Policy Review: Mandatory Health Test of Migrant Workers

This policy review paper is prepared by OKUP (Ovibashi Karmi Unnayan Program) on "Mandatory Health Test of Migrant Workers" under the project "Integrated services of safe migration, HIV prevention and care for migrant workers and families" supported by Robert Carr Fund for Civil Society Network and implemented in partnership with CARAM Asia. The aim of this policy review is to bring forth the discriminatory policy and laws affecting the health of migrants for greater attention and discourse in order of promoting wellbeing of the migrants and their families.

Significance of Labour Migration:

The stock of migrant workers in the GCC has reached over 22 million in 2013 which constitute 46% of the total population in the GCC States.[1] In Saudi Arabia migrant workers constitute 27% of the total workforce while Oman 29%, Bahrain 54%, Kuwait 61%, Qatar and the UAE 89% each. Contrary, the number of documented migrant workers in Malaysia is around 2.3 million (about 19%) amongst about 12 millions total workforce in the country.[2] The figure is likely to double if the illegally employed migrant workers in Malaysia are included.[3] Most of the migrant workers fill in the low-skilled job categories mainly in agriculture, construction, plantation, manufacturing, services and housemaids those are treated – dirty, dangerous and demeaning – and those the local citizens shun, making the countries especially the GCC highly dependent on migrants. Report indicates that these migrant workers together with natural resources like oil are the pillars on which the GCC-wealth is built in.[1] The research entitled "Foreign Labour on Malaysian Growth"[v] indicates that Malaysia can gain benefit from the long-term employment of both semi-skilled and skilled foreign labour than the locals.

Countries of origin also benefit from the deployment of its surplus workforce as remittances are a relatively constant and reliable source of income for them. Data show that around 2 million people enter into the labour market in Bangladesh every year against only 500,000 new jobs created for. Hence, Bangladesh has become one of the major labour origin countries in South Asia with, average, 400,000 annual deployment of its workforce. Remittances sent by the Bangladeshi migrant workers contribute about 12% of its annual GDP, considered as one of the

This policy review paper has focused on the major labour receiving countries absorb around 90% of the total Bangladeshi migrants particularly in the GCC (Gulf Cooperation Countries – Bahrain, Kuwait, Oman, Saudi Arabia, Qatar, UAE) countries and Malaysia. This policy paper has been prepared based on available policies and laws related to migrants' health as well as different reports, publications and available data and information from different sources.

major drivers of the country's economic development.

Regulation Adopted by the GCC States and Malaysia for Mandatory Health Test of Migrant Workers:

Despite the importance of labour migration in accelerating development in the countries of destination, migrant workers are compelled to go through health test for entry, stay and work. The Health Ministers' Council for GCC States, established in 1976, passed the first resolution to initiate the program of Pre-departure Medical Check Up for the incoming migrant workers in the Gulf States in January 1995. The resolution was approved by-laws and came into force as "Rules and Regulations for Medical Examination for Expatriates Recruited for work in the Arab States of the Gulf Cooperation Council" in May 2001. The law was amended in 2005 and 2009 during the 58th and the 66th Conference of the Health Ministers' Council. The law, comprised of 23 Articles and Appendices, has described the standards for accreditation of expatriate health check up centres, duties and responsibilities of expatriate health centres, list of diseases to be screened for and be considered unfit for work and reside in the GCC countries, penalties for the incorrect medical certificate provided by the health check up centres, regulation for coordinating the work between the Executive Board and GAMCA (GCC Approved Medical Centre's Association).

On the other hand, the Malaysian Immigration Act 1959, Section 8(3) instigate to craft the mandatory medical testing for foreign workers defining that any foreign worker (not tourists or expatriates) with a communicable or infectious diseases or mental disorder is denied entry into the country. The government of Malaysia established Foreign Workers Medical Examination and Monitoring Agency (FOMEMA) in 1997 followed by the Private Healthcare Facilities and Services Act 1998 and Regulations 2006 to carry out annual medical examination once the migrants are in Malaysia, at clinics approved by the FOMEMA.

The regulations of the GCC States and Malaysia have explained same rationales of the protection of their own people from the communicable diseases and the follow-up effects that might impact on the psychological and economic aspects of their society. The regulations have barely considered the human aspect of the migrant workers.

Regulation Adopted by Bangladesh for Mandatory Health Test of Migrant Workers:

Very recent, the government of Bangladesh has adopted its 7th Five-Year Plan FY2016-FY2020. Sector 3: Industrial and Economic Services of the National Plan has integrated migrants' health as one of the main components of Human Development and Migration under the sub-sector "Migration for Development" by saying ***"promote migrant-sensitive health policies,***

diseases prevention and care for migrants and their families without discrimination." This landmark plan has created scopes to make migrant-friendly process and procedures of the Health Test.

The importance of pre-departure medical examination of the departing migrant workers was first adopted in the Code of Conduct of Recruiting Agencies and License Rules (2002). Clause (f) of section 7 of the 2002 Rules stated that the recruitment agents must *"arrange the medical examination properly".* Nothing was there to guide the procedure of medical testing, particularly the infectious diseases including HIV. Bangladesh Overseas Employment Policy (BOEP) 2006 stated ***"ease the medical check up process"*** [for migrant workers] in the clause 7.8 of the appendix "Duties and responsibilities of different ministries/departments, offices, directorates, public and private organizations in respect of welfare of expatriates and overseas employment". However, clause 5.1.12 of the policy mentioned about awareness building among migrant workers about health related issues, especially of the HIV/AIDS viruses".

In 2008, the Ministry of Expatriate Welfare and Overseas Employment (MoEWOE) adopted the "Health Check up Policy for potential Bangladeshi Migrant Workers". Clause 8(j) of that stated ***the "quality of medical testing should be in line with international standard (WHO)"*** while clause 9(e) said ***"the medical report shall be considered 'confidential' and shall not be disclose in public".***

However, the policy has said little about the process, procedure, counselling, care and treatment, deportation without referrals in the name of so called 'UNFIT' stamped especially for infectious diseases like HIV/AIDS. The policy is much focused on the quality of medical testing in order to avoid resentment of the destination countries than the rights of migrants, especially in terms of HIV testing.

Bangladesh National HIV/AIDS and STD Policy clearly annulled the mandatory test for HIV infection or other SDTs for travelers and migrants in to, or out of, the country. The policy, in accordance with the international guidelines, has directives on HIV testing which includes informed consent, pre and post test counseling, confidentiality of the result, referrals of HIV positive individuals to the service providers etc. The National HIV Policy stated any test demanded by a third party using undue coercion is unethical and unacceptable and the mandatory HIV testing without '***informed consent***' has no place in an AIDS/STD prevention and control programme.

Practices of Mandatory Heath Test and Rights

Migrant workers are usually undergo a series of infectious and non infectious diseases during the mandatory testing which includes HIV, Malaria, Hepatitis, Leprosy, VDRL/TPHA (sexually transmitted infections/diseases), psychiatric illness, pregnancy etc. Different researches and studies indicate that the migrants' have hardly knowledge and information about the tests they undergo for because they are not provided any pre-test counseling by the medical centres. Most of the cases, they are asked for giving blood, stool and urine, chest X-ray, eye and physical inspection. The report of the 'Positive' results is stamped "UNFIT" and shared with the employers, the Immigration Departments or concerned authority of the destination countries by the GAMCA or the FOMAMA. This has led to violate the rights – put restriction on entry or stay, no access to universal healthcare and treatment, increase vulnerability to infect others, and boost stigma and discrimination. Disclosure of 'UNFIT' or 'Positive' result to the third party without consent and post-test counseling is violation of the principle of confidentiality which happened both at pre-departure and onsite, especially of the cases of HIV/AIDS.

Mandatory HIV testing of migrant workers is a clear contradiction of the ILO Code of Practice on HIV/AIDS and the World of Work. In consonance with the Code of Practice, and on the specific topic of migrant workers, the ILO Committee of Experts has stated that ***"the refusal of entry or repatriation on the grounds that the worker concerned is suffering from an infection or illness of any kind***

which has no effect on the task for which the worker has been recruited, constitutes an unacceptable form of discrimination." As ILO Member State, all the countries covered in this paper (*Bahrain, Kuwait, Oman, Saudi Arabia, Qatar, UAE and Malaysia*) have ethical obligation to respect the Code of Practice. On the other hand, the 2001 UNGASS (UN General Assembly Special Session) Declaration and Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS affirm that all UN Member States shall facilitate right-based HIV prevention programmes for migrant and mobile workers. The Millennium Development Goal (MDGs) and the Sustainable Development Goals (SDGs) asserted to uphold health rights for all – migrant workers fall in the ambit in these global goals to be achieved.

List of Diseases considered UNFIT to Work/Reside in GCC

Infectious Diseases:	Non infectious Diseases:
1. HIV/AIDS Reactive 2. Hepatitis (B) Surface Antigen+ and anti HCV 3. Microfilaria+ & Malaria+ 4. Leprosy 5. Tuberculosis any type 6. Venereal diseases, VDRL+ and THPA+	1. Chronic Renal Failure 2. Chronic Hepatic Failure 3. Congestive Heart Failure 4. Uncontrolled Hypertension 5. Uncontrolled Diabetes Mellitus 6. Known case of Cancer 7. Psychiatric Diseases & Neurological disorder 8. Physical Disability – color blindness and deafness 9. Having major operation 10. Hemoglobin below 10mg/dl

Pregnancy for women migrant workers

Health Difficulties and Vulnerabilities encounter by Migrant Workers abroad:

There is little data about the numbers of migrant workers either return own-self or face deportation every year due to various infectious and non-infectious diseases. OKUP study[vi] on women migrant workers show out of 249 returnee women, 12.04% returned due to sexual and reproductive health complication, 7.41% with psychiatric illness, 6.48% for being Hepatitis, 2.78% for HIV+ while the rest for torture and abuse related sickness including physical disability, hypertension, heart diseases etc. Although migration in itself is not a risk factor for HIV infection, the National AIDS/STD Programme (NASP) report 2014 exposed that out of 645 adults who were HIV positive and had been employed, 64.3% had previously worked abroad; while the same source reported 30% of the new infected people (469) in 2015 are the migrants and their spouses.

Different studies show that migrant workers are vulnerable to HIV for several reasons. Different sexual orientations and physical need push migrant workers to have risky sexual attitude; available scope of different forms of sexual relations including MSM (men sex with men) practices, along with sexual abuse and exploitation increase their vulnerability to HIV/STIs when they have little opportunity to learn of how to protect from HIV/STIs infection. In addition, migrants have hardly opportunity to have proper orientation before migration, lack of access to condom, treatment and related services in the countries of destination. Lack of official referrals

between countries of origin and destinations in regards to repatriation on the ground of HIV infection associated with stigma and discrimination delay access to services and treatment upon arrival of the migrants and increase HIV infection to spouses of the current migrants.

Different media reports[vii] show some 14,000 death bodies of migrant workers were sent home during 2008-2014. Amongst them 94% were considered as "*unnatural death*" majority due to heart attack or brain stroke at the age between 28 and 35. Around 61% of those came from the Middle East countries. Various factors – work category, weather, workplace duress, poor living condition, food etc., in composition of mental, physical and sexual abuse, exploitation, little knowledge and access to health information and treatment put migrant workers in risks to health.

Migrants' Access to Health Services and Treatment both in countries of Origin and Destination:

Unfortunately, migrants rights to access health services and treatment of around 16 infectious and non-infectious diseases have been discarded through putting ban to entry and stay followed by the mandatory health test, there is hardly access to treatment for other non-chronic diseases that the migrants encounter due to various occupational hazardous. Many countries across the gulf states of the Middle East enacted mandatory health insurance coverage for all the foreign workers, for instances, Saudi Arabia offers universal health care and extended insurance to foreign workers and dependents in 2008; employees of large firms in Oman receive employer-sponsored medical coverage; and Qatar has announced that all nationals and expatriates will be insured a mandatory health coverage law in 2015 whereas Abu Dhabi implemented a law that all employers must offer health insurance coverage to their workers while the Ruler of Dubai signed off on a mandatory insurance policy in November 2013 that will require all employers to provide health coverage for their employees – both national, and expatriate. Malaysia has also put mandatory health insurance coverage for foreign workers through EPP1. However, there are flaws in the policies in one hand, and also lack of appropriate implementation on the other. Migrants' especially who are engaged in the low skilled and low category works get hardly benefits out of these.

Numbers of migrant workers especially the women who encounter sexual or reproductive health problems, pregnancy, psychiatric complications or overloaded work and abuse related health difficulties are often forced to return without treatment. Many returnee women migrants report that they had given general medication once or twice but were refused appropriate treatment. They were sent back by the employers before expiry of their contracts. Most of the cases, the return airfare were met from their salaries.

There is no special treatment facility for the migrants return back with different forms of health difficulties in any public or private hospitals in Bangladesh. The severely sick and the critically injured migrants who hold legal documents only can get financial supports (maximum BDT 100,000) as well as repatriation services including ambulance and hospitalization in the public hospitals depending on application to the Wage Earners' Welfare Board. The migrants who left the country through official channels with proper documents but ended up undocumented due to various reasons and context abroad are deprived of these supports and services.

*I was diagnosed "Leukemia"… My employer told I had 'blood cancer' and I would die soon..The doctors and the nurses in the hospital assured me to provide my treatment free of costs. My employer refused it and got my discharged. I pleaded a lot to my employer to continue my treatment but she sent me back in such a critical condition….*OKUP assisted her to get support from the Wage earners' Welfare Board. She couldn't carry on the treatment cost and died within one year of return.

Conclusion and Recommendations

Notwithstanding little, the available data evident that migrant workers face different forms of health difficulties abroad, get infected with various infectious diseases, and ended up with deportation or forced return or repatriation in the coffins. It is fact that the migrants are recruited as healthy and **'FIT'** through mandatory health test but denied access treatment when they become sick and (so-called) **'UNFIT'** and throw out as unusable commodity. Countries both origin and destination must consider migrants as human being who can fall into different health risks due to workplace duress, poor living condition, weather, food or lack of knowledge and skills to prevent and protect from infectious diseases, or abuse, exploitation they face. The discriminatory laws and policies that deny access treatment and services are inhuman when the countries get benefited at the cost of migrants' toils, productivity and remittances. Hence the study strongly recommends that -

- The governments of origin and destination countries must replace discriminatory health examination policies and laws by putting **Migrant-friendly Health Examination** both at pre-departure and onsite. The framework of **"Migrant-friendly Health Examination"** must comprise of the principle of non-discrimination compare to the general public that stipulate equal treatment at destination ends and non-deportation especially in the case of HIV; is conducted in an enabling environment with Informed Consent, Pre and Post test counseling in a language the migrant workers understand, maintain confidentiality of results especially HIV/AIDS that must not increase stigma and discrimination; is responsive to the context of migrants that might include financial and geographical accessibility, gender and cultural sensitivity; and ensure referrals systems for treatment, care and support.
- The concerned ministries must undertake comprehensive health education on migrants' health and vulnerability to infectious diseases including HIV/AIDS at pre-departure level for all potential and departing migrant workers.
- The concerned ministries, directorates and departments must enhance cooperation and collaboration to ensure special and emergency health treatment and care in the public hospitals and specialized service providers for the migrants who return with health difficulties and infectious diseases.

References:

[i] & [iv] *Migration in the GCC countries – a double-edged sword by Erwin Reijenga, Sabastian Brukner, Erik Meji; http://www.rug.nl/frw/education/related/migrationinthegcccountries.pdf*

[i] *Malaysia Submission on Migrant Workers for the 17th Session of the Universal Periodic Report*

[i] & [v] *Foreign Labour on Malaysian Growth; Rahmah Ismail, Universiti Kebangsaan Malaysia, Selangor, Malaysia; Ferayuliani Yuliyusman; Universiti Kebangsaan Malaysia, Selangor, Malaysia; published in the Journal of Economic Integration/Vol.29 No.4, December 2014, 657-675; http://dx.doi/10.11130/jei.2014.4.657*

[vi] *A Decade of women migration from Bangladesh: Achievements, Challenges, Prospects; Islam.Shakirul/2013;*

[vii] *Hasan.Shariful/Prothomalo.com*

Ovibashi Karmi Unnayan Program (OKUP)
542 Mridha Plaza, South Dania
Dhaka – 1236, Bangladesh
Tel: +88 02 755 3737; Mob: +88 01819 224308
Email: okup.ent@gmail.com;
www.okup.org.bd
f:www.facebook.com/okupent

OKUP is a migrant association working for the promotion and protection of the rights of migrant workers including health and HIV/AIDS across the borders