Post Arrival:

Initial adaptation in destination areas

This is a time when migrants and other people on the move find their way in environments that may be new to them, develop social support networks, and identify ways to satisfy their basic needs. This is also a time when they may be particularly vulnerable to situations where sexual contacts expose them and their partners to HIV and STDs. Combined with pre-departure interventions for spouses and sexual partners in home areas, interventions at this stage need to focus on typical risk situations, encourage protective behaviors against HIV and STDs, and address the conditions that increase vulnerability. This period may take months to years, depending on the education levels of mobile populations, cultural differences between home and destination countries, and the degree to which mobile populations can benefit from social support structures created by earlier arrivals from the same country.

In areas where the migrants work and live, outreach work, peer-steered programs, and drop-in centers for those with health and other problems are useful interventions. Community building is essential, and protection and empowerment of women are important. Appropriate education about reproductive health is also essential and needs to be supported by family planning, abortion counseling, STD prevention and care, condom promotion, confidential HIV counseling and testing services, and attention to migrants' rights.

The Malaysian NGO Tenaganita worked with Bangladeshi male migrant workers, primarily assisting them with immigration documents. Based on the trust built in this way, extension workers from Tenaganita were invited into the compounds where migrants live, to organize focus groups to discuss reproductive health, migrants' sexual needs, and how to deal with STDs. The sessions often took place at night after workers returned from late shifts, and were conducted secretly because employers frequently objected to such interventions, fearing the organization of labor unrest. The men sometimes took Tenaganita staff to nearby brothels so they could educate sex workers about HIV/STD prevention.

Successful adaptation

The amount of time needed for people on the move to successfully adapt to their destinations depends on several factors. These include individual factors (character, educational, and cultural attributes), differences between countries and regions of origin and destinations (linguistic, religious, and other cultural characteristics) and the ability of migrants and other people on the move to cope with and adjust to these differences, and the effects of pertinent policies in destination areas and countries (e.g., national policies that isolate foreigners impede processes of adaptation while more liberal policies facilitate free movement and adaptation).

Successful adaptation in destination areas also depends on the presence or absence of social support networks that function to ease the transition from being a new arrival to becoming a member of a resident expatriate community.

Return

If and when migrants return to their home countries they need to reintegrate themselves, and this may sometimes be difficult. In many cases, they have experienced personal and cultural changes while away, and their changed behavior may lead to increased HIV/STD risk to them and their sexual partners at home. These kinds of situations also lend themselves to interventions.

Some programs are particularly concerned with returning migrants. With the help of the Bangladeshi NGO Shisuk and CARAM Bangladesh, the Welfare Association of Repatriated Bangladeshi Employees (WARBE) was founded to protect the rights of returned migrant workers. It also aims to create opportunities for discussion of sexuality, STDs and HIV/AIDS with returning migrants and their sexual partners. This is important because much of the Bangladeshi population considers that the HIV epidemic was brought home by returning migrants.

ACHIEVE. Inc/CARAM Philippines is currently engaged in action research and capacity building initiatives with returning migrant workers who have been diagnosed as HIV+. This program aims to generate data on conditions of returning migrant

workers living with HIV/AIDS for purposes of developing policy and program responses. It also aims to empower HIV+ migrants to confront and understand their new realities; facilitate their participation in current initiatives and actions and enable them to sustain their day to day existence. Their involvement in education, research, advocacy and care and support activities is integral and fundamental in the overall framework and perspective that ACHIEVE Inc/CARAM Philippines adheres to. Partnerships with Pinoy Plus Association (an organization of Filipinos living with HIV/AIDS) and the Positive Action Foundation Philippines (an NGO working on HIV/AIDS), along with other NGOs and key government agencies such as the POEA, OWWA and the Office of the Undersecretary for Migrant Workers Affairs (OUMWA) of the Department of Foreign Affairs are critical in ensuring that the various initiatives complement and interface with each other.

ANNEXURE-I
SRO GUIDELINES ON MEDICAL EXAMINATIONS

A. VALIDITY OF MEDICAL RESULTS

The medical examinations shall be valid for a period of six (6) months as embodied in our Memorandum of Agreement.

B. SUBMISSION OF MEDICAL REPORTS

The clinics are required to submit weekly reports to SRO every Monday at 1.00 pm.

The POEA-SRO accredited clinics are likewise enjoined to submit photocopies or duplicate copies of medical results to our office simultaneously with the submission of original medical reports to POEA.

C. MEDICAL RATING SYSTEM

Class A - applicants who are examined and are found to be physically fit to work: in excellent health characterized by the absence of any physical defects or ailments.

Class B - applications who are classified as physically fit to work but with minor ailments treatable within and not more than two (2) weeks time.

Medical results of such applicants should remain pending with the clinic for not more than two weeks or should be returned to POEA for cancellation.

e.g.: minor dental defects, intestinal parasitism, mild urinary tract infection, mild respiratory tract infection, and other diseases that are normally curable within the period of two weeks.

UNFIT - applicants who are found to be physically unfit to work:

1) C - applicants with minor ailments but curable in more than two (2) weeks time. Please note that any disease treatable within fifteen (15) days or more fall under this category.

e.g.: underweight and overweight PTB Pnoumonities, haemorrhoids, non-toxic goiter and other diseases that are normally treated for a period of more than two (2) weeks.

2) D - applicants whose ailments cannot be treated. It is characterized by serious illness.

e.g.: syphilis, advanced PTB, serious heart disease, and all diseases which render the worker unemployable.

D. UPGRADING PROCEDURES

a) Upgrading of Class B Applicants

The Clinic shall keep the medical referral of Class B applicants for two (2) weeks time but will have to inform SRO about the status of pending applicants that are upgrading treatment in their daily and weekly report. The Clinic must clear pending applicants in not more than two weeks time or return the medical form to POEA for cancellation.

b) Upgrading of Unfit Applicants

The Clinic shall immediately return the medical forms of unfit applicants to POEA. If the applicant has no objection, the clinic may advise him/her of the necessary treatment within a certain period of time or refer them to other reputable hospitals for further treatment. After such ailments had been cured, the clinic may still upgrade the applicant by issuing a letter or request for upgrading to our office SRO will then issue a new medical report if the position for the applicant is still available.

Applicants who were unfit due to any cases within and not more than four (4) months from the date of initial examinations shall be examined only for the disease or ailment for which they have been disqualified, before an upgrading letter is issued. The previous examinations wherein the applicants are FIT TO WORK shall be accepted and reflected in the new medical form. Please note that the remaining two months of the validity of the medical examinations are reserved for the maximum time within which the applicants is expected to be deployed to the Kingdom of Saudi Arabia.

E. CONDUCTING RE-MEDICAL EXAMINATION

1. The pre-departure medical examination must be scheduled five (5) working days before departure date to give ample time for the clinics to examine and submit re-medical results to POEA.

2. POEA shall specify in their re-medical referral to the clinics the applicants' departure date.

3. The clinics are required to call SRO (Linda Sindayen / Lorna Lindo / Gina Rey with telephone numbers : 817-14-18, 810-26-71 & 817-05-34) regarding unfit re-medical workers at least two (2) days at 12:00 noon before departure date.

4. Failure on the part of the clinics to inform SRO and POEA regarding failed or pending applicants in the re-medical examination shall make them liable for payment of fifty Dollar ($50) penalty as imposed by Saudia Airlines.

5. A repeat pregnancy test, Hepatitis B test and chest X-ray shall be conducted on the applicants prior to their departure. Chest X-ray and pregnancy tests are free of change while Hepatitis B Testing shall be shouldered by the applicant (P80.00).

6. Chest X-ray shall not be conducted for applicants whose first X-ray examination were given in less than three months.

7. Hepatitis B testing is valid for only two weeks before departure date.

ANNEXURE-II

MEDICAL TESTS REQUIRED FOR FILIPINO OVERSEAS WORKERS

As of 30 October 2000

FOR MIDDLE EAST COUNTRIES

KSA

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA
4. Aids Test
5. Hepa B / C
6. Psycho Test

KUWAIT

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA
4. Aids Test
5. Hepa B / C
6. Psycho Test

QATAR

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA
4. Aids Test
5. Hepa B / C
6. Psycho Test

OTHER ASIAN COUNTRIES

BRUNEI

1. Basic Medical Test
2. Pregnancy Test
3. Psycho Test

MALAYSIA

1. Basic Medical Test
2. Pregnancy Test
3. Psycho Test

HONG KONG

1. Basic Medical Test
2. Pregnancy Test
3. Psycho Test

FOR USA ANS OTHER TRUST TERRITORIES

Mandatory medical examinations to CNMI Countries

USA

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA
4. Aids Test
5. Hepa B / C
6. Psycho Test

GUAM

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA
4. Aids Test
5. Hepa B / C
6. Psycho Test

PALAU / SAIPAN

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA

FIJI ISLAND

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA
4. Aids Test
5. Hepa B / C
6. Psycho Test

PAPUA NEW GUINEA

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA
4. Aids Test
5. Hepa B / C
6. Psycho Test

AFRICA

1. Basic Medical Exam
2. Pregnancy Test
3. VDRL / TPHA
4. Aids Test
5. Hepa B / C
6. Psycho Test

TAIWAN

1. Basic Medical Exam
2. Pregnancy Test
3. Marijuana and Drug Test

EUROPEAN COUNTRIES

1. Basic Medical Exam
2. Pregnancy Test
3. Psycho Test

ANNEXURE-III

PROCEDURAL GUIDELINES ON REFERRAL OF GPB HIRES TO POEA RATING CLINICS

1. Medical examinations of overseas contract workers (OCWs), hired through the Government Placement Branch (GPB), should be conducted only by the POEA retained clinics upon presentation of a POEA Referral Form (RF) and in compliance with the Department of Health prescribed medical examinations and/or country/employer medical protocol or requirements.

2. Medical examinations should be done not later than the date prescribed on the RF unless delay is clearly not attributable to the medical clinic.

3. Results of medical examinations should be submitted to POEA on time based on the case prescribed release schedule. In the event that certain minor ailments need treatment, the clinic shall advise POEA of the estimated period of time during which the said treatment shall be undertaken so that the same may be referred to the employer/principal for consideration.

4. Medical examinations should be in compliance with the 3 months (6 months in the case of MOH-KSA hired workers) prescribed validity guarantee. (As part of that guarantee, medical clinics agreed to shoulder the cost of repatriation and other expenses in the event that the employer rejects / terminates concerned worker/s within 3/6 month from the date of examination due to medical reasons).

5. Submission of medical result, be it “FIT TO WORK” or “UNIT TO WORK” should be directly coursed through POEA by the medical clinics' representatives but never given directly to OCWs except when officially requested by the POEA.

6. Medical clinic should maintain medical records of OCWs, including chest X-ray films for at least 2 years, for reference purposes.

7. A week after the preceding month, all medical clinics retained by POEA should submit their monthly report on the number of OCWs examined by them through the referral GPB.

8. Medical clinics should comply with the medical protocol of POEA-GPB foreign clients including rules on upgrading medical results particularly those resulting in airlines fines for delayed or no-shows on scheduled flights.