

**STATE OF HEALTH OF INDONESIAN
MIGRANT WORKERS:
Access to Health of Indonesian Migrant Workers
2005 Report**

Solidaritas Perempuan
(Womens Solidarity for Human Rights)

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I. Introduction

a. Background of research

UN Convention 1990 on the Protection of the Rights of all Migrant Workers and Members of their Families recognizes the migrant workers right to receive any medical care that is urgently required for the preservation of Life and the right to receive medical care, irrespective of the status of in the country. But the reality the migrants faced could be very different, governments and society in destination tends to discriminate against migrants, stereotyped migrant workers as carrier of communicable diseases, and thus a threat to society.

Migrant workers, in every stage of migration process, are particularly vulnerable to violations of their right to health. The nature of the jobs of migrants that are usually the '3D' (dirty, demeaning, dangerous) jobs makes them specifically vulnerable to health problems. Another problems occurred are limited access of migrant workers to medical treatment and high cost of healthcare for migrants.

There is a need to overcome the problems that migrants faced in accessing health services. In the late 2004, Coordination of Action Research on AIDS and Mobility Asia (CARAM Asia) initiated research on the "State of Health of Migrant Workers". The research is being conducted by its partners in 11 countries in Asia. The report of this research will be use to advocate migrants workers right to health in the region.

b. Scope and limitations of research

Since this research relies heavily on qualitative data, the analysis does not represent the views of the entire migrant worker population in Indonesia. This report only provides snapshots of the realities that migrant workers face in relation to their access to health prevention and health care.

The primary data collection for process indicator was limited only within Karawang area and Jakarta's contiguous areas. In Karawang, because it is a major sending area of migrants, returnee migrant workers were easily available. Potential women migrant workers were easy to find in the training center/holding center in Jakarta or in its contiguous areas. However, since male potential migrants do not have to stay in the holding centers and they

only come to the agencies to enrolled and conducted medical test, we could not be able to conduct FGD with them. Therefore, their views and experiences are not reflected in this report.

c. Methodology

It was decided that to get a picture of the status of health of migrant workers, there are three indicators to look at, the structural indicators, impact indicators and process indicators. The process indicators and structural indicators were gathered by examination of laws, policies and regulations and other documents regarding migration, health and HIV/AIDS.

For the process indicators, the main research methods employed were FGDs with potential migrants and returnees and in-depth interviews with stakeholders. Stakeholders were sought from among the following groups: governmental officials (at national and local level), NGO representatives (migrant support and human rights groups), returnees, personnel of medical clinics and recruitment agencies. Other materials informing the report came from websites, from newspaper clippings and from copies of legal documents regarding migrant workers.

II. Country Situation

The number of Indonesians seeking to work overseas has grown rapidly in the past fifteen years. Official figures show that the number of migrant workers each year rose from less than 90,000 in 1990 to 338,992 in 2001 and to 474.310 in 2005. However, it is widely accepted that the actual number is higher than this, due to the extent of irregular migration. For the moment, the economic condition which has not fully recovered from the crisis in 1997, the high levels of unemployment in Indonesia, and the relatively low earnings of workers will continue to encourage Indonesians to seek employment abroad. The primary destination is Malaysia, where the Indonesian community amounts to approximately 1.4 Million, many of whom are irregular. The second destination with the highest number of Indonesian migrants is Saudi Arabia, followed by Singapore, Taiwan, and South Korea.

The remittances sent by Indonesia migrant workers continue to increase from US\$ 1.31 Billion in 2000 to US\$ 2.18 Billion in 2002. In 2005, the remittances

from Indonesian migrant workers are estimated to reach US\$ 2.7 Billion. However, the real cash inflow from Indonesian migrant workers might be higher than these figures because there is no data available on the money that comes through other channels. Government has targeted the remittances for 2006 to reach the amount of US\$ 3.5 - US\$ 4 Billion. To reach this target, the government expects the number of migrants leaving the country to rise from around 400,000 to 1,000,000 this year. It is also expected that the number of formal migrant workers will rise. Meanwhile, the government has also added nine new destination countries including Qatar, Bahrain, Macao, Australia and United States.

In Indonesia, migrant workers are acknowledged as national heroes because of their contribution as a source of foreign exchange. However, for a long time, many Indonesian migrant workers have become victims of abuse in all stages of migration. Prospective migrants become victims of recruiters who give them untrue or incomplete information about the whole migration process. Many of the migrants are also given travel documents that have been falsified. Potential women migrant workers are usually held in 'holding' or 'training' centers while awaiting clearance of their visa applications. This is supposed to take no longer than three months to six months depends on the destination countries. But many stay much longer than they should. The facilities are sometimes inadequate and women are often being victims of various types of harassment.

When abroad, many migrant workers endure physical and mental abuses from their employers. Some migrants also found that their working conditions were not consistent with the provisions in their contracts. For instance, they ended up working longer hours, or their salaries were not being paid fully; some did not get their salaries at all; while others were not given days off.

Many migrant workers, mostly the women, continue to face problems during the reintegration stage. They experience extortion at the airport and on their journeys to their home villages. They have to pay separate fees at various points during customs and immigration clearance for 'services' that do not exist. Despite persistent reports of returning workers having to pay illegal fees and other inappropriate payments, little have been done to solve these problems.

It is believed that the lack of legal instruments providing protection during all stages of migration is one of the main causes of the problems faced by migrant workers. For many years, instruments that regulate migrant workers were only at the ministerial level. In 2004, the House of Representative passed Bill no 39 on Placement and Protection of Indonesian Manpower in Foreign Countries. Although the objective is to protect Indonesian Migrant Workers, it only regulates the procedures of recruitment and placement. This Bill faced many protests from NGOs and recruitment agencies. It was argued that the Bill no 39/2004 does not provide significant changes in term of the protection for migrant workers as compared to Ministerial Decree 104.A/2002.

III. PRE DEPARTURE

Access to Preventive Health Information Services

Bill No 39/2004 on the Placement and Protection for Indonesian Manpower in Foreign Countries, article 34, states that before migrant workers are recruited, they have to be informed about the procedure of recruitment, document requirements, their rights and responsibilities, the situation, conditions and risks in destination countries, and system of protection for migrant workers. The objectives are to prepare the migrants psychologically and enable them to overcome the problems that they might face abroad. Provision of this information is done through two activities: the Pre Departure Orientation Seminar that is under the jurisdiction of the Director General of Placement and Training of Migrant Workers (DGPTMW) and Pre Departure Training that is held in private training and holding centers. Since all the potential migrant workers have to undergo medical test before their departure, we also tried to find out whether they receive information regarding their health through that process.

A. Pre Departure Orientation Seminar (PDOS) for migrant workers

The Decree of Minister of Manpower and Transmigration Republic of Indonesia no: PER-04/MEN/II/2005 mandates the implementation of the Pre Departure Orientation (PDOS) for Migrant Workers. The PDOS is conducted in one day with a total of eight hours. According to an official of DGPTMW, two hours of this training is dedicated to the inputs on the health issues of the potential migrants. The inputs are on Mental Health, Reproductive Health and HIV/AIDS. There are also inputs regarding the culture in destination countries, the role of the embassy, and regarding the work agreement. The official said that those inputs are specific for every destination country, especially those

related to culture, climate and law. These inputs are prepared by the Manpower Department in cooperation with Health Department, Ministry of Women Empowerment and Foreign Affairs Department. One migrant worker also stated that she received additional information about dengue fever.

“Yes, it contains 4 subjects: mental health, reproductive health, HIV/AIDS and others. We also give them materials related to the culture of destination country, the role of embassy, and work agreement. We ask the recruitment agencies to give them other materials in the training centres.... Yes specially teaching materials related to culture and law. Because every country has its own culture and law, we give different teaching materials for every destination country.”¹

According to the prescribed content of the PDOS, it should include the following:

a. Main inputs consist of:

1. Law and regulations in destination country
2. Immigration
3. Manpower/employment
4. Criminal law
5. Job contract;
 - Migrant’s rights and responsibilities
 - Salary, working hours, day leave/rest, insurance
 - Job type
 - Duration of the contract and how to renew the contract.
 - How to overcome problems/conflict

b. Supporting inputs

1. People’s habit in destination country
2. Culture
3. Knowledge on the danger of drugs and HIV/AIDS
4. Working risks that might occur in destination country

¹ Interview with Ms. Fifi Arianti, Director of Directorate of Socialization, Directorate General of Placement and Training of Indonesian Manpower in Foreign Countries, 25 October 2005.

5. How to send money home (Remittance)
6. Religious life
7. Knowledge on travel documents and the trips to destination country.

When asked about the information regarding health for potential migrants, an official from DGPTMW said;

“..we only provide information on reproductive health and drugs, danger of drugs...”²

During an observation in one PDOS session in Jakarta, we learned that there were 12 classes and around 80 migrant workers attended each class. In the class that we observed, there were 80 women and 4 men. When we attended the class, the input being given was on Drugs, HIV/AIDS and Trafficking. The instructor who gave the input was from KOWANI, a women’s NGO. Inputs on HIV/AIDS were about the symptoms, the channels of transmission, and how to prevent HIV/AIDS infection. In describing the channels of transmission, the instructor focused mainly on sexual relationships. She did not explain other channels of transmission. The teaching technique was straight lecture, which was boring for many of the migrant workers. Some of them fell asleep. Only 45 minutes was allocated for the inputs on HIV/AIDS, Drugs and Trafficking. An official of PDO said that for the migrant workers going to Asia Pacific, the inputs on HIV/AIDS is more important because those countries are more free in terms of social life and culture.

From the modules for the training for domestic workers who go to the Middle East, we learned that there were some false data on HIV/AIDS. The modules stated that people can be infected with HIV/AIDS when they wear clothes or use things that have been used by an HIV positive person. It also stated that HIV/AIDS can be transmitted through saliva. Information on how to prevent HIV/AIDS infection also contained pieces of information that were discriminatory such as, not using things that have been used by people living with HIV/AIDS, and not engaging in sex with people living with HIV/AIDS. The approach still stressed on normative approaches - people can prevent

² Interview with Ms. Lisna Pulungan, Director of Directorate of Empowerment, Directorate General of Placement and Training of Indonesian Migrant Workers, 24 January 2005

infection of HIV/AIDS by being more religious, avoiding free sex and not using drugs.

Although the PDOS is a government obligation, and according to regulation should be funded by DGPTMW, no fund has been allocated for these activities. Instead, an official of Service Office for the Placement of Migrant Workers said that DGPTMW requires each migrant worker to pay Rp. 50.000 to attend the PDOS³. The recruitment agencies handle all processing for the migrants. Because all these fees will eventually be deducted from the salaries of the migrant workers, it looks like the migrant workers are shouldering the cost of the PDOS.

B. Orientations at the Training Centers or Holding Centers

Every morning, the head of the Center facilitates a meeting with the migrants where information related to their health is given. They are advised to be clean and tidy and to have good sleep. Food is also discussed at length. The migrants are told to choose the food they eat – they shouldn't buy unhealthy food, specifically, oily foods and frozen foods. They are told that foods bought outside are unclean so they should avoid those to prevent coughs. According to a migrant worker, the information was easy enough to understand.

“Usually, we have session where we told to take care of our tidiness. We also have to take care our food, only eat good food, and have a good sleep. Therefore, we wont get any headache. Information was given by head of the center, do not buy unhealthy food. The way it was told is easy to understand.”⁴

“Health division told us to keep clean. They gave us information. If we get sick, they give us medicine and vitamins. When we were on meeting, they also taught us how to prevent from diseases. The information is easy to understand.”⁵

Some of the migrant workers said that they also got some information about how to prevent contracting diseases from posters that were displayed on the walls around the holding centers. For example, there were posters about

3 Interview with Mr. Jufri Nur, Head of BP2TKI, Jakarta.

4 Tri, during FGD with prospective migrant workers, a recruitment agency in Bogor, 7 October 2005.

5 Wahyuni, during FGD with prospective migrants, a recruitment agency in Bogor, 7 October 2005.

dengue fever. The posters taught the migrant workers that they have to stay clean and to put garbage in its place. They thought that the materials and language used in the posters were easy to understand.

An official from Service Office for the Placement of Indonesian Migrant Workers stated that inputs on health should be delivered at the training centers. However, when a prospective migrants asked about whether any inputs regarding health delivered in the training sessions, she explained:

“Yes, there are..... Like how to care for the elderly, like that.”⁶

We can say that in general, information that are being delivered in the Training Centers/Holding centers are mainly on Skills and Knowledge related to their job as migrant workers, as stated by a staff of a recruitment company.

“Yes. They have to be able to perform everything. From ironing. Washing the dishes. Doing the laundry. Some of us.. mostly those who are from the villages, asked to use washing machine.. well, they probably have never seen such a thing. There are cases like that. In here, we introduce them to washing machines. How to use it. Many are broken, like the iron.. they usually use charcoal (!), here we use electricity. So here, they fully learn....”⁷

According to a recruitment agency in Surabaya, they have tried to include inputs on HIV/AIDS in their trainings but they had protests from the parents of the migrant workers. They were condemned for encouraging free sex because the inputs contained information on sexual relationships and use of condoms. However, in Jakarta, pioneered by PT. Barfo, several recruitment agencies have incorporated inputs on HIV/AIDS and reproductive health in their training sessions. Yayasan Pelita Ilmu, an AIDS NGO in Jakarta, provided the trainer for this session.⁸

C. Medical Testing Requirements

6 Interview with Meliana, a prospective migrant workers, recruitment agency in Bogor, 15 October 2005.

7 Interview with Mr. Iwan, staff of a recruitment agency in Bogor, 5 October 2005.

8 Interview with Mr. Sakir, head of a training centers in Jakarta.

Every potential migrant is required by the law to undergo medical testing. The test is carried out at clinics appointed by Manpower Department. According to an official from Directorate General of Placement and Training of Migrant Workers, the selection of the clinics is based on the recommendation from Department of Health. The Department of Health provides the list of medical clinics and then DGPTMW decides which medical clinic is appropriate for the potential migrant. The criteria for selection of clinics are based on the clinic's capacity, equipment and accessibility. In the case for the migrant workers who are bound for Malaysia and Saudi Arabia, the medical tests are done at clinics authorized by the mentioned countries.

The medical testing usually takes place a day after the migrants come to the agencies. The transportation and the cost of the tests are shouldered by the agencies. The potential migrants do not have to pay at all at this point, even when they are found to be unfit. But eventually, these costs are deducted from their salaries.

"We never charge fees. Initially, they are not charged. Well, they have the salary cut. So there is no fee charged whatsoever. If from the medical we find them unfit, we do not charge fee either."⁹

The test results are sent to the agencies the next day. This is in the form of list of names with remarks that say if they are fit, unfit or pending. For those who are fit, they can proceed to the holding centers. For those who are pending, usually they stay for a couple of days and then they undergo a re-test. For those who are found unfit, they go home on the same day. Not all the potential migrants agree with the results. Sometimes they protest if they are found unfit. In this case, the agencies then ask them to do the same tests in another clinic. If they are found to be fit in other clinic, the agencies allow them to proceed to the holding centers and the cost of their second testing is reimbursed.

"There are cases. If such case occurs, usually we tell the person to go to Prodia. That is a good (clinic), yes. If there s/he has declared fit, we

will reimburse the fee. If unfit, well that is his risk. But the result is rarely wrong.”¹⁰

“No, she leaves home immediately after knowing that she is unfit. But, sometimes we don’t believe test result from one doctor. So we do the same test with a different doctor. Sometimes the result is different. My neighbor experienced it.”¹¹

The confidentiality of the workers’ health status is clearly not respected because the test results are not given to them directly. The health certificates are sent to the agencies and are kept there. It is not distributed to the potential migrants in the first place. Thus, most of the migrants who were found unfit did not know exactly what symptoms or diseases they have. The agency blames it to the fact that they only receive the certificates days before. However, even though they received it at the later, the agency does not have the initiative to send the results to the potential migrants. They wait until the sponsor asks them.

“Now is the announcement, yes, Mas,(?) then tomorrow, the result is out, the day after. Once considered unfit, the kid is directly sent home. Initially, we only receive reports through fax. The blanks (test result, medical report) were sent later on. However, sometimes, once they reach home, the sponsor asks for the blanks as reference to hospitals, if the kid asks.”¹²

It is very clear that the tests are conducted for the benefit of the receiving country only, not for the benefit of the migrants. The purpose of medical testing is to know the health condition of the migrants, to make sure only the healthy ones can go abroad. Many migrants are informed that the purpose of the test is to know their health condition or to make sure they are healthy. A potential migrant stated that the purpose is also for the concern of the recruitment agency.

10 Interview with Mr. Surono, a staff of a recruitment agency in Bogor, 15 Oktober2005.

11 NN, during FGD with prospective migrant workers, a recruitment agency in Bogor, 7 October 2005.

12 Interview with Mr. Surono, staff of a recruitment agency, 15 Oktober2005.

“I know based on my own experience, the purpose is to know if we are in good condition or fit before leaving. When abroad, if we’re being tested again, and are found unhealthy, it’s not their (recruitment agency) responsibility.”¹³

As a part of medical testing, the prospective migrants also have to undergo HIV/AIDS test. Even though Indonesia has a regulation that prevents the use of HIV/AIDS test as a requirement to work, migrants still go through the test because it is required by all the destination countries of Indonesian migrants,

No counseling was provided for the prospective migrants before and after the test. None of the migrants knew that they were being tested for HIV/AIDS because no one informed them about it in the first place. A migrant said that all she knew was her blood was being taken to find out if their blood was dirty or not. Some of them found out later that they were tested for HIV/AIDS. They did not mind the kind of tests done on them because the most important thing for them was to know whether they were fit or unfit.

“At the clinic, they take our blood then check it. I know nothing. What I know just I am fit. No counseling with the doctor.”¹⁴

“The truth is we were never told that we were being HIV tested. Blood test just to know that our blood is dirty or not. There was a woman who’s positively infected by HIV, she has told to get a treatment.”¹⁵

If there are migrant workers found to be positive for HIV, one clinic owner said that they would do a re-test in another clinic. If they are confirmed HIV positive, then the migrant would be referred to Pokdisus-RSCM (Working Group on AIDS-RSCM). Pokdisus is a non-profit institution that provides health education and training, hotline services, counseling and HIV testing, access to diagnosis and treatment, and referral hospitals. There, migrants get the same treatment as anybody else. There is no special treatment for the migrants since in Indonesia migrant workers are not yet considered high risk groups for HIV/AIDS and STI's.

13 Dwi, during FGD with prospective migrant workers, a recruitment agency in Bogor, 7 October 2005.

14 Titin, during FGD with prospective migrant workers, a recruitment agency in Bogor, 7 October 2005.

15 NN, during FGD with prospective migrant workers, a recruitment agency in Bogor, 7 October 2005.

Although official data about HIV/AIDS cases among migrant workers are not available, data from HIPKTEK (Association of Medical Clinic for Migrant Workers) show that there are 131 (0.09%) cases of migrant workers infected with HIV/AIDS from 145,298 potential migrant workers who underwent testing during their application to work in the Middle East from January-October 2005. This shows an increase from the previous year's data of 203 (0.087%) HIV positive migrant workers out of 233,626 who were bound for the Middle East.

D. Preventive Health Information by NGOs

Some of Indonesia potential Migrant Workers also has the opportunity to get health information from some NGOs. Indonesian NGOs that conduct some activities to increase migrant's awareness on health are SP, Yayasan Kembang, Yayasan Pelita Ilmu and Kowani. SP provide a community based program to increase migrants and their family on health issue by doing some discussions and disseminating some information materials on health issues. Yayasan Kembang also distributed health information to migrant communities. YPI have conducted education of reproductive health and HIV/AIDS in holding centers. They also developed VCT program (Voluntary Counseling and Testing) on HIV/AIDS for migrant workers. KOWANI, in cooperated with manpower department involved on Pre Departure Orientation Seminar (PDOS) as the instructor on topics of STI, Reproductive Health and HIV/AIDS.

IV. ON SITE

A. Access to Preventive Health Information and Services

Most of the returnee migrant workers who participated in our focus group discussions said that they did not get any information regarding health prevention in the destination countries. This is true for both the migrant workers who worked in informal sector and those who worked in formal sector. The difference is that the migrant workers who worked in formal sector such as factory got some training before they started working. But although they were provided with training, still they did not receive information

regarding health prevention. Some of them, however, got information about what to do when they got sick, who they should contact, who will pay the cost.

“There were direct announcements, if someone got sick, who should we contact. We must report to shift manager then our shift managers reported to personnel division so the documents might be proceed.”¹⁶

“When we’re there, the company didn’t care about our health. Their only concern is, when we got sick, we have to report to them and they will pay for the cost.”¹⁷

“When we were there, there was one week training before we get into our work... So if we got sick, the company will pay for the cost of medical treatment.”¹⁸

Some of the migrant workers relied on the health information that they got in Indonesia, either from Pre Departure Orientation or from the recruitment agencies.

“There was information from recruitment agency to take care of our health, but when we were there, none.”¹⁹

“We heard it here in Indonesia, whenever we followed Pre Departure Orientation.”²⁰

A returnee migrant from Malaysia said that in Malaysia, they saw posters at hospitals or they got brochures that contained information on how to take care of their health. Of course this did not happen to undocumented migrant workers. They didn’t have access to hospitals because of fear of getting caught by police and then deported.

16 Yusuf, during FGD with male returnees, Karawang, 28 September 2005.

17 Engkos, during FGD with male returnees, Karawang, 28 September 2005.

18 Jaenal, during FGD with male returnees, Karawang, 28 September 2005.

19 Toha, during FGD with male returnees, Karawang, 28 September 2005.

20 Siti, during FGD with female returnees, Karawang, 28 September 2005

“The brochures contained health care, for example, so if we would like to have sex ... so we must use condom to prevent AIDS. If we...ehem...if we don't want to get AIDS, use condom.”²¹

Unfortunately, only the male migrants who participated in our FGDs were able to access health information through posters and brochures. All women migrants that we had FGD with said that they never saw any posters or brochure in their destination countries. Perhaps this is because all of them worked as domestic workers and most of them worked in the Middle East where women do not have much freedom to go outside.

B. Access to Health Care and Services

Access to Health Facilities

Most of the migrant workers who participated in this research said that they have encountered health problems when they were abroad. These illnesses ranged from a light one such as, cough, headache and flu to serious illnesses such as typhoid, digested disease and stroke. Some of them experienced having fractured their bone due to accidents.

When the documented migrants got sick, those who worked in the formal sector would usually contact their supervisor or their team leader first. Others would contact their employers. It was said in the FGD that after telling their supervisor or employer, they were usually taken to hospital to get treatment. But not all got this positive response from their employers.

“My employer served in the security forces, he was a policeman, but he was really ignorant about my illness. The sicker I was, the more reluctant he was in getting me some treatment. I had to figure things out myself. I decided to seek treatment on my own.”²²

For undocumented migrants, mainly they informed their friends first, after that they informed their supervisor. The reason they told the supervisor is so they could get permission to get off work.

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Engkos, during FGD with male returnees, Karawang, 28 September 2005

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Samsuri Sidik, during FGD with male returnees, Karawang, 28 September 2005

There were several channels that they used when they were sick. It depended on whether they worked in the informal or formal sector, or whether they were documented or undocumented. For the documented migrant workers who worked in formal sector, some of them got treatment from health facilities provided by the company. If the company did not provide facilities they went to the public or private hospital that was appointed by the company. Others seek their own treatment but the cost can be reimbursed from the company later.

“When I was sick, I was brought to the hospital. But it was only for employees. The company’s hospital. They had a lot of employees, so anyone who got sick was brought there, to that hospital. So everything was taken care of by the company. So if anyone was sick, s/he did not have to go to other hospital; there was a special hospital for them already there.”²³

For migrant workers who worked in the informal sector, sometimes it was harder to get treatment. It depended on their employers. There were cases of domestic workers who were accompanied by their employers to the hospital. Some went alone. One domestic worker revealed that if the illness was not serious, her employer would not take her to the hospital. Samsuri Sidik, a returnee worked as driver in Saudi Arabia shared his experience below.

“..... I went to the hospital alone; it was not a hospital anyway, what I went to was more of a little clinic, like puskesmas (public health centre) here.”²⁴

For seafarers, since they were mainly out in the ocean, there was no access to hospitals. Although there was a clinic onboard, there was no doctor. They relied on first aid medicines. Only if the illness became serious would they be taken to the nearest hospital.

“We were at sea, so if anyone was sick, we only had the first-aid kit, some storage of medicine. If the illness was serious, well, like I said,

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Madsupi, during FGD with male returnees, Karawang, 28 September 2005

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Samsuri Sidik, during FGD with male returnees, Karawang, 28 September 2005

*just call the office, you only need to do that, call them and they would take you to the nearest hospital. There was a clinic onboard the ship, but there was no doctor. Only first-aid kit. (Some general) medicine.*²⁵

Undocumented migrant workers are the most vulnerable groups, because their access to health facilities could be very limited, in terms of distance, time and access to public health facilities. Many of the undocumented migrants in Malaysia worked in plantations or sawmills that are far from health facilities. Even though distance is not a problem, still they did not have access to health facilities because they did not have legal documents that was required to get treatment. Also they feared being caught. However, if they accessed the hospitals with their employers, no problem would occur.

*“That was the problem, going to the hospital was risky because there could be police there... if we were found without documents... we could be jailed for months, and would have to repeat the process... If we went on our own, we would be asked. But if the employer took us, the documents were not asked.”*²⁶

Usually, if they only experienced minor illnesses, undocumented migrants relied heavily on the medicines they could buy from kiosks. For serious diseases they go to private clinics or doctors. In this case, they pretended to be locals, they changed their names and they spoke in the local dialect.

If the undocumented migrants had serious illness and need to get treatment in hospitals, they had to bring a letter from the company to give to the hospitals as a guarantee. It seems that with this letter they could avoid being caught by the police since the company usually bribed the police because the majority of their employees are illegal.

“No, unless it was serious... I had a friend from Bandung who was ill. He had a stroke; he could not walk for months. I eventually told the company. With other friends from the West Java, we asked the company to take him to the hospital. He was illegal, but in the case, he

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Nurhasan, during FGD with male returnees, Karawang, 28 September 2005

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Toha, during FGD with male returnees, Karawang, 28 September 2005

*finally got a warrant from the company. This would not happen if his illness were not so severe*²⁷

Language Barrier

For many Indonesia migrant workers who worked in Malaysia and Brunei, language was not a problem when they accessed health care facilities there because their language is very similar to Bahasa Indonesia. But for most of the migrants who worked in other countries, language barrier was a problem when getting proper treatment. They could not explain what they really suffered from. Sometimes they just used signs or simply pointed to where it hurt. Sometimes they were accompanied by their employers or by staff from the company where they worked when they went to doctor or hospital. These people would then explained to the doctor about their health problems.

One returnee who worked in Saudi Arabia said that in the company where he worked there were doctors from each country of origin of the migrants who worked there. There was also a doctor from Indonesia, so language barrier was not an issue there.

*“In my case, there was a doctor from Indonesia. There were doctors representing all the countries from which the migrant workers came, for instance Pakistan, Indonesia, etc. There was one doctor representing each country. Because the doctor was Indonesian, it automatically made the process faster. Most of the people there do not speak Arabic. Most Indonesians prefer to keep in the company of their fellow-countrymen, speaking in Indonesian”*²⁸

Insurance – Cost of Treatment

Based on Ministerial Decrees No. 157/2003, while abroad, the migrant workers have to be insured by their employers. The insurance should cover risks faced by the migrants such as; accidents in and out of the workplace; cost of treatment and medicines; death caused by accidents or illnesses including cost of funeral and sending the body to Indonesia; unpaid salary and termination of contract by employer.

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ibid

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Madsupi, during FGD with male returnees, Karawang, 11 August 2005.

While the regulation said that the provision of insurance is the employer's responsibility, In reality, the premium is added to the costs that the migrants have to bear. This premium has to be paid before they go to receiving countries.

It is also stated in the regulation that if the workers want to extend their contracts, they have to pay for the premium themselves. This payment is given to the insurance company in the receiving country who has co-operation with the Indonesian insurance company.

The regulation also covers the issues on how to claim the insurance while. First the migrants have has to get an explanation letter from the Indonesia Embassy/Consulate, after that they have to get a recommendation letter from DGPTMW. Only after completing all these documents, can the migrants submit a claim to insurance company. If insurance company agrees to pay the claimed insurance benefit, the insurance company has to get recommendation letter from DGPTMW first. And the payment has to be given directly to the migrants.

These regulations are hampering the migrants' claim to their insurance benefit while they are abroad. The procedures are too complex, and time consuming. It is almost impossible for them to process all the documents required to claim their insurance.

Many male migrants in this research mentioned that they knew their employers in the receiving countries insured them or that their health problem was their employers' responsibility. No one mentioned about insurance premium that they have paid in Indonesia. Some mentioned the compensation/benefit they would get if they met accidents.

*"Insured. Every person working in Korea is definitely insured. Once was this person, whose hand was chopped-off (up to here), he received an insurance of about a million, if I'm not mistaken. A compensation. For the standards here, it was quite generous."*²⁹

“Everything is insured. That was the case when we had the accident. Our belongings, which also sank along with the ship, were compensated. After the accident, our salaries were raised and we were located to a bigger ship.”³⁰

Even though the migrants have paid their insurance premium prior to the departure and some knew they were or should be insured by their employer, they could not tell whether the money used to pay for the cost of treatment came from insurance or not. This shows that migrants did not know or are not aware of how to claim their benefits and how much it is. An experience shared by Obih, a migrant worker who worked in Brunei showed this fashion.

“Actually, I was insured by the employer. But when I was admitted to the hospital, there was no mention about the insurance. The medical expenses, the X-ray fee, the plane ticket home... these expenses were covered by my employer and my friends; they split the expenses 50:50, each covering 50% of the total. My friends’ money came from the pay they earned from work. The expenses included the admission fee, and the medicine. From friends and the employer. I don’t know whether the money from the employer was actually the insurance money.”³¹

Sometimes the migrants have to bear all the costs by themselves. Some migrants shoulder the costs partially. A returnee said that in Brunei, there was maximum allowance for health services provided by company. The amount was (only) 20 ringgits. If the cost of treatment exceeded it, the rest of the cost should be covered by the migrants. He said that it is a disadvantage of being a worker in a foreign country. However, another returnee shared a different story.

“Well, praise be to God, I never got sick. In Brunei, my friends who got sick, they went to the hospital appointed by the company. But to cover

30 Nurhasan, during FGD with male returnees, Karawang, 11 August 2005.

31 Obih, during FGD with male returnees, Karawang, 11 August 2005.

*the expenses, there was cut from the salary, which meant that they covered for the expenses themselves*³²

A returnee worked in Saudi Arabia as domestic worker had a worse experience. After getting treatment that she paid herself, her employer sent her to the embassy to be sent home to Indonesia.

*"I don't know, my employer should take responsible for my condition. If we went to the doctor, I pay the cost. My employer borrowed my money, 2500 riyals but she never paid it back. From the hospital, I did not go to my employer's house. My employer sent me to the embassy to send me home."*³³

However, not all the migrants had a bad experiences regarding cost of treatment. There were some, even though they did not mention about insurance, whose treatment costs were all covered by the employers.

*"I once experienced that. When it happened, I was getting something from the oven. I was pushing forward an instrument for the compressor part and it fell on my thighs. I was then taken to the hospital and for three days I was an outpatient. The factory covered all the expenses."*³⁴

*"Because I have health insurance over there, so whenever I get sick my employer gives me money to take medicine. There is cold season in Hong Kong. When the season change, people were easy to get flu. I usually take medicine if I get flu. My employer has own doctor. A private doctor, for his/her family. The worse is in 2003 I got my finger cut by knife when I cooked chicken. Then I go to the doctor. A specialist doctor, Elizabeth Hospital. I got 2 days bed rest. My employer handles all the cost"*³⁵

32 Jeje, during FGD with male returnees, Karawang, 11 August 2005.

33 NN, during FGD with female returnees, 11 August 2005.

34 Ujang, during FGD with male returnees, 11 August 2005.

35 Yuli, during FGD with female returnees, 11 August 2005.

For the migrants whose costs for treatment were not provided by their employers, it seems that the cost of treatment is major consideration for them before choosing health care facilities.

“Yes, I was afraid that the fees at that hospital would be expensive, but I wouldn’t know. There were a lot of big hospitals. But I simply wanted everything to run smoothly, I wanted to get the treatment cheaply. So I chose that hospital. The one the family often went to.”³⁶

Quality of Health Services (Experiences when accessing health care facilities)

The treatment the migrants experienced when accessing health care facilities varies depending on the country where they worked. In Saudi Arabia, one migrant said that the service was good. He did not find any difficulties when getting treatment and the staff treated them nicely and kindly. However, other migrant said that the quality of treatment depends on the how much it costs. Thus, according to him,

“If we had lot of money, the service is good. On the contrary, if we did not have lot of money, we only got regular treatment.”

In Korea, even if the language is still a problem in communicating with the staff of health care facilities, it did not affect the quality of the treatment. They did not find any obstacles when getting treatment. They received the same treatment given to Koreans. Ujang, a returnee who worked in Korea shared his thought about the treatment in Korea.

“Satisfied, because there, if you got sick, and admitted to the hospital/clinic, you will immediately get treated. The process did not take long. Here (in Indonesia), it took a long time.”³⁷

A former domestic worker who worked in Hong Kong said that when she was in a hospital, the service she received was good and the nurse was so nice. Her employer, who was a doctor, placed her in a VIP room. She mentioned that there was no discrimination between servant and employer. However,

36 Samsuri Sidik, during FGD with male returnees, 11 August 2005.

37 Ujang, during FGD with male returnee, 11 August 2005.

language was still a factor that determined the way the staff behaved towards the migrants.

“Once, I saw an employee who worked for 3 months. She cannot speak in Cantonese fluently. So she doesn’t understand. The doctor was angry/upset. Then the doctor talks not nice to her.... in the payment place, the nurse shouts at her.”³⁸

Generally, medical treatment for migrant workers in Malaysia shows discrimination when compared to the way they treat the locals. The cost is higher than the cost for the locals. A returnee from Malaysia felt the treatment was inhuman because the service for the migrants was very different. He said that once he got ‘unique’ treatment from a hospital. The doctor gave him medicine without doing test or examination on him first. Consequently, he did not take that medicine.

“The doctor is foreign graduation. The services to us are different, just like they don’t treat us humanly...I have my doubt when taking in the medicines. So finally I buy Bodrex (a common drugs to heal fever, influenza that sold widely in Indonesia) he-he-he...”³⁹

V. REINTEGRATION

Act No. 39 Year 2004 on Job Placement and Protection for Indonesian Migrant Workers in foreign countries provide that the agencies are responsible for migrant workers’ reintegration including provision of health services to workers who are not in good health condition during their return to Indonesia. In reality, Solidaritas Perempuan (SP) has found that several agencies did not pay attention to the health problems of the returnees. They were directly sent home by the agency without getting treatment first. Some of these migrants were assisted by NGOs to push the agencies to claim their insurance.

Migrant workers need to undergo medical check up before departure and upon arrival or while they are in destination country. They are not required to undergo medical check up upon their return to Indonesia. However, in late 2004, when

38 Yuli, during FGD with female returnee, 11 August 2005.

39 Engkos, during FGD with male returnees, Karawang, 28 September 2005

SP accompanied a migrant worker who was just deported from Malaysia to Cipto Mangunkusumo Hospital, the hospital required the migrant to undergo medical test before she can get treatment.

Raden Soekanto Central Police Hospital (RSCPH) is the only hospital where returnees are referred to get treatment. The cost of hospitalization comes from the insurance company through the agencies. Because of its location in Jakarta, it is only accessible for migrants who come home via the Jakarta International Airport. There is no data about health care accessibility of returnees who flew directly to other regions in Indonesia.

According to an official from DGPTMW, they (DGPTMW) cooperate with RSCPH in providing treatment for returnees, but an official of RSCPH revealed that there were no formal agreement between RSCPH and the DGPTMW appointing RSCPH as referral hospital for migrant workers. The history of RSCPH's involvement in providing treatment for migrants began in 1991 when they had an agreement with IMSA, a recruitment agency. Many recruitment agencies also refer their migrants to RSCPH. This official said that RSCPH became a referral for migrants because at that time its location was near the airport (Halim Perdanakusuma Airport), for security reasons and because there were many recruitment agencies located in the surrounding areas.

There is no special treatment for migrants who experienced health problems when they returned. The treatment they receive is the same as other patients. However, women returnees who experienced abuse in the destination country are treated at the Integrated Service Center (ISC), a special unit for women and children victims of violence. The treatment provided in ISC includes medical, medico-legal, psychosocial and legal aid. In 2004, a Medical Recovery Center (MRC) was established as an integrated part of ISC. This establishment was based on a MOU with the International Organization for Migration (IOM). The MRC provides medical and psychosocial treatment for victims of trafficking.

Some NGOs also provide access to healthcare for returnees such as free health services by Friends of Migrant Workers. Others, even though not specifically for migrants, have also treated some migrants, such as Yayasan Pelita Ilmu and Pokdisus –RSCM.

Despite several efforts to provide health accessibility for returnees, there are still some cases where the migrants still need assistance from NGO and sometimes they still face the burden in accessing health care facilities. Below is a story about a returnee who experienced health problem in receiving country and in reintegration stage.

Summary Wasiyah Bt. Karsudi (Migrant Health Case)

Wasiyah Bt. Karsudi was born in Banyumas, Central Java on 26 February 1966. She graduated from elementary school, got married at the age of 14 and has 3 children: 1 girl, 2 boys. On 4 April 2002, Wasiyah went to Malaysia for the 3rd time through PT. Usahatma Bunda Sejati to work for an employer named Yusmandi Bin Ismail and Rosmini Bt. Ahmad Husain. But since they divorced, Wasiyah started to get abused. She was made to work overtime. She was raped by Yusmandi's brother in law. When she asked for her salary, she got abused by Yusmandi's sister who beat her head against the wall until her right ear bled. Because of the heavy work, one day Wasiyah felt pain on her breast. It was examined by a doctor who told Wasiyah that she had breast cancer and that she must undergo an operation. After getting help from Tenaganita, on 1 November 2004 Wasiyah went back to Indonesia. She was then assisted by SP legally and medically. Wasiyah received medical assistance for her operation, chemotherapy, and radiation, from November 2004-November 2005. SP also pushed the employer to pay the remaining salary of Wasiyah. She only got 1450 RM while in Malaysia and her total salary should be 12.400 RM. On 10 February 2006, Wasiyah died. Apart from the gravity of her disease, it is believed that she had experienced less treatment from the hospital in her home town because she did not have enough money for better treatment

VI. F

convention, the government will pay more attention to the protection of migrant's rights, including their health rights.

2. Government has to make bilateral agreements with receiving countries in order to protect their health rights of migrants, especially concerning their vulnerability to HIV/AIDS.
3. Government has to provide better support and treatment for the migrants infected with HIV and their families.
4. Government has to increase migrants' knowledge and awareness on HIV/AIDS through information dissemination.
5. Government has to regulate recruitment agencies and make them provide proper health services for the potential migrants in holding centers.
6. Government has to monitor recruitment agencies to provide better facilities in the holding centers to protect the health of the migrants.
7. Government has to monitor the conduct of medical testing for migrant workers, especially in relation to mandatory HIV testing.

8. It is important to increase the involvement of NGOs and civil society in providing health care for the migrants, either prospective or the returnees.

VII. References

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