Policy Issues and Concerns With Regards to Migrant Health in Malaysia

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Introduction

The term "migrant worker" refers to a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national[1].

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[2].

For migrants, 'this translates into the physical, mental and social wellbeing of mobile populations and communities affected by migration'[3].

The application of international standards to look at migrant health can also be interpreted through the articulation of the right to health in the International Covenant on Economic, Social and Cultural Rights which recognizes that**,**

> *Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity* (Art 12.1, ICESCR)

General Comment 14 (2000) by the Committee on ESC Rights (CESCR)[4] ,

- further affirms the principles of non discrimination and equal treatment in exercising the right to health (para 18)
- includes the right to health to cover access to health care and the related socio-economic determinants of health including ….*'access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health'* (para 11)
- elaborates on the right to health to contain 'Freedoms' (Freedom over one's own body, control over the self, ability to make decisions that affect one's own health) and 'Entitlements (rights of access to services, information, etc) (para 8)

The above are especially relevant in the context of migrants who are constantly put into situations where,

- they are denied access to basic amenities through poor living and working conditions, and to services, information and programs that can help them have control over their health and lives, and,

[1] International Convention on the Rights of Migrants Workers and Members of Their Families 1990
[2] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
[3] Migrant Health for the Benefit of All, IOM, Eighty-eighth session, 8 November 2004, MC/INF/275, (http://www.iom.int/DOCUMENTS/GOVERNING/EN/MC_INF_275.PDF - on 03 June 2005)
[4] SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS - General Comment No. 14 (2000) - The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) CESCR - COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, Twenty-second session, Geneva, 25 April-12 May 2000, Agenda item 3

- lose the right to make decisions over their body and health due to policies or conditions imposed by employers.

Consideration of 2 Health Policies Covering Migrant Workers in Malaysia

Given the importance paid by Malaysia to migration as a co-factor of HIV infection as reflected in existing HIV/AIDS policy, this section will focus on 2 policies covering migrant workers which have important implications for the HIV pandemic.

1. Mandatory HIV Testing and Deportation of Migrant Workers
2. Double Fee Policy related to access to health care

1. Mandatory HIV Testing and Deportation of Migrant Workers

As in many receiving countries, in Malaysia, mandatory HIV testing of migrants goes hand in hand with their notification and deportation. Notification of these infectious diseases is required by the Prevention and Control of Infectious Diseases Act, while the Immigration Act 159/1963, is used to deport migrant workers with HIV and/or require them to submit to a medical examination if necessary[5]. This is also echoed by the national AIDS action plan.[6]

Fomema (Foreign Workers Medical Examination Monitoring Agency), the privatized consortium that has been awarded the contract to conduct the mandatory medical examination required of foreign workers prior to the renewal of their work permits, is on-line with the Ministry of Health and the Department of Immigration. Migrant workers are required to sign a consent form prior to taking the test though they are rarely aware that they are being tested for HIV. Nor are they provided with pre and post HIV test counseling. Often migrants are not aware that they are being deported because of their sero-positive status. In general, there is no referral service available to deported migrants to access even counseling support either in Malaysia or in their home country[7].

To consider the merits of the policy on mandatory HIV testing and deportation, it is important to consider the following:
1. concepts with regards to factors impacting HIV vulnerability of migrants
2. gains of mandatory HIV testing
3. international standards with regards to HIV testing

Concepts with Regards to Factors Impacting HIV Vulnerability of Migrants

The two concepts highlighted in the symposium on 'Mobile Populations and HIV' at the 12th International AIDS Conference in 1998[8] as crucial in effective HIV/AIDS prevention and care for mobile populations include,

- Vulnerability – that arises from the hazards or risky conditions in the migration process. The emphasis is on 'environmental factors' that place the migrant at risk to HIV and not on the migrant as a 'carrier of the virus'. An understanding of vulnerability requires the additional use of sociological and anthropological approaches as against a purely epidemiological approach usually adopted by governments.

[5] Mehrun Siraj, The HIV Epidemic in Malaysia - Law, Ethics and HIV, Proceedings of the UNDP Intercountry Consultation, Cebu, Philippines, 3-6 May, 1993 - ed. Robert A Glick - UNDP, 1993
[6] 'All foreign workers should be subject to medical examination on a regular basis (upon renewal of the work permit). Anybody found to be HIV positive should be reported to the nearest Health Officer. The worker should be referred to the Immigration Department for deportation'. Section 13.4.2. Plan of Action for the Prevention and Control of HIV Infection, AIDS/STD Section, Disease Control Division, Dept of Public Health, Ministry of Health Malaysia, 2000
[7] Tenaganita, Vulnerable, A Study of the HIV Vulnerability of Bangladeshi Migrant Workers in Malaysia, 2000
[8] The Forgotten Spaces, (Generic Manual on Pre-Departure, Post arrival and Reintegration Programs for Migrants), CARAM Asia, 2002

- Risk – is in relation to individual behavior and responsibility as migrants make choices to deal with the opportunities and threats that confront them in the satisfaction of their needs. The presumption of 'choice' is based on the supposition that migrants have the requisite space and 'enabling' environment that reduces 'vulnerability' to make informed choices.

Mandatory HIV testing and deportation proceed from the notion of migrants as a 'high risk' group and vectors of the disease. This is contrary to the reality that they are 'vulnerable' to contracting the infection because of risky migration conditions that compromises their health and human security. Thus, while it is unarguable that appropriate health education and interventions like condom distribution can induce behavior change and reduce risk, in themselves they are ineffective when the conditions of migration creating the 'vulnerability' have not been addressed. The factors of vulnerability include,

- abusive and exploitative living and working conditions
- lack of access to information and services (including health, legal etc) owing to language and legal barriers
- social isolation
- sexual harassment, and,
- stigma and discrimination among others.

In this sense, the policy of mandatory HIV testing and deportation is not anchored in an internationally agreed conceptual framework to understand the intersectionalities of migration and health and HIV/AIDS because it does not consider the factors of vulnerability of migrants to HIV arising as a cause and effect of mandatory HIV testing and deportation.

Gains of Mandatory HIV Testing - Does it Control the Spread of HIV or Contribute to Increased Vulnerability and Risk for Migrants?

The significance of HIV testing as an epidemiological tool or as a necessary medical intervention for treatment is not challenged.

However, evidence indicates that even though mandatory HIV testing and deportation of migrants is a favored tool of public health by policy makers especially in destination countries, to control the spread of HIV, the merits are questionable for many reasons.

- Debate among public health experts over the past 20 years on the efficacy of mandatory HIV testing has concluded in the development of international consensus and accepted guidelines on HIV/AIDS which reject mandatory HIV testing not only for its ineffectiveness to achieve its goals but also because of the moral and ethical questions it raises. Instead prevention, voluntary testing and counseling, research and access to treatment have been identified as the fundamental requisites of a successful plan to combat HIV/AIDS.[9]
- It does not prevent infection or risky behaviors and cannot detect the infection during the 'window period'[10]
- It creates a false sense of security in the host population that believes that they have 'deported' the virus and prevents the development of appropriate strategies to deal with the pandemic.
- Simultaneously, the arising stigma and discrimination deters migrants from taking the test, thus driving the epidemic underground and making the fight against AIDS even more complex and difficult.
- Moreover the cost of mandatory testing and deportation in terms of time and money does not reflect an efficient allocation of resources and diverts resources from more critical prevention measures.
- Deportation of migrant workers due to a false positive test result makes the discrimination even more severe.[11]
- In the context of migrants it denies them the right to gainful employment and a livelihood in spite of the fact that HIV positive individuals can lead productive lives and contribute to the economies and societies they live in.
- It seems to place the responsibility of handling the HIV epidemic on the migrant workers.

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[9] David Haerry, François Wasserfallen, Peter Wiessner, Compulsory HIV Testing from a Public Health and Human Rights Perspective – A Summary of Key Arguments to Support a Wider Discussion.
[10] Voluntary, Routine and Mandatory HIV Testing, http://www.avert.org/hiv-test.htm, as on June 6, 2005
[11] Tenaganita case files 2000.

In spite of the limitations in the estimation of HIV/AIDS figures in Malaysia because of compulsory selective testing and active surveillance of certain sub-populations and the specific focus on certain behavioral, demographic and biological variables, existing HIV/AIDS data in Malaysia and other countries poses questions with regards to the efficacy of mandatory HIV testing of migrants.

1. For example, can the use of mandatory HIV testing be justified for migrants who come from countries with a lower HIV prevalence than Malaysia?

   Estimates of HIV Adult (15-49) Prevalence Proportion (%) Rates at the End of 2003[12]

Malaysia	0.4	Vietnam	0.4
Cambodia	2.6	Indonesia	0.1
Burma	1.2	Pakistan	0.1
Nepal	0.5	Philippines	<0.1
		Sri Lanka	<0.1

   Are not migrants from these countries more at risk of contracting HIV if the logic of numbers is used? In fact, once again, given the inherent biases in the calculation of HIV figures, countries with a lower HIV prevalence like the Philippines, Pakistan and Sri Lanka attribute a major proportion of their HIV infections to out-migration indicating that migrants are more at risk of exposure to HIV infection through migration than of transmitting the same.

   In the Philippines, according to the National Registry of the Department of Health (2004), Overseas Filipino Workers (OFWs) comprised 32% or 702 OFWs who were HIV positive. The same is also true for Pakistan where statistics in 1999 showed that 80% of the 1600 people who were HIV positive were prospective migrants and returnees to/from the Gulf.[13] In Sri Lanka too, as per existing statistics 50% of reported HIV persons are returned domestic workers from the Middle East[14].

2. What has been the value of the policy of mandatory HIV testing in Malaysia (and the fear of migrants as vectors of the disease) if over the period 1986 to 2000 the proportion of foreigners (including migrant workers) who have tested HIV positive have consistently been marginal compared to other sub groups of population in Malaysia? In fact the AIDS Epidemic Update 2004 has suggested that 'significant factors in the epidemic are being missed' in Malaysia. [15] Further, is mandatory HIV testing effective if the numbers of HIV positive migrants has only increased marginally over the 18 year period?

HIV INFECTION REPORTED IN MALAYSIA

	1986-2000		**1986-2001**		**1986-2002**		**1986-2003**		**1986-2004**	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Malay	27,575	72.4	32,068	72.5	37,221	72.62	42,068	72.52	46,806	72.64
Chinese	5,830	15.3	6,733	15.2	7,758	15.14	8,746	15.08	9,532	14.79
Indian	3,339	8.8	3,853	8.7	4,378	8.54	4,886	8.42	5,354	8.31
Bumiputra Sarawak	49	0.1	67	0.2	91	0.18	128	0.22	162	0.25
Bumiputra Sabah	41	0.1	62	0.1	107	0.21	137	0.24	207	0.32
Original					36	0.07	39	0.07	39	0.06
Others in Peninsular	240	0.6	279	0.6	300	0.59	335	0.58	370	0.57
Foreigner	958	**2.5**	1,123	**2.5**	1,342	**2.62**	1,628	**2.81**	1,912	**2.97**
Unknown	12	0	23	0.1	23	0.04	45	0.08	57	0.09
TOTAL	38,044	100	44,208	100	51,256	100.00	58,012	100.00	64,439	100.00

Source: Ministry of Health, Malaysia - Derived from documents prepared by Resource Centre, Malaysian AIDS Council

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[12] Estimated number of adults living with HIV at the end of 2003 divided by the 2003 adult (15-49) population. Data as per the 2004 Report on the Global AIDS Epidemic, UNAIDS

[13] Awan, Zia Ahmed, Report of the National Consultation on Migration and HIV, LHRLA, 2000

[14] UNDP, Regional Update - Sri Lanka, http://www.hivanddevelopment.org/regionalupdate/srilanka/index.asp, as on 06 June 2005

[15] AIDS Epidemic Update, December 2004, UNAIDS/WHO – 2004

The above data indicates that the inclusion of mandatory HIV testing and deportation of migrants as a component of the national strategy to fight HIV/AIDS cannot be justified through existing data, especially given the cost of the exercise which is borne by the migrants at the end of the day.

Mandatory HIV Testing – A Violation of International Standards with regards to HIV Testing

In addition this policy contravenes international standards. For a nation that aspires to be a global player, this is not a very suitable situation.

The international standards breached in respect of the mandatory HIV testing and deportation policy include:

Violation of the 3Cs in the international guidelines set out by UNAIDS and WHO[16] regarding testing – namely, consent, counseling and confidentiality. Though migrants in this context have the right to refuse to be tested they do not have the right to choose not to be tested. In addition, CARAM's research[17] with migrants in Malaysia, Philippines and Bangladesh indicate that the awareness and understanding of consequences of taking the HIV test are poorly understood by most migrants. This is because of poor and/or no pre and post test HIV counseling.

- In addition, it violates the right to information and education, the right to privacy, the right to freedom of movement and right to livelihood, among others.

- In fact WHO is quite unequivocal in stating that,

  '*Mandatory testing and other testing without informed consent has no place in AIDS prevention and control programs*'[18]

  This is echoed also in the UNAIDS/WHO Policy Statement on HIV Testing, June 2004,

  '*UNAIDS/WHO do not support mandatory testing of individuals on public health grounds. Voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals. Recognising that many countries require HIV testing for immigration purposes on a mandatory basis and that some countries conduct mandatory testing for pre-recruitment and periodic medical assessment of military personnel for the purposes of establishing fitness, UNAIDS/WHO recommend that such testing be conducted only when accompanied by counseling for both HIV-positive and HIV-negative individuals and referral to medical and psychosocial services for those who receive a positive test result*[19].

  This is not the case in the Malaysian situation.

2. Access to Health Care Services

Prevention plays a critical role in the control of the HIV pandemic. Access to health care significantly contributes to these efforts by reducing the vulnerability to HIV infection and providing increased control over health outcomes.

The essential elements comprising **'accessibility'** with regards to the right to health includes,[20]non discrimination in terms of accessibility of health facilities, physical accessibility, economic accessibility and information accessibility. Economic accessibility is defined on the basis of the equity principle.

The Malaysian policy of Double Fees presumes that migrants place a burden on an over stretched public health services system. Thus, it requires, migrant workers like all foreigners to pay 'double fees'. In practice this means that migrants admitted to public hospitals pay first class fees, but will be entitled only to third class treatment. The out patient fee for migrants in public hospitals which used to be RM 2 (as against RM 1 paid by Malaysians) increased to RM 15 in 2004.

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[16] UNAIDS/WHO Policy Statement on HIV Testing, June 2004

[17] Verghis Sharuna, Promoting and Protecting Human Rights to Reduce the HIV Vulnerability of Migrant Workers, Population Mobility in Asia: Implications for HIV/AIDS Action Programmes, 5th ICAAP, UNOPS-UNDP, 2000, 87-103

[18] Statement from the Consultation on Testing and Counselling for HIV Infection, Geneva, 16-18 November 1992

[19] 15 Ibid

[20] Para 12 (b) of General Comment 14 (2000)

To accord third class treatment when an individual pays a first class fee is inequitable. It restricts the migrants' access to affordable and subsidized health care services and reflects the following issues that the policy fails to consider:

- the contribution of migrants to the development of the country and economy, by doing the dirty, dangerous, and demanding jobs shunned by locals.
- the entitlement of migrant workers to the same rights as all workers consistent with international standards for the treatment of workers and migrant workers.
- the fact that migrant workers are among the highest tax payers in the country. Except for domestic workers,, all other migrant workers pay a levy of about RM1,200 per anum, more than the amount many Malaysians pay in taxes. In addition, workers in the plantation, construction and manufacturing sectors are made to pay the premium of the Foreign Workers Compensation Scheme (FWCS), an insurance that covers them in case of accidents and work related injuries but which excludes invalidity pensions for work related disabilities. In all, migrant workers pay about the following amounts per anum towards the costs given below[21]:

Levy	:	RM 1,200
Visa (PLKS)	:	RM 60
Multiple Entry Visa	:	RM 15
Processing Fee	:	RM 50
Foreign Workers Compensation Scheme	:	RM 96
Annual Check Up Fomema	:	RM 190
Total	:	RM 1,611

In almost all cases, employers advance the above costs but subsequently deduct it from the wages of the migrant worker. In some cases, the coverage by the employer is partial. However, based on the above and generally accepted principles of health financing, why cannot subsidized health care be a right of the migrant worker who is contributing to national growth and productivity and paying higher taxes than most individuals?

The existing health inequity with regards to migrants creates consequences,

- at the personal level, high costs of health care (exacerbated also by policies of notification[22] of infectious diseases) leads to self medication, delayed visits to doctors or shunning of public health services fearing loss of employment and deportation. These factors have the potential to immuno-compromise migrants and make them vulnerable to acquiring HIV and/or or other infections. It also increases the potential for increased health inequalities.
- at the regional level, the health inequalities arising from poor access of migrants to health services in tandem with the policy of deportation for infectious diseases (some of which are easily treatable) has the possibility to exacerbate regional imbalances in the distribution of health. The existing national level analysis attributing migration as a major contributing factor to HIV prevalence in some source countries like the Philippines, Sri Lanka, Pakistan, Bangladesh etc could be taken as an indicator of this reality.

The Way Forward

The policy framework guiding the development of health policies for migrants in almost all destination countries is based largely on considerations of sovereignty of states and their right to determine policies that safeguard the health of their local population, national security and escalating health expenditures by the state. These are all legitimate concerns. But in themselves they are ineffective to guarantee the health of their citizens or to enable a nation to fulfill its duties as a responsible member of the global community.

[21] Hj Shamsuddin Bardan, Malaysian Employers Federation, Foreign Workers in Malaysia – Opportunities and Constraints, MTUC/ILO Regional Workshop on Migrant Workers in Malaysia, 18-19 April 2005
[22] Under Section 10 of the Prevention and Control of Infectious Diseases Act 1988 (ACT342)

Further issues that require consideration include recognition of the **regional dimensions** of migration, health and HIV/AIDS that requires **international cooperation** between states.

In this regard while the national AIDS action plan of Malaysia (2000) acknowledges the need for international co-operation and collaboration[23], the strategy for the same and links between issues is not elaborated.

Highlighting the importance of international policy development in the protection of health, the UN Special Rapporteur on Health states that, …'States are obliged to respect the enjoyment of the right to health in other jurisdictions, to ensure that no international agreement or policy adversely impacts upon the right to health….[24].

This is reflected in General Comment 14 … 'To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries...'[25]. This means that states must refrain from actions that violate the right to health in other countries.

Existing MoUs between Malaysia and origin countries focus on regulation of migrant flows rather than protective conditions for migrants, including protection of health.

While it is true that Malaysia has not ratified the ICESCR, these are internationally recognized standards that have the consensus of the international community and have been contributing to state practice. In addition, many of the sending countries are signatories to the ICESCR and have obligations to their citizens in guaranteeing the right to health – a fact that needs to be recognized and respected by Malaysia. Thus, it is not unreasonable to argue that these standards provide a suitable benchmark to review Malaysia's migrant health policy.

As migrants contribute significantly to the host country's development at the risk of their health and human security, destination countries like Malaysia share an immense regional responsibility to maintain and promote the general health of the region by undertaking socially responsible development policies that concurrently increase economic gains and reduce social costs.

Cooperation between sending and destination countries needs to be strengthened beyond trade, to the protection of health. For this, the importance of **human rights** as the basis for international understanding and cooperation and recognition of all human beings including **migrants** to the **right to the highest attainable standard of physical and mental health** cannot be emphasized enough.

In keeping with good public health policy and praxis, the **participation of migrants** in development of policies and interventions with regards to migrants and health needs to be facilitated.

Given the inter-sectionalities between the issues of migration, health and HIV/AIDS, inter-country and national strategies need to involve **multisectoral cooperation** involving all stake holders**.**

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[23] Section 6.8 Plan of Action for the Prevention and Control of HIV Infection, AIDS/STD Section, Disease Control Division, dept of Public Health, Ministry of Health Malaysia, 2000, pp 10

[24] Report of the Special Rapporteur, Paul Hunt, submitted in accordance with Commission resolution 2002/31, COMMISSION ON HUMAN RIGHTS, Fifty-ninth session, Item 10 of the provisional agenda, E/CN.4/2003/58, 13 February 2003

[25] Para 39, General Comment 14