Mapping of HIV Risk and Vulnerabilities of Temporary Contractual Workers from Pakistan to GCC Countries

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavioural Change Communication
BE&OE	Bureau of Emigration and Overseas Employment
CAA	Civil Aviation Authority
CWA	Community Welfare Attaché
DHQ	District Headquarters Hospital
EDO	Executive District Officer
EHACP	Enhanced HIV/AIDS Control Programme
ESCAP	Economic and Social Commission for Asia and the Pacific
ESCWA	Economic and Social Commission for Western Asia
EU	European Union
FIA	Federal Investigation Agency
FSA	Foreign Service Agreement
GAMCA	Gulf Approved Medical Centres Association
GATS	General Agreement on Trade in Services
GCC	Gulf Cooperation Council
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Information Education Communication
ILO	International Labour Organization
IOM	International Organization for Migration
KPK	Khyber Pakhtunkhwa
LHW	Lady Health Worker
MARP	Most At Risk Population
MNA	Member National Assembly
MO	Medical Officer
MS	Medical Superintendent
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
NIH	National Institute of Health
NSF	National Strategic Framework on AIDS
OEPs	Overseas Employment Promoters
OIs	Opportunistic Infections
OPD	Outdoor Patients Department
OPF	Overseas Pakistanis Foundation
PACP	Provincial AIDS Control Programmes
PE	Protector of Emigrants
PLHIV	People Living with HIV
POEPA	Pakistan Overseas Employment Promoters Association
UAE	United Arab Emirates
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Funds
UNGASS	United Nations General Assembly Special Session on HIV/AIDS 2001
VCT	Voluntary Counselling and Testing
WTO	World Trade Organisation

EXECUTIVE SUMMARY

Prior to the 1970s, Pakistanis emigrated towards the European Union (EU), North America, South America, Australia and Africans countries on different visas, including employment, visit, education, business, etc. Most emigrated either through the facilitation of their friends and relatives already working and residing in these countries or through their own efforts, and some permanently settled in their destination countries through various means. The role of the Overseas Employment Promoters (OEPs) in emigration was not a substantial one during this period. In the early 1970s, Pakistanis of various occupational categories, particularly engineers, doctors, nurses, skilled, semi-skilled and unskilled workers in the construction sector started to emigrate towards Middle Eastern countries in general and to the Gulf Cooperation Council (GCC) countries in particular, usually on two years employment visas.

Millions of Pakistani citizens have gone to the Gulf States in search of better employment over the last four decades. Under Section 15 of the Emigration Ordinance 1979, all intending emigrants are required to appear before the Protector of Emigrants (PE) for their registration and pre-departure orientation and briefing on laws of the host country, the terms and conditions of their contract and their rights and obligations while they remain employed abroad. Information regarding health issues, including HIV prevention, is also disseminated during these briefing sessions in all seven PE regional offices of the Bureau of Emigration and Overseas Employment (BE&OE). However, the volume, quality, capacity of orientation of briefing officials, and availability of relevant material is not up to the mark and just a few words of basic information regarding Acquired Immune Deficiency Syndrome (AIDS) is actually being provided to the intending emigrants. Most of the migrant workers do not go through their Foreign Service Agreements (FSA) due to their own low literacy levels and they place their trust in OEPs and, in the case of direct employment, in their friends and relatives. The Pakistanis who reach the destination countries through land and sea routes are not covered under these orientation sessions. The majority of Pakistani workers in the GCC are young, unskilled and largely un-aware about health risks.

Pakistan has a concentrated Human Immunodeficiency Virus (HIV) epidemic with 98,000 estimated persons living with HIV (PLHIV). Migrants are included in key national policy documents as one of the vulnerable populations to HIV. Gulf returnee migrants, their spouses and children make up a considerable proportion of the registered HIV and AIDS cases in Pakistan. The present study, comprising of a desk review and a multi-sited ethnography, was commissioned by the 'Working Group on Migration and HIV' with the aim to map out risks and vulnerabilities of temporary contractual intending migrants, Pakistani migrants already working and residing in the GCC countries and returnees from these countries.

It is evident from the literature review that migration policies in both sending and destination countries are largely not facilitating reducing the risk and consequence of HIV vulnerability among migrant workers. Migrants are often perceived and treated as individuals who can be exploited by any of the stakeholders in the migration process either in the country of origin or destination. HIV positive migrants are often not documented, reported to their origin countries and deported back without explaining their status or discussing their condition.

A typical migration cycle for a temporary contractual labourer proceeding to the GCC countries comprises of three broad stages: the pre-departure stage, stay and work aboard, and reintegration in the home country upon return. The main contact points in the pre-departure stage are: OEPs, GCC-approved medical screening centres, Protectorate of Emigration (PE) offices, and various government agencies at airports. The current study found high levels of ignorance and limited coordination regarding health issues of migrant workers, including HIV, at all contact points. Their situation often deprives them access to appropriate information regarding their legal rights, obligations and health. An attitude of shifting responsibility relating to the health and welfare of migrants from one entity to another is reflected amongst various departments and agencies. Most of them do not have any coordination with the Provincial or National AIDS Control Programme (NACP), Non-Governmental Organisations (NGO) providing support to people living with HIV (PLHIV) and other working for the welfare of migrants. Since 2007, no activity relating to training of stakeholders at various contact points and other preventive measures were in place by the NACP, NGOs and concerned international agencies.

Unregulated GCC screening system with stringent criteria that aim at choosing the 'best' candidates for employers in Gulf countries pushes some to adopt illegal means for migration. Pre and post test counselling for HIV, including informed consent, are not provided to candidates. A majority of them are advised by medical centres staff and OEPs to seek preliminary or *Katcha* tests (pre-screening), as they call it, to know their medical fitness beforehand so that they are not diagnosed unfit at the time of the formal tests. There are strong financial reasons for this health seeking behaviour Lack of counselling and referral mechanisms results in minimising the chances of confirmatory tests for those suspected of being HIV positive, and a missed opportunity for reinforcing prevention, counselling and care. The practice of repeating *Katcha* test gives rise to use of potentially dangerous home remedies and further exploitation of intending migrants.

In stage two of the migration cycle, the migrants face problems of integration in the host countries. Isolation from family and friends, shared accommodation at crowded places, sub-standard conditions of living and work, illegal overstay, exploitation at work places, and lack of recreation and entertainment are some of the risk factors for their general and health well-being. According to a recent study of Pakistani migrants in Gulf countries, 83% did not go through pre-departure orientations, 16% received had not received any information from government departments on policies, rights, working conditions, issues related to health, and other vulnerabilities, while 86% of them engaged in sexual contact with female sex workers in the host countries[1].

Migrants in GCC countries have to undergo mandatory yearly health checks for renewal of their visas and work permits. During these tests if someone is diagnosed with a disease like TB, HIV or Hepatitis B and C. They are deported to the countries of origin without proper information to them about their health status what to talk of councelling.Before deportation, the detained workers are often not allowed to collect their documents, belongings or even wages that their employers owe them. When they arrive at an airport in Pakistan they are detained for some time by the Federal Investigation Agency (FIA) for further investigation to establish their nationality. These investigations can sometimes take days and weeks if a deportee is not in a position to either prove his/her national status as a Pakistani citizen or is found involved in criminal activity in Pakistan or in the destination country. After clearance from the FIA, the returnee migrants travel to their home towns and villages. For returning or deported migrants who are HIV

[1] UNDP Regional Centre in Colombo (2009) "HIV Vulnerabilities of Migrant Women: From Asia to the Arab States"

positive, they are often diagnosed only after they have fallen sick. Some, after they have undergone a long painful and financially draining process of diagnoses and treatments from various health care providers. By the time a migrant is diagnosed as HIV positive, many of them have already infected their spouses and others, either through sexual contact, and/or other means of transmission such as sharing of needles, blood transfusion, and or use of contaminated medical instruments. HIV testing of spouses and other family members takes even longer time due to social stigma. Compliance with Anti-Retroviral Therapies (ART) is challenged by prevailing myths and misconceptions about HIV. Support from the Government and NGOs for Opportunistic Infections (OI) medicine and general reintegration does not cover all those in need. Self pity, withdrawal and dependent-patient's role are the outcomes of the lack of support from family, neighbours, relatives, NGOs, state, and society. Once the pride of their families due to the remittances they send back home; the returned migrants are now rendered economic dependents and social outcasts. In many instances, risky behaviours continue to take place because of lack of awareness and sensitization.

As a matter of public good and specifically to address vulnerabilities of intending migrants, the GCC screening system in Pakistan should be thoroughly reviewed with the consultation of the concerned Ministries and Departments of the Government of Pakistan. Formation of a national level GAMCA should be encouraged to coordinate between BE&OE, the health departments and the regional GAMCA offices as well as to oversee the working of medical centres. Strong linkages between various contact points of migrants should be established to encourage mutual facilitation and accountability. Advocacy should be done with the GCC to ensure proper implementation of protocols at the approved screening centres, and also to revise protocols, if necessary, with a view of decreasing stigma, discrimination and other consequences to the intending migrants. Referral mechanism to Voluntary Counselling and Testing (VCT) centres and a strong liaison with NGOs working with PLHIV should be set up at all the GCC screening centres by introducing a system of reward/incentives for concerned staff of these centres to ensure referral of HIV positive cases and other health conditions. Awareness and sensitisation of officials and staff at all contact points should be done to improve their understanding and attitudes towards HIV/AIDS and the welfare of migrants. Briefing curriculum of the Protector Offices should be reviewed for inclusion of health and HIV-related information. Briefing hall facilities should be up-graded and Behavioural Change Communication (BCC) material should be made available at all contact points. The Overseas Pakistanis Foundation (OPF) should also take steps to assist social and economic reintegration of PLHIV returnee migrants.

1. INTRODUCTION

From 1971 to June 2011, more than 5.7 million Pakistanis temporarily migrated from Pakistan to different countries of the world for the purpose of employment either through OEPs or on direct employment visas arranged on their own or by relatives and friends already working and residing in destination countries. At present, it is estimated that there are about 6 to 7 million Pakistanis who are working and residing in different countries around the world. The share of Pakistani migrants in the world migrant community of an estimated 214 million is around 3 percent which is comparable to the share of total Pakistani population of 180 million (3 percent) in the global population of about 6 billion.

During the last five years, more than 96% of all Pakistani emigrants went to the GCC countries namely: Kingdom of Saudi Arabia (KSA), United Arab Emirates (UAE), Sultanate of Oman, Qatar, Bahrain, and Kuwait. The remaining 4% went to other countries, such as Libya, Malaysia, Republic of Korea, EU and other developed countries. The share of female workers among the total Pakistani migrant workers who proceeded to the GCC countries during last five years was about 0.12 % (2,200). The majority of Pakistani migrant workers in the GCC countries are aged between 20-30 years. Most are unskilled labourers with very low educational profiles.

During the last 40 years (1971-2011), the amount remitted by these Pakistanis is more than 100 billion US Dollars which played a vital role not only in the improvement of socio-economic status (SES) of migrants and their families at the micro level but also in the development of the national economy at the macro level. In the fiscal year 2010-2011, foreign remittances from expatriate workers reached around US$ 11.2 billion, of which 5.2 billion were remitted from Saudi Arabia and the UAE alone[2].

Apart from visible positive economic impacts of external migration at all levels of Pakistani economy, some negative consequences worth mentioning include 'brain drain phenomenon', psycho-social stressors related to difficult living and working conditions of migrants, sacrifice and suffering of the families of migrant workers in the countries of origin, and health of migrant workers including increased risk to communicable diseases like TB,

[2] http://tribune.com.pk/story/206207/remittances-surge-to-all-time-high-of-11-billion/

HIV, Hepatitis, STIs and Skin Diseases in the destination countries and its further spread in the country of origin are major problems which need to be addressed. Various national and international partners are currently making an effort to prevent and reduce the transmission of HIV infection among migrant workers and their families and the present operational research is part of such efforts.

1.1. Labour Migration from Pakistan to the GCC

The Bureau of Emigration & Overseas Employment (BE&OE) was set up in October 1971 under the directive of the President of Pakistan by amalgamating three different agencies – viz the National Employment Bureau, the Protectorate of Emigrants (PE) and the Directorate of Seamen's Welfare. This Bureau functions as the central agency of the Federal Government responsible for registering and processing foreign demands for Pakistani manpower. It also assists and equips prospective Pakistani workers for their overseas placement in the public and private sectors through licensed Overseas Employment Promoters (OEP). Previously, the BE&OE functioned under the administrative control of the Ministry of Labour and Manpower, but since July 1, 2011 it has been transferred under the Ministry of Overseas Pakistanis. Since its inception till June 2011, this department has played an important role in securing overseas employment for approximately 5.6 million Pakistani workers. The department has seven PE Regional Offices, namely in Rawalpindi, Karachi, Lahore, Multan, Quetta, Peshawar, and Malakand. The main functions of the BOEOE are performed in accordance to the Emigration Ordinance 1979 and rules made there under.

The Emigration Ordinance of 1979 is a law which grants vast powers to the Director General of the BE&OE, the PE, and the Community Welfare Attaché/Labour Attaché to deal with all matters pertaining to overseas employment of Pakistani workers. The Emigration Ordinance of 1979 cover all matters that regulate the entire emigration process either through OEPs or direct employment. The Ordinance also provides protection to all intending emigrants and addresses their grievances and complaints.

Under Section 15 of the Emigration Ordinance 1979**,** all workers recruited for employment abroad are required to appear before the PE for their registration, and pre-departure orientation and briefing regarding the terms and conditions of their Foreign Service

Agreement (FSA). During this visit, they are supposed to be briefed about the laws of the host country, the terms and conditions of their contract, and their rights and obligations while they remain employed abroad. According to the law, no one can leave Pakistan for overseas employment on an employment visa unless they are registered in the OEP and have a certificate of registration stamped on their passport.

1.2. Overview of the HIV Situation in Pakistan

With HIV prevalence rates of less than 0.1% among the general population, Pakistan was classified as a low-prevalence country until early 2000s. However, the country has since then entered into a 'concentrated epidemic' with HIV prevalence rates crossing the threshold of 5 percent among two at-risk groups; i.e., the injecting drug users (IDUs) and the transgender and male sex workers in some cities. According to the Government of Pakistan and UNAIDS/WHO,, Pakistan has estimated 98,000 persons living with HIV with the epidemic spreading rapidly among IDUs and transgender sex workers and associated populations. By the end of March 2011, only 4,455 HIV positive people were registered at 15 Treatment Centres in various cities, with 2,027 on Anti-Retroviral Therapy (ARV)[3]. Among the reported cases, the primary route of transmission is heterosexual sex, followed by contaminated blood and blood products, homosexual or bisexual sex, injecting drug use, and mother-to-child transmission. HIV prevalence among IDUs is particularly alarming as it has been reported to be 21% according to third round of IBBS conducted in 2008-09. Given the linkage between risk groups such as IDUs and sex workers with other vulnerable populations such as prisoners, migrants, spouses and sexual partners of at-risk groups, youths, and sexually active men and women, the spread of the infection to other segments of the populations cannot be ruled out. Moreover, the socio-economic conditions of the country including inequities, low levels of education, high unemployment rates and unstable law and order situation leading to high levels of migration, internal displacement as well external refugees, are conducive to potential increased vulnerability.

After the first case of HIV in Pakistan was diagnosed in in 1986, a flurry of activities resulted in the formulation of a National Committee on AIDS which later in 1988 became the National AIDS Control Programme (NACP) within the Federal Ministry of Health. Initially,

[3]Monthly report of HIV treatment centers, National AIDS Control Programme, National Institute of Health (NIH) Islamabad.

the NACP was more of a laboratory-based programme for providing diagnostic and clinical management services. It gradually increased the scope of its work and arranged awareness campaigns and workshops, educational events, research and surveillance, development of guidelines for clinical management, blood safety, improving care and support, and dissemination of information materials. A strategic planning process was initiated in 1999-2000 with the support of UNAIDS and other partners to enhance the HIV response and make it more inclusive and dynamic. The Government of Pakistan (GOP), World Bank, bilateral and multilateral donor agencies funded the Enhanced HIV/AIDS Programme (EHACP) which focused on Key-at-Risk Populations (KAP) and has been guided by the National Strategic Framework (NSF) I and II. A third NSF for 2012-2016 is currently under formulation. The 2009 National Health Policy includes HIV/AIDS as a priority area for intervention. A draft National HIV/AIDS policy and H Law have also been prepared and have yet to be formally vetted.

1.3. Scope of the Current Study

The current study was commissioned by the Working Group on Migration and HIV, comprising of the International Labour Organization (ILO), Joint UN Programme on HIV/AIDS (UNAIDS), United Nations Children's Fund (UNICEF), International Organization for Migration (IOM), BE&OE, NACP and the Provincial AIDS Control Programmes (PACPs) of Khyber Pakhtunkhwa (KPK) and Punjab. The aim of the study was to map out HIV risk and vulnerabilities of temporary contractual migrants from Pakistan to the GCC countries.

A temporary contractual migrant worker typically comes across a number of important stakeholders at key contact points during the three phases of the migration cycle (Table 1). Mapping of the information given by the various stake holders at these key contact points and resulting decisions made by the migrant worker was considered a gap area in understanding the HIV vulnerabilities and consequent risks faced by the migrants abroad. The working group on Migration and HIV recommended a detailed operational research to understand the various vulnerabilities induced by the various facilitators of the migration cycle

Table 1: Key Stakeholders and Contact Points in a Migration Cycle

Migration Cycle	Key Stakeholders
ORIGIN	Offices of licensed Overseas Employment Promoter (OEP)
	GCC Approved Medical Centres
	Protectorate of Emigrants (PE)
	International airports
DESTINATION	Employers/Sponsors, workplace and residential labour camps
	Different community groups formulated on the basis of nationality, local areas, profession, neighbourhood, and personal friendships/interests
	Community Welfare Attaché (CWC) posted in the Pakistani Embassies and Missions in the GCC countries
	Medical centres of the Ministry of Health conducting mandatory medical test either on arrival or at the time of renewal of work permit (Iqamas)
	Deportation camps or centres
RETURN	Immigration authorities
	Airport staff
	Family, friends

The published literature is full of details on a number of individual, structural and environmental factors influencing the vulnerability and risk of a migrant to HIV throughout the migration cycle. The present research aimed at exploring the common as well as the different factors which GCC migrants encountered compared to the migrants in other parts of the world. The research also aimed at understanding possible solutions from the various stakeholders to inform policy recommendations to reduce migration related HIV vulnerabilities and risks faced by the temporary contractual labourers and their families. The figure 1 below gives a brief overview of the various factors affecting a migrant as well as the related stakeholders.

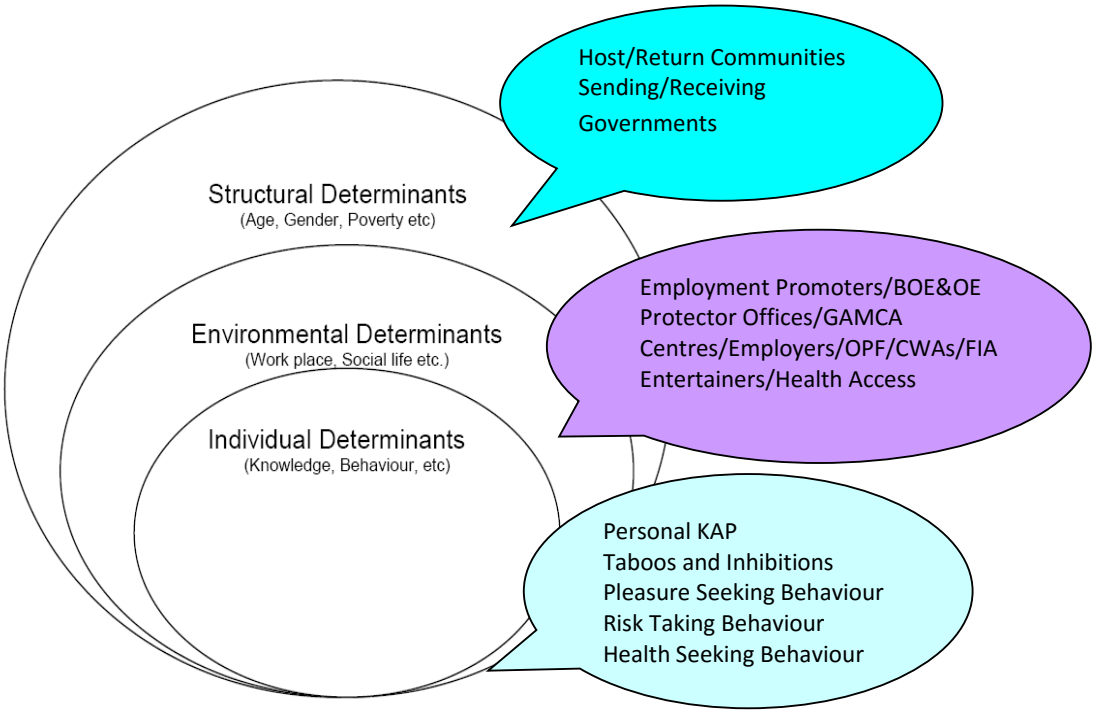

Figure 1: Conceptual Framework: Stakeholders and Determinants of HIV Risk and Vulnerability for Temporary Contractual Labourers to the GCC

2. METHODOLOGY

The operational research plan and preliminary drafts of the semi structured interview guides were prepared and finalised in a working group meetings. Following that, two Provinces, KPK and Punjab, were selected for carrying out fieldwork for the current research based on the magnitude of external migration of labour migrants. The districts among the provinces were prioritised according to the following criteria:

Table 2: District Prioritisation Criteria

Province	Districts	Prioritisation criteria
Punjab	Rawalpindi, Lahore, Multan	• High caseload of prospective migrants • Presence of BE&OE Protectorate Office/Airport/ • OEPs/FIA/Provincial AIDS Control Program offices • Diversity within the Province
Khyber Pakhtunkhwa	Peshawar, Malakand	

A team of three experienced researchers was selected to carry out the fieldwork in above mentioned districts. These included, a senior sociologist also serving as director research in BE&OE, an anthropologist with a strong background in HIV research, and a psychologist. The research team was supported by a public health specialist in migration and HIV related issues. The research team held an inception meeting to plan the fieldwork and revise the interview guides. The interview guides were finalised in the light of the existing literature and working groups' approval was obtained prior to conducting the fieldwork. Meanwhile, the anthropologist in the research team carried out a desk review of existing published and grey literature on HIV risk and vulnerabilities of migrant labour to the GCC countries, and sero-prevalence and transmission dynamics among returnee migrants in Pakistan.

To collect the data for this research, the team visited Rawalpindi, Islamabad, Lahore, Multan, DG Khan, Gujarat, Peshawar and Malakand in the months of May and June 2011. Visits to DG Khan and Gujarat were not part of the original plan; however, these two districts were included in the sample on the basis of field findings and recommendations of study participants. Facilitated by local IOM staff, the BE&OE and the PACPs, the research team visited the offices of OEPs, the regional Protractor Offices, the GCC approved medical centres and their association office (GAMCA), HIV Treatment Centres, and the offices of Federal Investigation Agency (FIA) and Civil Aviation Authority (CAA), as well as medical clinics at airports. In some cases, the team also held meetings with senior health authorities, including medical superintendent of DHQ and civil hospitals, EDO (health), and a regional deputy director of FIA. In addition to these, the team visited the PACP in KPK and a home of a peer educator in one of the districts in Punjab. Table 3 below shows the regional distribution of the sampled respondents for this study.

Table 3 Number, Type and Geographic Distribution of Respondents

Sample	Region							Total
	Rawalpindi/ Islamabad	Lahore	Multan	Peshawar	DG Khan	Gujarat	Malakand	
Intending Emigrants	15	10	8	10	-	-	8	51
Overseas Employment Promoters	5	7	3	6	5	-	6	32
Returnee migrant PLHIV and their spouses	-	-	-	1	11	9	-	21
PACP/DHQ/Civil hospital/VCT centres	2	1	-	5	3	5	-	16
Protector of Emigrants and briefing officers	2	1	2	2	-	-	1	8
GCC-approved medical centres	2	2	2	2	-	-	-	8
GAMCA offices	1	1	1	1	-	-	-	4
FIA officials	3	2	1	1	-	-	-	7
Airport medical clinic	1	2	-	1	-	-	-	4
CAA medical dispensary	1	1	-	1	-	-	-	3
Deportees	2	1	-	-	-	-	-	3
Returnee migrants at airport	-	2	-	-	-	-	-	2
Airport manager	-		-	1	-	-	-	1
Total	34	30	17	31	19	14	15	160

A number of qualitative research methods and techniques were used to collect data during the field visits. These included participant observation, individual and group interviews, and focus group discussions. Secondary data in the form of reports, datasheets, protocols, guidelines, and pamphlets were also collected. A further description of the study sample regarding the profile of persons included in the sample and the methods used to collect data is given in the Table 4 below.

Table 4 Data Collection Methods

Data collection site	Sample	Data collection method/ technique
Office of the Protector of Emigrants	Directors Deputy Directors Briefing Officers Intending migrants OEPs	Individual and Group interviews, Focus Group Discussions, Participant Observation, Observations
OEP offices	Managers Owners	Individual and Group Interviews, Observations
GAMCA offices	Manager/in-charge	Individual Interviews, Observations
GCC approved medical centres	In-charge/doctor	Interviews, Observations
Airports	Airport manager FIA officials Airport medical clinic's in-charge CAA dispensary in-charge Returnee migrants Deportees	Individual and Group Interviews, Observations, Brief interactions
FIA regional office	Deputy Director	Individual Interview
Treatment Centres	Treatment Centre in-charge/doctor Clinical psychologist/counsellor Returnee migrant PLHIV	Individual and Group Interviews, Observations Groups Discussions
PACP/District health office/DHQ/Civil Hospital	EDO Health Medical Superintendents	Individual Interviews, Meetings, Observations
PLHIV peer educator's house	PLHIV and spouses	Group Interviews, Observations

Besides taking detailed notes, interviews and group discussions were also recorded in some cases after obtaining informed consent from participants. Photography as a research technique was also used to capture the field settings. The interviews were later transcribed and shared among the research team members. Each team member read all transcripts separately to code important segments of data and note down analytical observations. Triangulation was done both at the data transcription and interpretation level. Initial draft of the report was prepared by exchanging those notes, observations and analysis by all team

members in a number of meetings. The final draft was prepared by all team members together.

3. DESK REVIEW

A review of articles in peer reviewed journals, published and unpublished reports of the UN agencies, Pakistan's NSF I and II, policies for HIV, reports and reviews of freelance researchers was done. The particular focus was on migration, mobility and HIV risk and vulnerabilities of temporary contractual labourers in the GCC countries. The desk review was enriched by Key Informant Interviews during visits to the field for conducting the ethnographic part of the research. During these visits, hard copies of quantitative sero-prevalence data were obtained from Treatment Centres and PACPs to complement the information obtained from the documents reviewed.

3.1. HIV and Migration

A link between migration/mobility and HIV vulnerability has been discussed since the beginning of the AIDS epidemic[4]. The initial approach to this discussion concerned itself with the proposition that members of a mobile population might contribute to spreading HIV by carrying the virus from one place to another. This 'individual-centric' approach which sought to identify migrants as 'vectors' of HIV was later replaced in many countries by a less stigmatising approach of examining the conditions and structural elements in the process of migration which may increase HIV vulnerabilities of migrants.[5] Thus, being a migrant in and of itself is not a risk factor; however, certain activities and conditions that are present throughout the process of migration substantially increase vulnerability to HIV. Some of the main vulnerability factors include substandard living environments, high rates of alcohol use, and sex with multiple partners or commercial sex workers. These vulnerabilities are evidenced by higher prevalence rates among those who migrate for employment. For example, in southern African mining companies where 95% of the work force is comprised of migrant workers, the average HIV infection rates were found to be close to 18%. Furthermore, in Senegal where 82% of men between 20-40 years of age travel each year for employment, labour mobility was found to be the only factor significantly associated with

[4]Amat-Roze 1993; Hunt 1989; International Migration 1998; UNAIDS 2001
[5]Decosas & Adrien 1997 'Migration and AIDS', AIDS Vol. 11 (Suppl. A) S77-S84.

HIV.[6] In Pakistan, though there is limited epidemiological evidence of a correlation between HIV and migration, a study of 600 internally migrated men in Lahore in 2006 reported that 13% migrants have had extra-marital sex in last 12 months with an average of 8 partners of which 62% were female sex workers (FSWs).[7] According to a 1998 census, an estimated 10% of all adult men in Pakistan live and work away from their families as internal or external migrants.

For international labour migrants, a number of socio-demographic, economic and political factors in origin and destination countries influence the vulnerability and risk to HIV infection. Separation from spouses and families, unfamiliar social and cultural norms, language barriers, substandard living and exploitative working conditions, including sexual violence are some of these factors. Isolation and stress resulting from migration may lead the workers to engage in increased risky behaviours, e.g. unsafe casual or commercial sex. This risk is exacerbated by inadequate access to HIV services and fear of being stigmatized for seeking HIV-related information or support. Moreover, migrant workers are rarely entitled to insurance schemes that make health care affordable. Appropriate health care is also often inaccessible because migrant workers may be living in geographically isolated areas, e.g., construction and mining sites, with little provision of health services. However, each and every Pakistani emigrant who is proceeding abroad for the purpose of employment is provided insurance cover for death or disability of PKR 1 Million or USD 11299 (1 USD = 88.4 PKR) for a period of two years (renewable for further periods) after payment of only one time premium of PKR 2000 or USD 22.6 at the time of his/her registration with the PEs.[8]

Despite the United Nation's recognition of the relationship between HIV and migration in paragraph 50 of the United Nations General Assembly Special Session on HIV and AIDS report in 2001 urging member states to facilitate access to HIV prevention, including the provision of information on health and social services for migrants and mobile workers, there is a lack of coordination among policy makers to address health issues of migrant workers. Both sending and destination countries maintain many of the social, contextual and policy factors contributing to increased health risks for migrants. Host countries often profile people according to their health status and block entry to those who are TB,HIV or Hepatitis positive. Such policies have often led to an increase in illegal and

[6]IOM & UNAIDS. "Migration and AIDS" International Migration 36(4) (1998) p. 460
[7]Faisel A, Cleland J. Migrant men: a priority for HIV control in Pakistan? Sex Transm Infect 2006; 82: 307-10.
[8]Bureau of Emigration, Government of Pakistan

undocumented migration and can deter migrants from utilizing effective prevention services. In many destination countries where migrants are seen merely as a source of labour, they are denied adequate health care and education services and when economic growth declines, these workers are expelled from the host countries and forced to return home. More than 100 countries restrict people living with HIV from entering or remaining in a country for any purpose; international labour migrants may be refused entry or face deportation if they are found to be HIV-positive. Where HIV testing occurs in the context of migration, internationally agreed standards for informed consent, confidentiality and counselling are not routinely applied[9]. Due to their illegal status, undocumented migrants face even greater challenges in accessing health information and services prior to departure, in-transit and at destination.

3.2. HIV Risk and Vulnerabilities: Migrant Workers in the GCC

Exploited, marginalized, discriminated and stigmatized throughout the migration process, migrants are often perceived as individuals with limited or no rights. Their basic rights to agreed salary and favourable working conditions are violated or at least overlooked. Temporary contractual labourers have little or no rights to legal or social protection and generally lack access to HIV services and information.[10] Employers in the host countries usually do not provide health care free of charge; whereas given their limited financial means, restricted access to information, discrimination and language barrier, seeking health care in the time of need is a real challenge for migrants. Most GCC countries lack any referral system or support mechanism for HIV positive migrants.[11] The migrants who have been diagnosed with HIV and deported from the GCC countries in recent years have suffered severe economic loss to them and their families. One of the reasons for host countries' reluctance to make Antiretroviral Therapy (ART) available to migrant works is the fear that it would lead to an increase in number of HIV positive people trying to enter or staying in their countries, whereas in reality it is the economic opportunity in destination countries that remains the driving force for migration from south Asia.

[9]CARAM (2007) State of health of migrants: mandatory testing CARAM, Kuala Lumpur
[10]UNAIDS (2009) Migrant workers and HIV vulnerability in South Asian and South East Asian countries: http://www.unaids.org/en/resources/presscentre/featurestories/2009/may/20090518migrantworkersed/
[11]UNDP & ILO (2010) HIV/AIDS and Mobility in South Asia: http://asia-pacific.undp.org/practices/hivaids/HIVAIDSAndMobilityInSA.html

Intending migrants are required to undergo mandatory HIV testing at the GCC approved medical centres after payment of a prescribed fee of PKR 3,000 or USD 33.9 where they are tested without pre and post-test counselling. Despite this pre-departure medical screening, mandatory tests, including HIV are also in place in few cases in the countries of destination at the time of arrival. During their stay as regular migrant workers, they are required to submit the yearly mandatory health screening reports including HIV Test, in order to maintain their stay and extend their work contract in the host countries. Worldwide, there are now 30 countries that deport HIV positive expatriates; these include all Gulf countries. In most cases, HIV positive migrants are deported back without an explanation of their HIV status to them or discussing their condition.[12] Some are even detained in deportation camps and are unable to collect wages that their employers owe them before their deportation to the country of origin. Imposing mandatory testing and the resulting deportation is not only a violation of human rights of the migrant workers but is also counterproductive from the public health point of view as it might drive those who are aware of their personal health conditions or HIV status to shun the health care system because of the fear of being deported as a result.[13]

A recent study of HIV vulnerabilities included interviews with 97 Pakistani male migrants in Pakistan, UAE and Bahrain. A large majority of the respondents reported to have received only informal information about HIV from their friends, relatives and colleagues prior to their departure. Eighty-three percent did not go through pre-departure orientations from any concerned government department, whereas 16% received no information from the official government departments on policies, rights, working conditions, issues related to health, and other vulnerabilities.[14] Given the volume of unskilled workers for temporary contractual labour, the low levels of HIV/AIDS awareness and the lack of a meaningful formal pre-departure orientation add to the vulnerabilities of a great majority of Pakistani migrants to GCC. The findings of the above study may not necessarily be generalized as the sample in above study was 97, A large number of intending migrants do attend pre-departure

[12]Human Rights Watch (2009) Discrimination, Denial and Deportation—Human Right Abuse Affecting Migrants Living with HIV
[13]Gilmore, N. (1998) "Human Rights Issues and migration"' presentation at the 12th World AIDS Conference, Geneva, Switzerland
[14]UNDP Regional Centre in Colombo (2009) "HIV Vulnerabilities of Migrant Women: From Asia to the Arab States"

orientation and briefing sessions arranged in the regional offices of the PE of the BE&OE however the portion of briefing on HIV needs to be improved significantly.[15]

According to the above study, the living and working conditions of migrant labourers are sub-standard and hazardous. With limited access to health facilities, orientation or check-ups, the unskilled labourers are subjected to long working hours with no fixed salary, and deprived of rest, off days, and recreation. Most of them live at the camp sites for the entire duration of their stay in the host countries. Those who live privately have often shared accommodations to save money. One room can be shared between 8-10 people. Given the unhygienic and sub-standard living condition, migrants suffer from a variety of health issues including diarrhoea, Hepatitis A and other infectious diseases.[16] According to the study respondents, the Pakistani Embassies or Missions in the host countries do not have any organized policy on providing help and support to them in cases related to health issues, including HIV. Moreover, the local authorities do not exchange information with the Pakistani Embassies or Missions on deportation of temporary contractual labourers due to their health issues and HIV status.

To put in to context the above vulnerabilities and their contribution to HIV Risk the study also mentioned the high risk behaviour of the Pakistani migrant workers as below

"*Eighty-two percent of Pakistani migrant workers being engaged in sexual relations with female sex workers during their stay in the host countries. Those who engaged with sex workers cited three reasons: 1) Pakistani men do not have easy access to female sex workers in their home country; 2) as migrant workers who are away from their wives for a long time, they need to fulfill their sexual needs; and 3) it is relatively easy for young migrant workers, who tend to be sexually active, to engage with sex workers*".

Taking advantage of the ambiguities of the complex migration process, both sending and destination countries avoid responsibility for the welfare of migrants throughout the migration cycle. Ironically, some international conventions make it easy for states to evade accountability for violation of the human rights of migrant workers. For instance, the *General Agreement on Trade in Services* (GATS) which is applicable to all member states of the World Trade Organization (WTO) does not take a rights-based approach to labour migration[17]. In fact, it provides a leeway for states to exclude migrant workers from domestic

[15]Key informant: Bureau of Emigration & Overseas Employment, Government of Pakistan.
[16]UNDP Regional Centre in Colombo (2009) "HIV Vulnerabilities of Migrant Women: From Asia to the Arab States"
[17]Labour migration is particularly affected by Mode 4 of GATS, which targets Temporary Movement of Natural Persons (TMNP)

legislation and basic human rights. To address the vulnerable situation of migrant workers and the discriminatory practices of host countries against them, the United Nations adopted the *International Convention on Protection of the Rights of All Migrant Workers and Members of Their Families* in 1992, which came into force on July 1, 2003. However, none of the GCC countries have either signed or ratified this convention.[18] Among the labour sending countries of South Asia, it has been ratified by Sri Lanka and signed by Bangladesh only.

On the positive side, regional consultative processes on migration have been initiated with representation from states, international organizations and, in some cases, non-governmental organizations (NGOs) for information exchange and discussion of migration related issues of common concern. The Colombo Process, officially known as 'Ministerial Consultation on Overseas Employment and Contractual Labour for Countries of Origin in Asia' began in 2003 between governments of eleven Asian labour-exporting countries, including Pakistan, with IOM as its secretariat. Later in 2005 it was expanded to include labour-receiving countries of the EU, the Gulf and Asia at the Abu Dhabi Dialogue in 2008. The Abu Dhabi Declaration constitutes a milestone in regional cooperation on contractual labour mobility by aiming to develop partnership between source and destination countries for optimizing the benefits of migration to countries and migrant workers.[19] The inter-regional workshop on strengthening dialogue between the Economic and Social Commission for Western Asia (ESCWA) and the Economic and Social Commission for Asia and the Pacific (ESCAP) countries on international migration & development held in Beirut from 28th to 30th June 2011 was also a positive effort by two above mentioned commissions of the United Nations to resolve the issues of sending and receiving countries through direct consultation and dialogue.

3.3. HIV among GCC Returnee Migrants

For about a decade after Pakistan's first case of HIV was reported in 1986 the majority of new infections were among men who had been exposed to the infection while abroad. During the period 1996-98, 58 returned migrant workers with HIV represented more

[18] United Nations; Treaty Collection http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-13&chapter=4&lang=en accessed on 1 July 2011

[19] UNDP & ILO (2010) HIV/AIDS and Mobility in South Asia: http://asia-pacific.undp.org/practices/hivaids/HIVAIDSAndMobilityInSA.html

than half of all reported cases, with wives of five returning migrants also testing positive for HIV[20]. By 1999, approximately three-fourths of reported HIV infections occurred in migrant workers returning from the Arab Gulf states.[21] By 2010, a considerable number of patients in the HIV clinics were migrant workers, their spouses or children.[22] Among other labour-sending countries of South Asia, the data on HIV sero-prevalence among returnee migrants or on the proportion of returnee migrants among PLHIV does not exist in India, Maldives and Bhutan, while 67 % in Bangladesh, 41% in Nepal and 52% in Sri Lanka of people living with HIV and AIDS are returnee migrants and their spouses and children.[23]

While interpreting this data, the assumption about large percentage of returnee migrants among estimated PLHIV in a country should be taken with caution. Many migrant workers undergo job-related testing, both prior to departures and often periodically during their stay abroad. On the other hand, HIV testing among the remaining general population is relatively absent. Moreover, the difference between the healthcare seeking behaviour of returnee migrants with that of the highly marginalised and stigmatised risk groups like IDUs and sex workers, as well as their differential access to health care facilities, which affect the chances of being diagnosed with HIV, should also be taken into account while interpreting the significant proportion of returnee migrants among PLHIV registered at treatment centres.

Despite the bias of HIV testing among migrants, some of the people living with HIV in Pakistan did become infected while working in the GCC countries.[24] By the end of March 2011, the total number of PLHIV registered with various Treatment Centres in Pakistan was 4,455, which included 3,399 male, 873 female and 183 children.[25] Some evidence from the PACPs collected during the course of this review show that:

- From 2003 to March 2011, 39 PLHIV registered with the Sindh AIDS Control Program were returnee migrants.

[20]UNDP Regional Centre in Colombo (2009) "HIV Vulnerabilities of Migrant Women: From Asia to the Arab States"
[21]USAID (2010) Pakistan HIV/AIDS Country Profile: www.usaid.gov/our_work/global_health/aids/Countries/asia/pakistan
[22]Khan AA, Ayesha Khan (2010); The HIV epidemic in Pakistan, J Pak Med Assoc Vol. 60, No. 4
[23]UNDP & ILO (2010) HIV/AIDS and Mobility in South Asia: http://asia-pacific.undp.org/practices/hivaids/HIVAIDSAndMobilityInSA.html
[24]Shah SA, Khan OA, Kristensen S, Vermund SH: HIV-infected workers deported from the Gulf States: impact on Southern Pakistan. *Int J STD AIDS* 1999, 10(12):812-4
[25]National AIDS Control Programme, Monthly report of HIV treatment centers, March 2011

- A total of 133 among 1,473 PLHIV registered in Punjab have a history of having lived abroad. Thirty two (32) registered female PLHIV in Punjab may have been infected by their returnee migrant husbands.
- In KPK, a total of 352 PLHIV were reported to be returnee migrants out of 728 PLHIV registered at Peshawar and 65 PLHIV at the Kohat Treatment Centres.[26]

Presently, there are no set formats for recording specific information regarding HIV positive returnee migrants, neither are they categorized as a separate risk group at the level of the Treatment Centres. Hence, the above data is not the true representation of the reality which may be even worse.For instance, no migration segregated data among registered PLHIV was available from the largest Treatment Centre in the country, PIMS in Islamabad, which had a total of 1,091 registered PLHIV by the end of May 2011. Similarly many deportees who have been deported on health grounds over the years have been re-integrated into Pakistani Society without even knowing their HIV status.

Though it is difficult to establish that returnee migrants among PLHIV contracted the virus while working in the Gulf countries and infected their spouses through sexual intercourse, a large number of them tend to believe that they got infected while abroad. Nevertheless, very few admit involvement in unprotected sex or any other high risk activity while in the GCC countries. Most of them seem to explain their infection as a result of "living in unhygienic quarters" and "sharing accommodation with infected persons."

Pakistan regards migrant workers as a key vulnerable population needing interventions to stop the spread of HIV, as evidenced by the NSF I and II.[27] The NSFs and the draft National HIV/AIDS Policy envision specific interventions for migrants and their spouses, including ensuring pre-test and post-test counselling and referral. However, at present, the country lacks a database or a system of recording information about returnee migrants. There is no available record of migrants deported by foreign countries due to their HIV status. Moreover, unlike some other countries of South Asia, for example Maldives, the returnee migrants in Pakistan are not required to report to any government agency or

[26]The number of persons living with HIV in Pakistan with a history of migration are believed to represent a more substantial number than those reported here. However, until a systematic review of the profile of people living with HIV from the 15 Treatment Centres is undertaken, the total number is not known.
[27]National HIV and AIDS Strategic Framework, 2007-2012, Ministry of Health, Government of Pakistan

department upon completion of their employment contracts abroad and most of them return directly to their home towns.

4. FINDINGS FROM THE FIELD

The findings from the field are organised around an ethnographic description of the contact points for migrants in a typical migration cycle, and their experiences of these contact points, especially with reference to HIV risks and vulnerabilities. An effort has also been made to 'give voice' to the respondents by substantiating the analysis with their verbatim words. A separate section on HIV risks and vulnerabilities summarises the key findings. The last section presents recommendations.

4.1. The Migration Cycle

A typical migration cycle for a temporary contractual labour consists of three main stages, namely the pre-departure stage, the stay and work in the destination country stage, and the stage for return/deportation and reintegration in the home country. The following sub-sections describes the risk and vulnerabilities faced by migrants in each of these stages of the migration cycle.

4.1.1. Stage One: Securing Visa and Travel to the GCC

Temporary contractual labourers travel to the GCC countries either through an overseas employment promoter or on direct employment visa. These licensed overseas employment promoters process their demands on behalf of companies/employers using their personal and professional contacts with overseas employers/companies in the destination countries. The OEPs routinely secure demand of various categories for Pakistani workers. For those travelling on direct visa, the visas are arranged by friends, relatives or co-villagers and community members already working in the GCC. Most intending migrants possessing direct visa hire services of the OEPs for processing their visa after paying a processing fee as specified by the BE&OE. 'Processing' includes getting the visa stamped from the relevant embassy, facilitation in medical screening and trade test, if required, registration with the Protector Office, and arrangement of tickets.

Overseas Employment Promoters

Under section 12 of the Emigration Ordinance 1979, Federal Government appoints a person a specific OEP on his written request on prescribed form after fulfilling the legal requirements and conducting required enquiry for the purpose to assist or to recruit any person who immigrates to a destination country for the purpose of employment. Initially, after processing of the request of Pakistani nationals through the BE&OE, the Federal Government issues a license to the OEP for a period of three years after the latter deposits approx. USD 1200 (PKR 100,000) as cash security and approx. USD 2400 (PKR 200,000) as Defence Saving Certificate in addition to a three year renewal fee of approx. USD 500 (PKR 45,000). After the expiry of the initial period of three years, the license of those OEPs who have sent more than 50 workers abroad will be renewed for a further period of three years. The OEPs who process the demand of less than 50 workers but more than 10 will be renewed for two years and the renewal of one year will be given to all remaining OEPs on their request. Presently, the total numbers of 1,599 licensed OEPs are operating in the country.

Table 5 Number of OEPs

Protector Region	No. of licensed OEPs, July 2011
Rawalpindi	546
Karachi	247
Lahore	339
Peshawar	172
Quetta	002
Multan	123
Malakand	170
Total	1,599

Licensing and registration: After obtaining a license from the Government of Pakistan, the OEP make efforts to procure overseas demand from foreign employers. Under the Emigration Laws 1979, foreign employers issue power of attorney to authorise an OEP to recruit workers of various categories on their behalf and a demand letter consisting of terms and conditions of employment. Under Rule 19(1), these documents are required to be attested either by the Ministry of Foreign Affairs of the host country or the Embassy of Pakistan in the destination country or Embassy/Mission of the receiving country in Pakistan. Some OEPs have recently pointed out that they face various problems regarding submission of the passports of their workers for stamping of their visas with certain Embassies.

Organisational structure and capacity: There are great variations in terms of OEPs' organisational capacities and the number of workers sent abroad by each. Some have large and expensive offices with staff numbering in dozens and facilities like briefing and meeting halls, waiting rooms, separate staff rooms, and rest areas for applicants, etc.; whereas others have small, one or two room office premises with a couple of staff present at a given time. Some OEPs also use their office premises for subsidiary businesses, e.g. overseas education consultants and travel agencies. A few have also set up their own trade test centre or own a GCC approved medical centre.

Long established and well networked OEPs have sent tens of thousands of workers abroad. They enjoy good relations and trust of the employers in the Gulf countries and routinely receive recruitment requests. The novice and relatively less networked OEPs send only a few workers every now and then. A large number of OEPs recruit workers for Saudi Arabia and the UAE only. When asked about their future business expansion plans, most of these OEPs expressed desire to increase the number of workers they send to Saudi Arabia and the UAE. However, they were reluctant to expand their networks or secure demands from the countries other than GCC. Apart from procuring demands from Saudi Arabia and the UAE, the OEPs are not securing jobs for Pakistani workers from other GCC countries because of greater competition from other South Asian countries resulting in a falling demand for Pakistani workers.

The Pakistan Overseas Employment Promoters Association (POEPA) is the representative body of OEPs. Different groups of OEPs contest elections with each other to win the annual election of POEPA office bearers. The POEPA is marred by mutual conflicts and disagreements between opposing political groups. As a result, the union hardly serves the purpose it was created for. Most of the small scale OEPs reported that they pay annual fees to POEPA because it is a formal body but they hardly expect any support from it for solving their problems. In addition to the central POEPA, there are also regional bodies at the level of their respective protectorate.

Granting permission for overseas demand: After satisfactory completion of attested power of attorney and demand letter under Rule 19, the Protector of Emigrants grants permission to an OEP to advertise demand in the leading newspapers and recruit the suitable applicants on behalf of their employers.

"Our recruitment process is very clear and transparent. We advertise in the newspapers. People contact us. We screen them according to the criteria given by the company which includes age limit and apparent physique" [OEP]

Some OEPs use the database of their intending migrants, which they routinely update. For some recruitments, the human resources (HR) representatives of the employers might also take part in the selection process, which involves interviews and/or 'appearance screening' of a large number of applicants at OEP's office or a big hotel hall. This however, depends on the policies of the employer, volume of recruitment and the category of workers. The representatives of the employers are present mostly in case of a large overseas demand of skilled, technical and highly qualified categories. For unskilled labour, they usually trust the OEPs to recruit appropriately for them. Whereas, in case of highly skilled labour, e.g., engineers, IT specialists, etc., a telephonic or Skype interviews with employers might be arranged by the OEP. For certain technical positions, the intending migrant has to produce a certificate from a recognised trade test centre. In some cases, the trade test centre might send the certificate directly to the employer, while in the majority of cases it is attached with the applicant's documents.

The relationship of trust: Some OEPs have written brochures and booklets on the recruitment process, application forms, sample of employment agreements, registration cards, checklists, and an introduction to the OEPs achievements and organisational structure. Whereas these brochures and checklist might be helpful for literate applicants, they are mostly attuned to establishing credibility of the OEP itself. The information exchange is mostly verbal and interpersonal as the majority of applicants are illiterate or less educated. Very few have a grasp on the procedures or requirements of the application process; hence they leave it to the OEP to handle these. For instance, upon our request to give a breakdown of the fees that they had paid for securing employment, visa, medical screening, and registration with the Protector Office, most of the intending migrants responded by saying *"our agent would know that, we paid a lump sum amount"*. While a large majority knew the exact amount of fee they had paid for medical screening, none could tell that a part of the fee they pay to register with the protector office is for their insurance and another part is for the OPF welfare fund. The OEPs have developed good liaison with the Offices of the Protectors;

their representatives often accompany intending migrants to the Protector Office for facilitation in registration and briefing.

The Foreign Service Agreement: Foreign Service Agreement (FSA) is the document of employment contract between the employer and the intending migrant. The FSA has to be signed between the parties before the intending migrant is brought to the Protector Office for registration. Typically, an FSA contains detailed terms and conditions of employment as mentioned in the demand letter, and it is the duty of an OEP to discuss these with the intending migrants so that they make an informed decision to take up a job abroad. The Protector of Emigrants or any other authorised officers verify and attest FSA subject to personal appearance of intending emigrant under the rules. Some OEPs negotiate terms and conditions of demand letter with the employers before recruiting workers on their behalf. They claim that if satisfactory terms and conditions are not conceded by a company they decline to recruit workers for them. However, most of the OEPs accept these documents without any negotiations.

> *"If we think that the terms and conditions put forth by a company are not satisfactory, we refuse them. Sometimes, we suggest them some changes and if these are in accordance with the company policies they make these changes, otherwise, if they don't we refuse to work with them."* [OEP]

Depending on the policies of the employers/company and the level of 'good will' towards the OEP, the latter may successfully secure some concessions for their workers.

> *"Recently we had demand for a driver. They said that they will provide salary and accommodation and 'try' to provide food as well. We told them that it was not fair to say that they would 'try' to provide food. So we asked them to provide food as well and they accepted it."* [OEP]

> *"The problem we face is when we compare the skills of the applicant with the requirements of the companies, because the companies require highly skilled people whereas the people here have experience of having worked in their own villages or small localities. So matching the descriptions and specification is a problem we have to support the applicants in. We have to tell*

the companies that the atmosphere and culture here is very different and that the skills are very low compared to their standards. We ask them to train these people while on the job." [OEP]

The FSA is usually written in English and Urdu and in several cases also in Arabic. However, most of the intending migrants are illiterate or cannot read their FSA necessitating the need for translation of the FSA to ensure that the migrant worker understands the agreement before signing. According to one OEP:

"We translate the FSA and describe it to the worker in his own language like Pashtu or Punjabi. We make sure that the client is accompanied by his father or brother when we are explaining the details of his employment to him....When a worker signs the FSA he might want a translated copy so that he understands what he signs. We provide this copy to avoid any confusion in future. We give them time to think over it and to take advice from others as well." [OEP]

Briefings by OEPs: Some large-scale OEPs have a briefing hall facility in their offices to collectively discuss the terms and conditions of employment for large batches of recruits. The briefings also include dos and don'ts of travel, and conditions of stay and work abroad. However, none of the OEPs mentioned AIDS awareness or health in general, apart from safety measures at work places, as part of the briefing they give to intending migrants. These briefings are mostly focused on terms and conditions of employment and how to maintain good relations with the company management and co-workers. Some also include an introduction to socio-cultural environment of the destination countries.

"We brief them that the environment in the destination countries would be multi-cultural; there are Indians and Filipino, etc..., and that they have to keep their [Pakistani and Muslim] identity intact. We tell them how to manage their living there and how to deal with problems... In terms of health, we tell them about the safety measures, like protection from the sun." [OEP]

HIV and AIDS: The HIV/AIDS awareness level among OEPs was very low. All of them had heard about HIV, but none could explain satisfactorily about the modes of transmission or risk behaviours apart from sexual contact with sex workers. The sources of information for

majority of them were the television and newspapers. While talking about HIV/AIDS, the moralistic argument against the infection dominates their discussions, associating HIV to 'bad practices' of 'bad people'. Only few mentioned that blood transfusion, re-use of needles, blade and surgical equipment could also put those people at risk who are otherwise not involved in risky sexual behaviours. Condom as a protection against STI and HIV was a mentioned by a few only after prompting but they were uncomfortable about speaking on this topic.

> *"I have heard about HIV and AIDS. We see the adverts. It spreads from 'sex problems' and sharing of blades. One should avoid sexual transmission. One should use condoms if one cannot avoid extra-marital sex."* [OEP]

> *"HIV does not spread by touching. Some doctors say that one should avoid eating together. But I think it does not spread like that."* [OEP]

Some OEPs were enraged over the fact that their clients are diagnosed HIV positive by the GCC approved medical centres but when they go for confirmatory tests in other labs including at Agha Khan, Shoukat Khanum Hospitals or the NIH, they are declared negative. Moreover, when they return to the GCC centres with these results, they decline to entertain them again. On the other hand, one OEP 'understood' that the GCC approved medical centres have a stricter criterion for declaring people medically fit.

> *"Obviously, Agha Khan is not GAMCA related so they do not think about this issue. This HIV person (who was diagnosed HIV positive during screening for the GCC and was later declared negative by Agha Khan) would think that he is fit. He won't take any preventive measures; he would be a source of spreading HIV by using blades or having sex."* [OEP]

Though health and HIV are not part of their usual briefing sessions, these topics might come under discussion from time to time: "*Our briefing does not include the topic of health as such, but we tell them how to take care of themselves and others on the project site."* On prompting whether they discuss AIDS as well, one OEP said:

"Yes we do tell our workers. They say 'we are going as labour. We can hardly provide for running our households. What 'ayashian' [excesses] could we afford?' That is what they say but we still try to give information" [OEP]

Another OEP did ad-hoc 'profiling' of the intending migrants prior to their medical screening based on the geographical area they belonged to. According to this OEP:

"Mostly the people from South Punjab are unfit because of HIV. There are also other reasons for being unfit. Most of the people are from South Punjab. The ratio of people from hilly areas is very low." [OEP]

GCC Approved Medical Screening Centres

Medical screening is mandatory for all temporary contractual migrants to the GCC before their departure from Pakistan; UAE is the only exception to this rule where the medical tests are done at the time of arrival. However, some employers in the UAE as well require their potential workers to go through medical screening before departure. The GCC has approved a number of medical centres to carry out this screening in Pakistan. Medical fitness certificates from other check-up facilities apart from those approved by the GCC are not acceptable. The screening data of the GCC approved medical centres are maintained in an online system with access limited only to the approved medical centres and their associations, the GCC embassies in Pakistan, and possibly other concerned departments in destination countries. Those declared 'unfit' are banned for life from entry into any of the GCC countries.

The GAMCAs: There are a total of 22 GCC approved medical centres in Pakistan. They have formed themselves into 5 regional associations called the Gulf-Approved-Medical-Centres-Associations or GAMCAs. Each of the following cities has its own GAMCA.

Table 6 Number of GCC Medical Centers

Regional GAMCA	No. of GCC Approved Medical Centres
Rawalpindi/ Islamabad	5
Karachi	3
Lahore	4

Peshawar	5
Multan	3
Quetta	1
Gujranwala	1
Total	22

A national level GAMCA does not exist in Pakistan. Every GAMCA is a cartel in itself, restricting entry of new medical centres into the association and avoiding formation of a national level association. GAMCA officials and medical centres in-charge were apprehensive of the motives of present research upon our contact with them. Perhaps they thought that we were exploring the scope for entry of new medical centre into the GCC screening system and thus a potential challenge to their monopoly. One centre in-charge actually cautioned us *"approval of new medical centres is really very difficult. A heavy amount of more than 10 million is required to establish such a centre but there is no guarantee for approval of this centre by the GCC."* The response from a number of medical centres we visited was less than cooperative. They seemed to believe that any information shared by them regarding the workings of their medical centres would be used against their monopoly. Upon explaining our purpose, one GAMCA in-charge said *"You should go to hospitals to find people for HIV interventions or for counselling at Protector Office."*

Each GAMCA has an office set up to facilitate the screening process. The office premises in most cases are small with low capacity waiting areas. The associations are run from the funds collected by member medical centres. Their working is supervised by the elected chief executives from amongst the members on rotation bases. The primary function of a GAMCA office is to issue appointment slips to intending migrants and ensure equal distribution of the applicants to all associated medical centres. GAMCA also maintain a database of the 'fit' and 'unfit' clients resulting from medical screenings at all associated medical centres. There was some ambiguity regarding the status of GAMCA vis-à-vis the GCC requirements. Some respondents reported that the formation of GAMCA was a requirement by the GCC whereas others said that it was a local initiative to ensure equal distribution of applicants in a region; *"the whole purpose of the existence of GAMCA is to take all centres along"*. GAMCA, thus played the role of discouraging competition among the GCC approved medical centres. According to a medical centre in-charge:

"GAMCA's policy is to equally distribute the numbers among all centres. This is actually the reason behind forming GAMCA. You know some medical centres might provide better facilities, some might offer better terms and conditions and involve themselves in negative competition" [Medical Centre in-charge]

One GAMCA in-charge reported that they send their quarterly reports to the GCC regarding the details of their overall performance of all associated centres during the quarter concerned.

GCC-Approved Medical Centres: Most of the GCC approved medical centres are located at easy access by public transport. They can be described as sufficiently well-equipped and modern. There are proper waiting areas, queuing up counters, IEC material, drinking water and other such facilities. The GCC has set up minimum standards for approved medical centres, which include, according to one centre in-charge, *"given specifications, the machines, the set-up, even the measurements for size of the doctor's room, the waiting area and the laboratory."* Moreover, *"If these standards are not met the license is cancelled."* The impression, we got from our visits was that these centres are exclusively dedicated to provide screening services to Gulf intending migrants and were in fact set up for this purpose only. However, in one case, where the centre in-charge was a local politician, the medical centre premises were also being used as an office of a political party. The owner of this centre was a sitting Member of the National Assembly (MNA).

GCC has clear cut guidelines about the medical tests required for screening as well as carrying out these tests. These guidelines are available with medical centres in the form of a booklet. In theory a team of experts from the GCC should visit all approved medical centres at least once in a year to inspect and evaluate their working and to validate the availability of testing facilities in accordance with the guideline. However, we were told that the team has not visited Pakistan for the last few years due to security concerns. Nevertheless, there are examples from the past, when the licenses of few approved medical centres were cancelled on the basis of the findings of the inspection team. Likewise, we were told that the GCC imposes heavy penalties on the concerned medical centres, if there are serious discrepancies in their test results compared to the results of the medical tests done at the time of arrival in

the GCC. One centre in-charge told us that the penalty can range from $500 to $1,000 per case.

All GCC approved centres claim that either they already have the most advanced and the best lab machinery, or in the process of procuring the latest machines. All of them have Eliza testing facility available in their labs in addition to Rapid Testing Kits for HIV.

The process of medical screening: The first step for an intending migrant for his medical screening is to queue up in front of the GAMCA office of his region. Because of long queues, these offices are recognisable from a distance. According to an understanding reached among all five GAMCAs, each GAMCA has exclusive rights over providing medical screening to applicants from the region under its jurisdiction. For example, GAMCA Lahore should ideally not provide medical screening to an applicant who has his permanent address in Peshawar, as testified by his national identity card. However, in practice this understanding might not always be acted upon.

The long wait in queues and production of correct documents results in appointment with one of the approved medical centres. Though the GAMCA staff work to distribute applicants equally among all centres, some intending migrants, via their agents, have preference for better reputed medical centres. The request for sending to a particular centre is generally accepted and an appointment for the same day is given on a piece of paper. An applicant with very obvious symptoms of illness or disability, e.g., skin problems, broken finger or squinted eyes might be advised to return later after the symptoms disappear or in case of a permanent disability, drop the idea of going to the GCC altogether. Nevertheless, the ratio of those screened out at GAMCA offices is very low.

> *"If there is some injury or a very obvious skin problem, we do not entertain such clients. Otherwise the medical examination of the internal problems takes place only at the medical centres"* [GAMCA in-charge]

The next stop for an intending migrant is the queue outside the designated medical centre which is also recognisable from a distance due to applicants outside. After a thorough body search, the intending migrant is allowed inside the waiting area to wait for his turn to be called for examination and samples collection. There are separate counters for those who

come to collect their test reports. Depending upon the rush of applicants, the waiting time can take from a couple of hours to a full day. The walls of the waiting hall are decorated with health education posters mostly on Hepatitis prevention. In some cases there are also warnings against falling prey to 'fake agents' (discussed below) hovering outside the centre premises who claim that they can get the 'unfit' results changed into 'fit'. These warnings are followed by descriptions of proper procedures for medical screening.

Fake agents and falsifying results of the screening system: Almost all centres in-charge conceded that there are some irregularities at their centres as some of the staff might collude with fake agents outside and might in fact take bribes to change results. The moment an applicant comes out of the medical centre after giving his biological samples, a fake agent convinces him to hand over his receipt for collection of results on his behalf and to ensure that the result would not positive for any illness. Many fall prey to these agents' deceit. Afterwards, the agent collects the report on the due date. Regardless of the original results contained in the report, the fake agent shows a forged version to the intending migrants bearing that they were declared 'unfit'. Taking advantage of the panic, it creates for the intending migrant, the agent asks for bribes to get the results changed from the medical centre through his connections. Some applicants fall prey to the agent's ploy and are ready to give bribes. On extorting money from the applicant, the agent produces original version of the screening certificate.

> *"In some cases , these agents collect the 'fit' reports from us whereas they show the fake reports to the clients which shows them, for example HIV positive. Then they negotiate money for changing the results. After securing money they give them the original results that we had issued."*[Medical Centre in-charge]

A couple of centres in-charge were so bothered by these fake agents that they installed a huge banner at the entrance to the centre dissociating themselves from anyone claiming to be their agent. These banners requested the applicants to inform about any person who approached them with a claim to influence their screening results so that these criminal elements could be handed over to police.

Another practice to cheat the screening system is that some applicants might bring a brother or a relative to give biological sample in their place. A few centres in-charge claimed that they make sure that they take biological samples of only the original applicants by verifying their identity through original passport, photograph, thumb impression and signatures.

> *"Our method is fool proof but still some people try to dodge this system. For example someone brings his look-a-like brother to give samples if he was himself 'unfit' because of Hepatitis C a few weeks ago. This creates doubt in our mind, that is, how come he reduced the Hepatitis C ratio so quickly. Then we interview such person and ask him straight if he is the client's brother. Some people confess that they are not the real applicants. There are good people around, you know!"* [Medical Centre in-charge]

A few centres in-charge pointed a finger to the OEPs for trying to cheat the medical screening system. The OEPs, according to them, are always in search of some gaps in the system and try to exploit this to their advantage. One of the ways is to bribe the low ranking staff of the medical centres and the other is to use fake stamps and prepare fake documents. Some, according to medical centres in-charge, even guide the intending migrants on how to cheat the system.

> *"We hand over the medical certificates to clients for Oman and we also send a list to the Oman Embassy. Now what happens is that, as I told you earlier, some people here also have Oman embassy's stamps and make fake certificates...they have our stamps and our signatures... You might know that even Pentagon's passwords were stolen, we are nothing! I admit to you my passwords were stolen. Some staff member did it through some spy ware... Ten to fifteen people were cleared in that. Now I have separate laptop for putting results online. I use it now exclusively for uploading the online results."* [Medical Centre in-charge]

> *"The recruiting agents have a big role in that [cheating]. The common labour class people do not know the procedures. It's the agents who give the guidelines."* [Medical Centre in-charge]

"The agents are the ones who are more in contact with them and they are the ones who tell them about the loopholes, like go there, meet that person, change the centre or [tell them] to send someone else in one's place and to collude with staff here or to deceive them somehow, all these things." [Medical Centre in-charge]

Results collection: The medical screening reports are available for collection on the third day of the test. There is no uniform policy on who can collect the reports. A few medical centres claimed that they hand over the report only to the applicant in person whereas others said that anyone who produces the receipt can collect results on behalf of the applicant. A couple of centres in-charge also mentioned sending the results on postal addresses of the applicants, in case they lived in far off places and could not come to collect reports in person. In many cases, the representatives of the OEP collect reports on behalf of the applicants.

Online database of screening results: As a matter of policy the final tests results, 'fit or 'unfit', should be uploaded on the online database by the concerned medical centre on daily basis; and a copy should also be submitted to the GAMCA office. However, in practice some centres delay it by few days while other delay by as many as 10-15 days. According to one centre in-charge:

"We normally put the results online 10-15 days after the repeat confirmation test. This is so for all unfit cases. What actually happens is that these people have spent 4 to 5 lac Rupees on visa. Some have sold their land, some gold and some property. The moment we put their results online... [It is] report[ed] to the Embassy, we cannot remove it [afterwards]. In other words, the person we declare unfit online is 'finished', he cannot go [to GCC countries] forever. Now, maybe we made a mistake. It can be a human error or a machine error. So, we wait for 10-15 days to give time to someone who wants to challenge us... the person might go to Agha Khan or Shoukat Khanum or some other place and get different results." [Medical Centre in-charge]

Once the screening result of an intending migrant has been uploaded on the online database, it is near to impossible to legally change their status. The GAMCA and the medical

centres do not revise their decision or re-do the screening even if the intending migrants produce medical fitness certificates from reputed laboratories like the labs of Shoukat Khan Memorial Hospital & Research Centre, the Agha Khan Hospital, or the National STI/HIV Referral Laboratory at the NIH.

Repeated and 'Katcha' tests: A large number of intending migrants are told to come back after few weeks for a repeat test especially if they are found to have above normal level of Liver function Tests especially Alanine Aminotransferase ALT which indiacted liver cell death. The medical centres in-charge defend the practice of repeated tests by saying that they want to be sure about the fitness of an applicant before issuing a certificate, so that they could avoid fines and penalties from the GCC by minimising the discrepancies in their test reports with the results of medical examination done upon arrival in the destination country. Consequently, if the medical centres have any doubt about the increased level of ALT, they ask the clients to come back at a later date. They say that they can also not declare such person unfit because that would be unfair to him, but at the same time they cannot take the risk of declaring him fit because he might turn out to be Hepatitis positive by the time he travels to the GCC countries.

On the other hand, the OEPs claim that the repeated tests on the basis of "*Jigar ki garmi*" (heat in the liver) *'diagnosed in every other applicant'*, are only an excuse for minting more money. They argue that the slight increases in ALT levels, colloquially termed as '*garmi*' or heat, at the time of collecting blood samples need to be explained in terms of the extreme weather conditions in Pakistan and the fact most of these applicants are already fatigued due to travelling long distances on patchy roads in rattling buses to reach the medical centres. One OEP even claimed that "*Jiger ki garmi*" is not included as criteria for fitness in the GCC guidelines. He suggested that POEPA, the trade union of OEP should look into this matter urgently and the GCC guidelines should be made available to every OEP.

OEPs have devised two strategies to deal with the issue of repeated tests; one is *'katcha tests'* and the other is advising applicants to practice some home remedies before going for medical screening at the GCC medical centres:

a. *Katcha* (preliminary) test or what they call 'OPD': The clients are encouraged to go to Outpatient Departments (OPD) of the government hospitals or to any private

labs to make sure their test results are normal before they go for the medical screening at the GCC medical centres. In a few cases, there were hints that even some GCC centres also provide the facility of '*katcha'* tests.

"First we ask the person to get the 'katcha' medical done. If that test comes alright then we ask them to get the 'paka' medical test done from the same centre." [OEP]

"There is no time limit for a person who wants to come again for a test. Usually they get their tests done from other labs before and if they think they will pass the test [at the GCC approved centre] only then they come back through the GAMCA." [Medical Centre in-charge]

b. Home remedies: To bring down the level of ALT before their next visit to the medical centre, the OEPs advise the intending migrants to practice home remedies, including avoiding food with hot properties e.g. egg and meat, and intake of items having 'cold' properties e.g. sugarcane juice. Some also advise the intending migrants to skip breakfast on the day of their medical test. The sugarcane juice which is the most popular home remedy is often available only at very unhygienic roadside places thus a potential risk to health of the applicant.

Screening centres and the OEPs: The representatives of the OEPs generally do not accompany the intending migrants either to the GAMCA office for taking appointment or the medical centres for the screening tests. This is partially because they have no role in the whole process which is organised around queuing up and token system, and partially also because the OEPs generally do not enjoy good relations with GCC approved medical centres. Their main grievance against the centres is, according to them, the unnecessarily repeating of medical tests of their clients which causes delays in visa processing and is troublesome for the intending migrants residing in smaller towns and cities. The OEPs argue that the medical centres are not ready to listen to them in case of any complaint or clarification and they have no means to convince them on the issue of repeated tests: *"When we speak to them they say that they have their own standards and that they do not accept any Agha Khan or any Shoukat Khanum"* [OEP].

Moreover, some OEPs reported that in some cases the medical test results of the GCC approved medical centres do not match even with each other: *"one medical centre would diagnose a problem in x-rays, while the other would diagnose a problem with something else"* [OEP].

A few OEPs, however, acknowledged that the GCC medical centres have to be very careful before issuing a medical fitness certificate to an intending migrant and that they are justified to have their own parameters and rules.

> *"One medical centre had diagnosed a person with HIV. They went to Agha Khan and were cleared but he was not cleared by the medical centre and his results were not changed. I talked to the doctor and the doctor said that the reading is not alarming at this time but maybe after three months when he departs for GCC his reading might increase. That person did not go abroad."* [OEP]

The very strict criteria for medical screening that results to a life time ban on those declared unfit leads to adoption of illegal means, according to some OEPs. The illegal means, were, however, not specified except a reference to *'those that create problems during immigration'*. The OEPs suggested that some checks and balances on the GCC medical centres and an appeal system against declaring 'unfit' should be in place. In their defence, one of the medical centre in-charge clarified that:

> *"It is important to understand that the people we designate as 'unfit' are not actually ill. For example if there is minimum spot on the lung, the person is unfit for us according to the GCC instructions. GCC have used the word 'minimum spot'. Whereas the minimum spot is very common in our villages because most people are poor and do not have healthy water etc. Children's TB is very common in our rural areas. When such child grows up as healthy person he might still have that spot left without him knowing about it. He is healthy otherwise but is unfit for us."*[Medical Centre in-charge]

Medical screening centres and PLHIV NGOs: Inter-linkage with two PLHIV NGOs in Punjab for referring those found to be HIV positive were mentioned by only one medical

centre in-charge. However, these linkages, according to him were not currently active because the NGOs had lost interest *"due to funding constraints that they faced recently*". This centre in-charge also mentioned a weak liaison with the PACP in past for referral of HIV positive individuals. Almost all medical centres in-charge reported that they advised HIV positive people to visit the NIH for confirmatory tests but they doubted about the rate of compliance with their advice.

HIV and AIDS: Only one centre in-charge mentioned that he had attended an orientation/training on HIV and AIDS in the past. Stereotyping of the returnee migrants as vectors of HIV was reinforced by some medical centres in-charge — *"it's not only a perception but a reality."* Moreover, moralistic assertions were evident from their discussion of migration and HIV. According to one medical centre in-charge:

> *"Eighty percent of the intending migrants are illiterate. They come from far-flung rural areas. They don't even know how to get their medical screening done, how to go about things and how to deal with people, etc. When such an uneducated person goes abroad, he knows nothing; he becomes a source of bad repute for the country. He is illiterate; he does not know how to talk...they should be made to understand that they have to act like an ambassador of the country and not to destroy its image. Whoever comes to me, I tell them 'for God sake our passport has become very notorious now!'"* [Medical Centre in-charge]

According to another, *"as patriotic Pakistani, as human beings and also as doctors, it is our duty to try to minimise these things in our society."*

Many medical centres in-charge held the illiterate intending labour migrants responsible for their lack of awareness about HIV and AIDS: "*Even on television these people do not watch informative programmes, rather they prefer watching dramas and stuff like that."*

There were great variations in the numbers HIV positive diagnosis at these centres. The majority of the centres in-charge reported that the percentage of unfit cases for all diseases/infections (mainly Tuberculosis, Hepatitis B & C) was from 4 to 5 percent, whereas

the numbers of those screened out because of HIV was very insignificant. The numbers for such cases given by some medical centres in-charge ranged between 4-8 cases per annum. However, one medical centre in-charge claimed: *"We get at least 5-7 people in a month that we have doubts about their HIV status."*

Also, there are variations in the models and brands of laboratory machine being used at different centres for HIV testing. Apparently the only instruction from the GCC is that HIV tests should be conducted on Eliza machine, the model and brands are not specified. Some centres are still using Best2000, others have Axium machines while a few have upgraded to Architect machines. Issues of cost per test and the accuracy of test results related to different types of machine were mentioned by some medical centres in-charge. In some cases the suspect cases of HIV are referred to another GCC centre with latest laboratory machine for confirmation before disclosure of test results to the applicant. One centre in-charge in particular was not sure about the accuracy of his laboratory machines:

> *"This is Pakistan, many standards, whether they are yours or mine, are questionable to a large extent. We do not know how many days the Abbot's consignment was held at customs. Maybe the custom inspector was on leave and the consignment remained in the sun for 15 days. There are possibilities like this. If it remains in sun for a long time, it starts giving more false positive. Eliza is basically a colour. It is basically the intensity of this colour that is measured. If the kit is kept in the sun for a long time the colour develops by itself in the heat. That is why we repeat the tests."* [Medical centre in-charge]

The people in-charge of the Medical Centres were also unsure about the types of machines being used for HIV confirmatory tests at the National STI/HIV Referral Laboratory of the NIH. They were unaware about the availability of Western Blot at the NIH laboratory. A few even asserted that the machine at NIH must be out-dated because it's a government sector facility and that if the NIH had latest machines like them there would be little or no discrepancy between their test results and that of NIH laboratory.

Pre-test counselling is not a practice at the GCC approved medical centres. These centres are usually crowded with people queuing up before the glass counters to submit their

appointment slips and obtain tokens for their turn to give biological samples. Collecting the samples in the lab is a quick process because of the rush of people in the waiting area. There are no counsellors among the staff of the medical centres. The majority of intending migrants are unaware of the number or types of tests required for screening. According to one centre in-charge:

> *"Only the educated people know that all these tests are done. A common labour class person does not know. We also do the Sexullay Trasmitted Infection STI test to detect sexually transmitted disease. When we tell them later then they have some objection on finding out that this was also diagnosed. It is obvious that STI is through sexual transmission."* [Medical centre in-charge]

On a question regarding possibility of pre-test counselling especially for HIV at his medical centre, one medical centre in-charge suggested that the responsibility for such counselling is with the OEPs or agents. According to him:

> *"It's the agents that send them to GAMCA or take appointment on their behalf. If possible these people should be given counselling beforehand at the point of their contact with agents. They should be told that if there is something like that what should be their conduct [tarz-i-amal] and that they should know beforehand. They should not be stopped from tests because they will know their status only when the tests are done but they should be told that after the test they should not get depressed or anything. Counselling should be done at that level/point."* [Medical centre in-charge]

Before labelling an applicant as HIV positive, some centres do take measures like repeating the test on their own machines using the same sample or sending the sample to another GCC approved medical centre with better lab machines for cross checking. Some even ask the applicant to come back at a later date to give a fresh sample. However, these practices are random and are not part of any of their protocols.

> *"If someone is positive we repeat the test. We give a month's time and when he comes back again we repeat the test. We also try to get the test done from some other GCC approved centre as well...there was one HIV positive person*

last month, we have still held, we have asked him for Western Blot but that test is a bit costly. He says he will arrange money and come back." [Medical centre in-charge]

According to another medical centre in-charge *"we do not label anyone; we label them only when we are 200 percent sure because as you know there is so much stigma attached with HIV"*.

In most of the cases, the post-test counselling is done with HIV positive applicants by the centres in-charge. However, none of them is trained in pre- or post-test counselling for HIV. The focus in these, possibly very short, post-test counselling sessions is to convince the applicant to repeat their tests from a GCC approved centres in a big city, or some other private sector laboratory or from the NIH.

"If someone's test indicates that he is HIV positive, I personally sit with him and tell him that his test results with us are not "theek" (correct) and that he should get them done from somewhere else also, for example we have a centre at Shifa hospital or we send them to NIH and say that they will guide them further." [Medical centre in-charge]

Since the medical centres in-charge and their staff lack training on HIV counselling, the post-test sessions can sometimes be counter-productive. According to one medical centre in-charge:

"There are problems. They usually say that they have never done anything like that...illegal sexual relationships, etc... No one is willing to accept such things. Take their past history for instance, if someone has been to Dubai or lived abroad before as well. In my eight years there was only one case in which that person had acknowledge that that had happened to him 'iss tarah ka muamal hoa tha' otherwise, no one accepts this. They also say that they are not suffering from any illness; there is no 'takleef', no 'bemari' (disease). Many of them deny it and insist 'your machines are wrong, we are not wrong.'" [Medical centre in-charge]

Almost all medical centre in-charge talked about the stigma attached with HIV/AIDS. In some cases, it manifested even in their own conversations. For instance, complaining about the non-compliance of some of the HIV positive diagnosed applicants with the advice to visit NIH or PIMS for further guidance, one medical centre in-charge said:

> *"We ask them to report at these two places and get their treatment over there. There are very few who go [to NIH or PIMS] because of the 'Badnami' (stigma) attached with this 'bemari.' On our part we do not have any such authority that we could send them to a 'Thana' (police station) or spare our staff to take them there."* [Medical centre in-charge]

Referral to NIH was mentioned by a majority of the medical centres in-charge. However, none of them knew the exact facility available there for HIV confirmatory test and a further referral for free treatment and care and support. Apart from one medical centre in-charge, none of them were ever contacted by a government department or an NGO for referral of HIV positive cases.

> *"After repeating the tests and confirming the results, we inform the applicant that he is HIV positive, that we will give him 'medically unfit report', and that he is unable to go to the GCC countries. We also tell him that he should go to AIDS control centre in the NIH or there is also some centre in the PIMS...I don't know what exactly it is..."* [Medical centre in-charge]

The majority of them talked about NIH laboratory with some resentment that instead of confirming HIV test results issued by them, the NIH often reverses them which has implications for them in form of applicants coming back with an assertion to change their results from positive to negative. Some of them attributed this trend to *'out-dated'* lab machines at NIH. Nevertheless, many applicants who go to Agha Khan or Shoukat Khanam laboratories also often come with different test results. The immediate response to such applicants is to ask them to refer to the instruction printed on the new test report regarding a repeat test after 12 weeks. If an applicant or his OEP still insists, they simply tell him that the GCC has its own standards regarding the threshold level of antibodies for screening HIV positive.

"Some people went to NIH and the test results at NIH were negative or they went to some other laboratory and the results were negative. Common laboratories do not have Eliza machines. They use some device method which is not that sensitive [accurate]. In some cases they go back to their areas e.g. Jhelum, Mandi Bahudin and get their test done from there and come back to us with negative test results. But we tell them that in our sensitive machines there result is positive so we are unable to declare them fit until they are HIV negative according to our machines. We tell them to wait a bit come back again for HIV tests. There are very few such cases who come repeatedly otherwise they do not come back." [Medical centre in-charge]

The threshold level was further explored with one of the medical centres in-charge. He explained it as following:

"Actually the value of anti-bodies in 7-8 people we suspected of HIV in the last one month was very low. One [on the reading scale] is the standard; if it is more than 1 then the person is considered HIV positive. Among these 7-8 people the reading of antibodies varied, someone had 2.1 and someone 1.8. The GCC standards are very strict. Personally, I cannot call them HIV positive. Till today I never had a person who I think was really HIV patient".

Explanations like these can leave doubts in the mind of an intending migrant about his HIV status. Consequently, many do not return for a repeat test at the NIH. The contradictory test results for HIV from different laboratories may undermine voluntary HIV testing and counselling for not intending migrants and their agents but also those closely associated with them.

Case Study of an Intending migrant diagnosed with HIV by one of the GCC approved medical centres

This case study was volunteered by a representative of an OEP upon the research team's visit to their office. It is reproduced here in first person with some deletion of repetitions.

I would like to share with you one such case. It has been one to one and a half years since this happened. We had a worker who had nomination from a company to process his visa. We went for his medical screening from XYZ medical centre in Lahore. When the report came after two days, it said that he was HIV positive. We told him "you cannot proceed because you are medically unfit". He asked us the reason. We said that he was HIV positive. He was very much worried. People in those areas do not know much about HIV. He cried and came to Lahore [from Peshawar] *"ro ro kay preshan hoa aur Lahore a gia"*. He said he did not have any such illness and that he never went out of Pakistan. We got his medical test done from Shaukat Khanum and Aga Khan Hospital and the reports from both said that he was HIV negative. We took those reports and the worker to XYZ medical centre. They said they could not do anything as the report they issued was authentic and they did not accept '*nahin mantee'* either Shoukat Khanum or Aga Khan. The worker stayed in Lahore for three days, we ran after them [the medical centre] many times and raised a lot of noise '*shoor dala'* but they refused us. We talked to their in-charge Dr. XYZ, he also refused to listen to us saying that he could do nothing. He mentioned "We do not entertain, '*nahi mantee'* [SK or AK results] if he is positive according to our test then he is positive." We asked them to take the blood sample again but they said that they could not do that again. 'We cannot change our report', they said. We asked, if we could go to some other GAMCA centre. They replied that it is not possible because they had uploaded the result online. We took the worker to the press, the C42 channel. The media people also did not give us any response. They did nothing. They totally ignored it saying that it was not a big problem. The worker was very depressed. He got his tests done from various centres. He spent a lot of money. He had to come from KPK and that also cost him money.

Q. Did you collect his report?

Two days after the tests we sent someone to collect the report. He brought the report and it said very clearly that the person was medically unfit: he was HIV positive. We informed him on phone that he was medically unfit and that we could not send him abroad. He asked what the problem was and we told that he had an AIDS problem... He also brought reports from Islamabad and Rawalpindi labs but they declined them as well.

There is another medical test at the time of arrival. So far we have never had a complaint that

a worker we sent as 'fit' was found to be 'unfit' there, including for HIV problem...We have never encountered any health problems of the workers we send there. However, over here there are these problems; sometimes they say ALT has increased and sometimes decreased.

If their result was accurate, they wouldn't neglect such big laboratories like Agha Khan and Shoukat Khanum. We have had so much confrontation and argument with XYZ medical centre that they did not want to see our face again.

Registration of the Agreement with Protector of Emigrants

After completion of all required formalities including medical and technical tests, all intending emigrants appear before the Protector of Emigrants to fulfil the requirements of Section 15 of the Emigration Ordinance 1979 for registration of their agreements (FSA) and pre departure briefings. Most of them are accompanied either by the representatives of their OEPs/agents or with their friends and relatives to guide and facilitate them throughout the process.

The detail of service charges for registration of intending migrants through OEPs and on direct employment visa is as under:

Table 7 Service Charges for Intending Migrants

Government Dues	OEP Facilitated	Direct
Service Charges	PKR 6,000 (USD 67)	-
Welfare Fund (OPF)	PKR 2,000 (USD 22)	PKR 2,000 (USD 22)
Insurance Premium	PKR 2,000 (USD 22)	PKR 2,000 (USD 22)
Registration Fee	PKR 500 (USD 5)	PKR 2,500 (USD 5)
Adhesive Stamp	PKR 10 (USD 0.1)	PKR 10 (USD 0.1)
Total	PKR 10,510 (USD 116)	PKR 6,510 (USD 73)
NICOP	PKR 1,275-2,175(USD 15-25)	PKR 1,275-2,175(USD 15-25)

The Pre-departure briefings: The frequency and format of briefings is not similar and varies across all Protector Offices. There is a set curriculum for briefings consisting of multimedia slides; however, only large regional centres make use of the multi-media and the briefing rooms. The post of briefing officer was vacant at Protector Office Malakand whereas in others, relatively newly appointed briefing officers with little experience or exposure to

destination countries and limited understanding of registration and insurance procedures. Depending on the number of intending migrants, one or two briefing sessions might be held every day at the larger regional offices with an attendance of around 30-40 intending migrants at each session. In smaller regional offices, the formal briefings are held infrequently. Often, the briefing officer might have an informal chat in his room with a group of 10-15 intending migrants if they are available to be around at a given time.

While the applications are processed, the briefing halls serve as waiting rooms for the intending migrants and accompanying representatives of OEPs. After depositing the bank fees, most of them rest and wait in the briefing halls till the start of the briefing session. On our visits, some intending migrants waiting in the briefing halls were busy filling some forms with their OEP representatives/agents, while others were having a nap in their chairs. Some even looked uncertain about what was going to happen next; these were possibly those who had 'azad' or direct visa, had opted not to hire the services of an OEP, and had come to the protector office on their own.

The walls of the briefing halls particularly, and the office premises in general, are full of posters containing information on the mandate of the Protector Office, the procedures and requirements for insurance and submission of fees in banks, the travel advisories, the do's and don'ts in the destination countries, and how to project a positive image of Pakistan abroad. A few posters also contained information on HIV/AIDS.

The composition of groups for briefing varies from day to day. On a given day the briefing hall might be crowded with nurses, doctors, engineers or technicians selected in a single batch by a particular OEP whereas on other days it might be a mix of unskilled and skilled labourers and professionals both through OEP and direct (azad) visa indenting to migrate to Gulf countries as well as Malaysia and other traditional and non-traditional countries. There are often a couple or more repeater migrants who have lived and worked in destination countries in the past. An experienced briefing officer would modify the contents and the tone of the briefing in accordance with the composition of the group. A good start is generally to have a quick round of introduction of the participants, especially regarding the country of destination, the category of employment visa, and the previous history of migration or exposure to destination countries. The repeater migrants are sometime

encouraged to share their experiences while briefing on the language and culture of the destination countries and the possible problems at the work place.

Before starting the briefing, the representatives of the OEPs and agents are sent out of the hall to minimise disruption caused by their whispering or napping during the session. Most participants are attentive towards the briefing in the beginning but as the session prolongs they start losing interest. Personal likes/dislikes and worldviews of the briefing officers were evident in the briefing session that we attended. For instance, in some briefing sessions, religion and morality was also emphasised. The habits, socio cultural back ground, language and ways of cooperation of migrants from other manpower exporting countries like Philippines, Bangladesh, Nepal and India were also discussed in the briefing sessions. Asked about the main topics covered in a briefing session, one briefing officer responded spontaneously; *"First of all is the language topic...culture...halal... means whatever you purchase check it is halal, avoid small mistakes like smoking, narcotics, insurance, protection material."*

On a rare occasion, a less experienced briefing officer who has no exposure to a GCC country might be confronted by a repeater migrant on the veracity of his/her information or claims about life in these countries. Consequently, cross questions or conversations are not encouraged in few cases during the session. As part of the format, they do ask, at the end of the briefing, if there are any questions. According to one briefing officer:

> *"Sometimes there are irrelevant questions like 'when we go there what will happen? We do not know any one, etc.' If someone asks questions like that then we say this is not our role to answer such questions and tell them that if they want any guideline we can give them. Most people ask me questions regarding insurance, for example 'if we misplace the certificate, what should we do?', 'when will we get the certificate?' and so on."* [Briefing officer]

When asked to comment on the possibility of interpersonal or more interactive briefing in small groups throughout the day, the briefing officers said that they were already overburdened with office work.

Health and HIV: Health is only a small portion of the briefing curricula. The main topics under this section are the safety measures at the work place. There are a couple of slides in the multimedia file on HIV/AIDS, however, these slides are either skipped or skimmed quickly, as the officials are not properly trained regarding health issues including HIV/AIDS and no relevant material related to HIV is available in Protector Offices.

> *"As far as the AIDS slide is concerned, people ask strange questions so I show that slide very quickly and move on. For instance, a few people said that their cousins have also married [abroad to non-Pakistani] and that they faced no such problem. I don't discuss this. How should I answer that?"* [Briefing officer]

Marking our presence as a special occasion, one Protector of Emigrants himself addressed the intending migrants:

> *"Mashallah (By the WILL of GOD), Alhamdo-lillah (Thank GOD), Subhanallah (Praise to GOD), we are all Muslims; we do not belief in any 'galat kaam (wrong doings/Sins). We believe in 'sahi kam' (fair acts/Pious acts). So when you go abroad, as you will be very careful about other things, you should also be very careful about wrong illegitimate relations because there are such diseases lying out there [abroad] 'aisee aisee bemarian bahar pari hoe hain', that they can be dangerous for your life."* [Protector of Emigrants]

Only a few briefing officers had attended an orientation/training on HIV/AIDS. According to the protector of emigrants, since 2007 no training on HIV prevention and AIDS has been arranged by NACP and other national or international agencies. The officials who were responsible to provide the orientation and briefing availed of the three-days training during the period 2003 – 2007, but since then have either been promoted or transferred to some other places. Further trainings or refresher courses for briefing officers were not mentioned anywhere. HIV awareness and sensitisation level was low. With current levels of sensitisation there was little willingness among them to speak openly on HIV and related issues during their briefing sessions.

"[With current slides] we have to explain about HIV and AIDS, which is a bit problematic. So, if there are [good] slides we can show them the slides and discuss short questions briefly. That would be a better way." [Briefing officer]

Briefings and the OEPs: The majority of the OEPs praised the briefing sessions held at the Protector Offices. One of the benefits of these briefing according to one OEP was that *"when the workers come back to us after attending those briefing they discuss with us the things they were told about." [OEP]*

Airport-Departure

Random checking of protector stamp on passports: As a matter of policy, staff of the offices of the Protectors of Emigrants should be deployed at deployed at the international airports falling in their respective jurisdictions to ensure that all the travellers on a work visa have their passports stamped from the Protector Office. This would testify that they have obtained registration from the Government of Pakistan, which is legal requirement for all Pakistani overseas workers. However, at present only random checks are done at airports by the staff deputed with this additional responsibility. The Protector Office does not have a separate counter in the immigration area. The visiting Protector Office staffs has been issued entry cards for departure lounges by the CAA and are facilitated by the FIA's immigration staff to carry out their work on their infrequent visits. In absence of a designated protector staff at the airport, the FIA's immigration staffs carries out the checking of protector stamps on passports. Recently, sixteen inspectors were inducted by the BE&OE for this purpose. They are currently under training. The BE&OE also hopes to revive its counters at all airports in the near future. Most intending migrants, especially those in unskilled and labourer categories come from small towns and rural areas. At the airports, they are about to experience air travel for the first time in their lives. They may be excited and stressed at the same time. Moreover, the extra ordinary security checks and the hi-tech modern environment of the departure lounge might add to their over-conscious state of mind.

HIV and AIDS: No awareness about HIV/AIDS is currently provided to intending or returnee migrants at the airports. The health facilities available at the airports are CAA medical centre/dispensary and an airport medical clinic of the Federal Ministry of Health.

The mandate of the former is to serve the airport staff and their families for their health needs, while the latter is assigned with the main task of screening the arriving passenger for infectious diseases such as yellow fever, swine flu, etc., from time to time. The airport medical clinics are also responsible for providing first aid to passengers in transit. Neither of the two facilities considers it as their responsibility to sensitise the travellers about HIV and AIDS or to provide referral services. Moreover, HIV awareness and sensitisation level of their staff and that of airport management was found to be very low. A few staff members reported to have had a training/orientation on HIV and AIDS in past; however, they complained about the lack of refresher trainings.

Expressing his opinion about the pre-departure HIV screening of temporary contractual labourers at GCC approved centres, one Medical Officer (MO) at an airport said that from epidemiological point of view screening at that stage was less useful because *"you are not exposed to HIV here, you are more prone to AIDS when you go abroad, you do not have family and you indulge in risk behaviour."* He pointed out that no medical screening is done when the workers were going back to the GCC countries after availing their leave. They keep coming and going without HIV screening whereas they could possibly get infected on their visits subsequent to first visit and screening.

4.1.2. Stage Two: Work and Stay in GCC Countries

Besides earning a livelihood, a large number of temporary contractual labourers are motivated to travel to Saudi Arabia on a work visa because it also affords them an opportunity to perform Hajj or Umrah and visit other holy places. Some are attracted to the UAE, Dubai in particular, after listening to stories full of glamour and fascinations. So, different individuals have different expectation of their stay in the countries of destination. However, the majority of them are not certain about the actual condition of their stay in the GCC countries. Not many have read or understood the terms and conditions contained in their FSA. Most rely on hearsay and the information provided to them by the OEPs or their own contact already working abroad. In some cases, those travelling on a company visa disappear from the airport the moment they land. They have already set up plans to reside and work with their contacts already in the destination country. A few work with the company that employed them for their initial contract period of two years or until they establish their

personal contacts and networks with people outside the company. According to an OEP, *"in the last one year, about 30-40 people did that with us, we don't know how to deal with this problem. The moment they become a bit 'stable' or have made contacts with people, they run away"*. Among those who cannot become 'stable', some chose to come back to Pakistan before the term of employment is over. There are two ways to do that. One is to give an application to the company management to terminate them, and the other more problematic course is to create troubles for the employer so that they 'forcefully' terminate and send them back. The later course is adopted to avoid blame from the family back home for being lazy or for wasting their money. According to an OEP:

> *"Some people are forced by their families to go to Saudi Arabia for earning money but once they are there they cannot bear the heat, so they deliberately choose this path [disturbance creators], so that they are sent back. In this way they can also evade the blame."* [OEP]

Community Welfare Attaché: Under Section 7, of the Emigration Ordinance (1979) the "Federal Government may, for the purpose of safe guarding the interests of emigrants and promoting overseas employment, appoint a person to be a Labour Attaché/Community Welfare Attaché (CWA) in a place outside Pakistan and may define his duties."[28] The powers and duties of a CWA under Rule 5 of Emigration Rules (1979) are defined as under:

> *(a) be responsible for the promotion of overseas employment;*
> *(b) be responsible for the welfare of the emigrants;*
> *(c) be responsible for safeguarding the interest of emigrants in the host country including setting of the disputes and negotiations with the employers;*
> *(d) attend to all complaints of the emigrants and find adequate remedy therefore or report to director general; and*
> (e) *Send periodical reports as may be required by the Director General on all aspects of his activities, including labour market trends, inflation and cost of living"*. [Emigration Rules, 1979]

[28] Emigration Ordinance 1979, Government of Pakistan.

Presently, twenty CWAs are posted in different Pakistani Missions abroad, out of which eleven are posted in the GCC countries. To fulfil the provision of Rule (5), CWAs visit leading companies of the destination countries, labour camps, jails, hospitals and deportation camps. In addition to above, CWAs organise functions of national importance, attest to manpower demands, develop contact with different community groups, address complaints of Pakistani migrants, issue NOC regarding burial of dead bodies of Pakistani Nationals in the destination countries or regarding transportation of dead bodies to Pakistan, attend community functions and assist Pakistani nationals in case of accidents and other emergencies. The CWAs also develop contact with concerned local authorities to maximise Pakistani manpower export and to provide legal help to Pakistani migrants.

Accommodation and work conditions: According to the terms and conditions of demand letter also mentioned in FSA, the employers are responsible to provide accommodation and transport facilities from residence to work place and back to residence, to those migrant workers either who have been recruited through OEPs or directly hired by the company after signing of a proper agreement. On the other hand, many Pakistanis arrange/purchase visas for their friends from smaller companies or by individual sponsors after payment of huge amount (PKR 300,000 to 500,000 OR USD 4000 to 6000) with the understanding that these workers will work with their relatives/friends who have arranged visas for them or to work independently under the legal umbrella of their sponsors. Depending on the nature of work, working site and size and reputation of the company, different types of accommodation are provided to the migrant workers. Normally, large and well reputed companies provide reasonable and worth living accommodations to their employees. However, smaller companies and individual employers violate their contractual obligations and either to avoid or provide substandard accommodations to their employees. A large number of Pakistanis opt to arrange their accommodation on their own and they prefer to live with their friends, relatives, or people of their same areas of Pakistan. The people from KPK call these accommodations ‘deras’. Usually, 8 to 10 people live in a single room. The family visa can only be issued for the families of those migrants who are drawing a certain minimum prescribed salaries or fulfil other legal conditions vary from country to county in the GCC region.

Health insurance and medical facilities: Apart from other facilities, it is responsibility of all employers in the destination countries to provide proper medical facilities to their migrant

workers in case of their illness/injury. However, this facility is fully provided by the larger/well reputed companies and violated the same condition by some smaller individual employers which is clear violation of the laws of country of destination that can be challenged in the labour court. Recently, GCC countries have introduced the system of health insurance called "Taminat" which is mandatory for all employers to provide this facility to their employees. Under this scheme, after payment of a certain percentage amounting to 10 to 20 percent by a migrant worker, he/she becomes entitled for full medical treatment in case of different type of diseases.

Socialising and recreation: Pakistani migrants working or residing in the GCC countries have formulated various professional, cultural, recreational, linguistic and regional informal organizations or groups. These groups or organizations arrange different types of socio-cultural, recreational and religious events and celebrate Independence Day and Pakistan Day. Famous larger companies of destination countries provide variety of recreational facilities including different types of supports of country of origin and destination. However, a large number of migrant workers cannot avail the opportunity of recreation and support due to their long working hours and lack of interest of their employers.

HIV/AIDS Awareness: At present, there is no system available to disseminate information to Pakistani migrant workers in the GCC countries regarding their health issues including prevention of HIV. No specific training regarding health issues of migrant workers including HIV/AIDS has been imparted to CWAs or other embassy staff, and community groups by any national or international agency. Normally, it is assumed that if a migrant worker is found HIV and Hepatitis B and C positive during his or her medical test either on arrival or at the time of renewal of their 'Iqamas' (work permits)is being deported to countries of their origin without declaring their positive status. This will be confirmed during the visit of the planned scoping mission by the Working Group on HIV to the UAE in fall 2011. This kind of situation makes the migrant workers more vulnerable towards HIV/AIDS and other infectious diseases.

4.1.3. Stage Three: Back in Pakistan

According to an estimate, out of total 5.6 million Pakistanis who have travelled to the GCC countries from 1971 to June 2011 for the purpose of employment either through OEPs or direct employment, about 50 % have returned back to Pakistan. They came back to Pakistan either after completion of their normal contract period, termination of FSA by both the parties or thorough forced deportation in case of violation of local laws.

The immigration counters: The first contact for returnee migrants at the time of arrival in Pakistan are the airport immigration authorities. In their legal parlance, the FIA distinguishes between two types of deportees, i.e. on regular passport and on emergency passports (EPs). The majority of the regular passport holder deportees are those who are denied entry in the destination country on account of being blacklisted because of some past crime that they might have committed in the host country during their previous stay or because of expiry of visas. Before travel from Pakistan, these migrants are unaware of their inclusion in the blacklist and the prospect of being sent back from the airport in destination country.

The deportees on EPs are mostly those who were apprehended by the authorities of host countries because of overstay or involvement in some minor crimes. These also include workers who have lost their passports, wish to travel back and request the Pakistani Embassy to issue emergency passports/out pass (one page single time travel document).

Upon arrival, the deportees in either category are detained at the airport by the immigration authorities for investigations to establish their Pakistani nationality. If there are any doubts about nationality or if the EP holder is found to have been alleged with a serious crime in the destination country, s/he is sent to a detention centre outside the airport for further investigations. Detention of EPs holders at the airport normally takes around half an hour whereas investigations at the detention centre can take much longer. According to one FIA official:

> *"We deal with the people coming on emergency passports in a similar fashion as the [other] deportees. There is investigation and all that. If there were serious allegations against him in the destination country like drug trafficking, etc., such a person is definitely sent to the cell for more investigations. The allegations might not have been proved in the destination country like Saudi*

Arabia or the person might have served the sentence and then sent back here but we still hand over such person to our investigation team."

Usually, deporting authorities mention the reason relating to the minor crimes of deportees and it usually does not come to the knowledge of emigration authorities that some have been deported from the GCC countries on the basis of his health status, including HIV positive cases. As far the EP holders are concerned, the FIA has no means to ascertain the real reason for their deportation. Some FIA and airport officials sympathise with deportees.

"I always say that no one should go abroad from here [unka koi wali waris nahin hota], (they have no one to own them)." [MO at airport]

Awareness of HIV among airport officials: The officials interviewed at the airports for this research included the MO of the CAA dispensaries and the airport medical clinics, the FIA immigration staff, and in one case an airport manager. The level of awareness and sensitisation among the officials varied. The medical officers had a better knowledge about the routes of transmission of HIV and the preventive measures, however, they were less sensitised on specific issues of HIV and AIDS. A recurrent theme in the discussions with airport staff was the 'foriegnisation' of HIV/AIDS — i.e. it's a disease of others.

"Most diseases come from abroad. AIDS also came from abroad; there was no disease like this in Pakistan. These things come from abroad. Now the question is how they come from abroad. These same people go abroad, they get infected and it is from them that the disease spreads." [MO at airport]

Very few had attended a training or orientation on HIV and AIDS. Although these orientations were rated useful, the officials reported that not everyone who attended these sessions took interest in the contents: *"Some people were taking interest while others were always thinking when the session would end."* One MO reported that during this orientation session he learnt *"what 'museebat' (trouble) this AIDS actually is."* He also claimed to have learned about the routes of HIV transmission: *"It spreads from fluids that come out of the body like oral fluids, sweating, etc."*

HIV Screening of Returnees: HIV screening of all returning migrants was considered near to impossible for three main reasons. Firstly, the returnees are in great hurry and are unlikely to cooperate; secondly, the airport medical facilities do not have capacity in terms of human resource and equipment to carry out screening at a large scale; and thirdly, any large scale screening for HIV at the airports would create a media hype and a negative reaction from different quarters in the society and lastly *"HIV testing all over the world is voluntary."*

> *"There is such a chaos at airports, some people have lost their luggage others have some other worries and on top of that if we approach them to request blood tests, they won't cooperate."* [Medical Officer at Airport]

> *"The media will make noise that the airport authorities cannot properly perform their job of sorting out people, luggage and facilitating them in that regard instead they extract blood. So, there are issues like that which become a problem for airport authorities."* [Medical Officer at Airport]

Even though the airport officials across different agencies were reluctant to take further responsibility with current staff capacity, almost all of them welcomed the idea of establishing HIV testing centres at airport or at least widely advertising at the airports, the availability of confidential and free of cost testing, counselling and treatment services. According to one MO, airports were the best places for HIV intervention for a number of reasons:

> *"If you can intervene with people who are bringing back AIDS, you can timely stop its spread to the general population more easily; secondly airports are also the best place because at other places people do not want to go for HIV testing due the stigma attached with it. The benefit at the airport is that you are alone and no one will know if you went for HIV tests. So the willingness on part of individual for HIV testing can be much better at the airports."*

Reunion with families: After going through the immigration counters, the returning migrants, including deportees, are not required to report to any Government agency. They are usually received by family and relatives waiting impatiently at the arrivals and taken straight

to their home towns. The majority of them are either unmarried young men or had travelled to the GCC countries immediately after marriage. The unmarried are subsequently married using the savings from remittances whereas the married ones are re-united with their spouses after a long break. Hence, both are sexually active immediately after return.

In some cases, it was reported that some of the young returnee migrants take up risky behaviour like drug use, same sex relations, multiple sexual partners, and visiting 'hijra'(transgender or eunuch) and female sex workers. They justify such 'pleasure seeking' activities by arguing that they had lived a dull life in labour camps in the Gulf for quite some time and now it was their turn to enjoy some pleasures of life by spending some of that earning. One view among our respondents was that the newly returned migrants are targeted by bad elements in the neighbourhoods to draw them into their company. By spoiling these relatively affluent young returnee migrants into 'pleasure seeking activities', the bad elements among relatives, neighbours and childhood friends benefit to satisfy their own desires for drugs and sex.

HIV diagnosis: Most of the HIV positive returnee migrants come to know about their HIV status several months after their arrival when they fall sick and start seeking diagnosis and treatment. Depending on the severity of illness, financial affordability, access to health facilities, and HIV awareness of the health care provider or the people they know, a returnee migrant might be referred to a private lab for HIV tests and subsequent confirmation at one of the 15 VCT centres and/or NACP's referral lab at NIH. This can take from few weeks to several months and in the process, it incurs heavy financial loss on the returnee and his family. The diagnosis of HIV further aggravates the situation. Shock and denial are followed by stigma and discrimination. A few choose to become career patients while most are lost to oblivion. Once the earning hands for their families and the pride of their parents, they are now forced to live a life of economic dependents and social undesirability.

> *The doctor kept giving me injections for 6 months but my health did not improve. Sometimes I had headache, sometime my legs were not with me. Then the doctor sent me for tests."* [Returnee migrant PLHIV]

"We sold all the cattle, the gold and the property... everything... for treatments. We came to know about it [HIV] only when we had lost everything." [Returnee migrant PLHIV]

The fact that many of the PLHIV registered at the treatment centres are spouses and children of returnee migrants is indicative of the late diagnosis among them. Moreover, preliminary diagnoses at the private laboratories are often not accompanied by appropriate pre-test and post-test counselling. Not all of those referred for confirmatory test or treatment make it to the VCT centres. Among those who do, most have already infected their wives by the time they are convinced about using protection during sex.

HIV tests of family members: After continued counselling by the VCT staff, the majority of HIV positive returnee migrants eventually bring their wives and children for HIV tests before they have fallen sick too. However, very few are willing to let their spouses know that they are being tested for HIV. They request the VCT staff not to disclose to their spouses and that the tests are for Hepatitis or diabetes, etc. The health staff mostly obliges. If the spouses are found to be HIV positive, the process of disclosure is long and painful. If they are negative, the chances of bringing them again for a repeat test after few months are grim.

"They asked me to get my wife checked... we made an excuse to her that the tests were for Hepatitis or diabetes ...it's been about three years.....they did not ask us to repeat tests....we were satisfied with that first test. Also, she has also remained in good health. If there was any problem with her health then we might have suspected something" [Returnee migrant PLHIV].

Treatment care and support: Although formal protocols for recording migration history or an assessment of the routes of transmission among those diagnosed positive at the VCT centre do not exist, some counsellor, informally discuss these topics with the PLHIV. The majority of those with migration history to the GCC countries deny sexual contact abroad as a possible rout of transmission for them. Instead, they argue that they contracted the infection because of living and working in unhygienic conditions where they might have come into contact with contaminated substances like camel blood. Hence, the data on number of migrants among PLHIV and their possible routes of transmission is sketchy and incomplete. To elicit accurate information from the migrants, one of the strategies used by

the staff at treatment centre to establish the possible route of transmission was to tell them that there are different types of treatment for people with different routes of transmission. Consequently, a returnee migrant would request the counsellor *"I got infected because of contact with contaminated animal blood but you should give me medicine for sexual transmission route."*

Almost all HIV positive returnee migrants were satisfied with the attitude of VCT centres staff and the availability of anti-retroviral (ARV) medicines. However, there was resentment regarding the lack of availability of medicine for OIs for which they said they are referred to the OPD of the hospitals where they face stigma and discrimination from doctors, paramedics and other patients. According to one respondent:

> *"I went to an ENT specialist for my throat infection. I told him I was HIV positive. He not only refused to give me treatment but misbehaved. He even said "the best thing is that a person like you should die." This is what a DOCTOR said. These are his words"* [returnee migrant PLHIV]

In the absence of a CD4 machine in the same city, the respondents complained that their biggest problem was travelling to Lahore or Islamabad to determine their viral load, i.e., CD4 count. Given their ill-health, cost of travelling and the time needed, getting the viral load test done was a physical, mental and financial burden for these respondents. According to some respondents, a couple of PLHIV NGOs had contacted them for membership by promising support for CD4 viral tests related travel, and provision of medicine for opportunistic infections, among other things. However, this support did not materialise for a large number of them. Instead, they argued that PLHIV have formed themselves into competing groups, each associated with one of the NGOs, and that they hardly benefit individual PLHIV.

> *"When we went to them in the beginning they told us that even if our children are ill they will provide medicine for them as well. They did this to bring us into their fold."* [Returnee migrant PLHIV]

No systematic data was available on the rate of anti-retroviral therapy (ART) adherence. It was shared with the research team that among two pockets of HIV

concentration in DG Khan district, a large number of PLHIV from one particular area had stopped visiting the VCT centre under the influence of a local Hakeem, who claims to have 'cure for AIDS'. Moreover, the Hakeem was also reported to be spreading misperceptions about ARV medicines, e.g., these are meant to induce impotency, etc. Apparently, the public health authorities were unable or unwilling to intervene in this situation. Similarly, in Gujarat district, a former vaccinator who reportedly himself was HIV positive, widely believed to have spread the infection through use of contaminated syringes was still practicing quackery with help of his Lady Health Worker (LHW) wife and spreading misperceptions about ARVs.

Stigma and discrimination: Stigma and discrimination towards PLHIV was not limited to health care providers only, the majority of respondents had experienced these at their homes, in neighbourhoods and at work places. A few reported to have been thrown out of their jobs due to their HIV status whereas other narrated painful stories of their 'inhuman' treatment at the hands of former friends, admirers, colleagues, relatives and co-villagers.

Self Pity: Some positive returnee migrants explain HIV as their fate, as will of God and as something which has permanently paralysed them into remaining 'patients' for the rest of their lives. Asked to explain HIV, one respondent stated the following:

> *"It is a 'takleef' [suffering]... You come into it... It's like a tree that has been eaten by insects from inside...a tree that starts falling gradually and eventfully comes down. Whereas a tree that is not eaten from inside is strong, but we are like the that is being eaten up from inside ... So it is worrying, of course it is, but what can one do."* [Returnee migrant PLHIV]

Another respondent in his 20s, who appeared to be in good health, was asked to share his plans for future. He responded: *"Everyone knows that I am HIV positive"*. Asked again specifically about the type of work he planned to do to make a living, he said *"people see you with such hatred here, they would shoot you if they could...its fate, what can I do."* He was gradually sliding into the role of dependent-patient. He counted on his family or help from Government or NGOs to support him for the rest of his life. A few respondents also compared their current state of helplessness with that of their independent past. One of them, who was infuriated by the lack of promised support from an NGO, said:

"Pain and suffering is part of life, we were not like this all our life. Before this disease we were also princes of our time [waqt ke badshah thee]. A person who has even a bit of ego left in him would not spread his hands like that, no matter what. These NGOs should be shut down; they have no right to exist." [Returnee migrant PLHIV]

Risky behaviours: The majority of HIV positive returnee migrants reported that they had heard about AIDS before but they did not know how it spread. They were satisfied with their current knowledge about the infection, the protective measures to stop its spread and how to keep their illness in check: *"for me there is a clear cut treatment for this illness 'try to keep yourself healthy'"*. Nevertheless, risky behaviour continued to be practiced by many of them. While visiting the healthcare providers including dentists and surgeons, the majority do not disclose their HIV status due to stigma and discrimination. A few, however, claimed that they make sure that their used syringes are broken and disposed of in front of them. Some have not disclosed their HIV status even to their wives. According to one respondent, he did not disclose his status to anyone because he had witnessed the fate of an HIV positive person in his neighbourhood many years ago. That person had also returned from Dubai:

"Even though he was not ill at that time, people did not allow him come even to the mosque. We used to get scared to hear that he was HV, at that time it was known to everyone as AIDS. Nobody allowed him to come inside the mosque to do the 'wado' (abolution) to say prayers. He was not allowed in the weddings. His relatives left him. Because of this fear [I didn't disclose my status to anyone] I had seen his 'injam' (end)". [Returnee migrant PLHIV]

When asked about using protection in his sexual relations with his wife, this respondent said:

"No, because of this fear I have stopped doing it [intercourse] at all. I threw away the condoms in the canal because of the fear that it might break or leak....my wife understand that I am a stomach patient and my liver is weak".

The same question was asked from a youngish man whose wife was also HIV positive. He reported not using condoms because the doctors had told them that it won't make any difference since they are both HIV positive.

5. Conclusion

Pakistan has a concentrated HIV epidemic among key risk groups, including persons who inject drugs and in the context of sex work. The trends of registration at AIDS treatment centres suggest that a large number of HIV positive persons in Pakistan are returnee migrants and their family members. Therefore, the Government of Pakistan regards migrant workers as one of the vulnerable populations in the AIDS response. Based on a qualitative research, this report has tried to explore some of the HIV risks and vulnerabilities of Pakistani migrants to countries of the GCC. Instead of 'blaming it all on the migrants' or treating them as 'vectors' of HIV, this study took a holistic view of the situation to bring to the fore the structural factors most pertinent to risks and vulnerabilities of this population.

Whereas labour migration from Pakistan to the Gulf countries takes many forms, a typical migration cycle consists of three main stages, the pre-departure stage, work and stay in the Gulf, and return to Pakistan. An individual passing through these stages comes across a number of key contact points at origin, destination and return. On one hand, some of the main risks and vulnerabilities of migrant workers can be traced to these phases, and, on the other hand, the different phases also provide opportunities to address the most common HIV risks, vulnerabilities and impact on migrant workers.

Intending migrants are often mishandled and exploited at the GCC approved screening centres. The Government does not provide sufficient legal cover, protection or safeguard against violation of the intending migrants' human rights. It does not monitor or regulate the activities of GCC medical centres, which operate exclusively under the mandate given by the GCC to issue fitness certificates to aspiring migrants, using the strictest criteria possible. In theory, a team of medical experts from the GCC should visit all screening centres at least once a year; however, it seldom happens in practice. Therefore, the screening centres have become a powerful cartel that operate without monitoring of or accountability for maintaining minimum standards of medical professionalism and ensuring rights of the population. They have been entrusted with the power to impose a life time ban on intending migrants from going to Gulf. This often results in adoption of illegal means to migrate.

One particular form of exploitation of the intending migrants is the practice of *Katcha* (preliminary) test — a candidate is advised to undergo preliminary tests for number of times to know his fitness status beforehand so that he is not diagnosed 'unfit' in the final test. This practice comes at a great financial cost and health risk to intending migrants and their families. Contrary to internationally established norms, pre-test and post-test counselling is not done at any GCC approved medical centre; thus, negatively effecting the chances of any subsequent confirmatory tests, use of preventive measures, and psychological well-being of individuals. Many are diagnosed false positive. Subsequent tests at other reputed laboratories confirm them HIV negative. This undermines the credibility of HIV testing in Pakistan. No referral system exists between GCC medical centres and the government's VCT or NGOs providing care and support for people living with HIV.

Officials and staff at all contact points, including doctors and paramedics at medical centres, lack basic knowledge and awareness about HIV, its routes of transmission and the preventive measure. Some of them could not even tell the difference between HIV and AIDS. Many link HIV to sexual contacts outside or marriage only and consider returnee migrants as 'vectors' of disease because of their 'low morals'.

Late diagnosis of HIV among returnee migrants is a risk not only for transmission to family members but also a strain on their financial resources and psychological well-being, as they visit several different health providers and are given a number of diagnoses and treatments. Only few Treatment Centres provide OI medicine and CD4 machines are available only in a few big cities. No support from state or society exists to help the returnee migrants reintegrate in the society.

6. RECOMMENDATIONS

The recommendations of the research can be divided into three catagories

Short Term Recommendations:

1. A scoping mission by key stakeholders should be undertaken to assess the health vulnerability of temporary contractual migrants at destination
2. The GCC authorities should be approached to ensure implementation of its protocols for medical screening, and for further improvement in testing protocols including pre- and post-testing counselling for HIV. Advocacy should also be done for annual

inspection and evaluation of approved medical centres. GCC Centre representatives would be invited in the stakeholders meeting planned in this project.

3. Referral system and linkage between the GCC approved medical centres, National STI/HIV Referral Lab and the ARV Treatment Centres should be improved. If possible, HIV case managers in districts should be assigned with the task of providing counselling and guidance to those diagnosed positive at the GCC approved medical centres.
4. Officials of the Protector Offices, the staff the medical screening centres, the OEPs, airport agencies' medical staff and health care providers should be given trainings and orientations on HIV and AIDS awareness, sensitisation and referral.
5. Briefing curriculum and capacity at the Protector Offices should be improved. HIV and other health related topics should be made important part of the briefing.
6. Migrants specific information material including pictorial and audio-visual material regarding HIV/AIDS should be developed and to disseminate at major contact points.
7. Provision of an Urdu translation of FSA to intending migrants should be mandatory.
8. Sensitization campaign and dissemination of information through community welfare attaché and leading community groups/organizations should be initiated regarding HIV prevention.
9. The OEPs should be sensitised to negotiate the conditions of demand letters with foreign companies and employers to make these conditions sustainable not only for employers but for intending emigrants also.

Medium Term Recommendations

10. VCCT centres should be established at the airport medical clinics by upgrading their existing lab facilities and human resources.
11. Waiting facilities in OEPs, Protector Offices and the GCC medical centres should be used for showing documentaries on general information about destination countries. HIV awareness and protection related information can be tailored into these documentaries.
12. Availability of VCCT, free diagnosis and treatment and care & support should be widely advertised at all contact points, especially at the airports for the benefit of returnee migrants. However, this campaign should be sensitive and integrated within other health-related guidance to avoid possibility of further stigmatising returnee migrants or place of contact for intending migrants.

13. Management Information Systems (MIS) systems at HIV treatment centres should be upgraded to record data on migrants and their spouses and children among PLHIV registering with them. Strict guidelines of medical confidentiality should be ensured.
14. OPF welfare funds should take steps to ensure social and economic reintegration of HIV positive returnee migrants. A separate fund for PLHIV returnee migrants might be established for their welfare and rehabilitation.
15. Greater linkages and collaboration should be developed between NGOs working for PLHIV and those working for welfare of migrants.
16. Availability of free-of-cost OI medicine and easy accessibility of CD-4 viral load machines should be ensured for all PLHIV, including returnee migrants.

Long Term Recommendations

17. The threshold criteria of presence of antibodies for labelling HIV should be uniform across all facilities providing HIV testing facilities within and outside the GCC screening system. Closer liaison between well reputed laboratories, medical centres and PACPs of the health departments should be developed for exchange of knowledge and expertise.
18. The practices of GCC medical screening system should be further regulated by the health departments in all Provinces.
19. Monopoly of the regional GAMCAs should be reduced through the formation of a national level oversight committee duly mandated by the Government of Pakistan and the GCC. The function of this committee shall be to encourage competitive service provision at medical centres and to support an appeal mechanism against medical screening results as well as other check and balances of the GCC approved medical centres as required from time to time.
20. Pakistan Overseas Employment Promoters Association (POEPA) should be empowered to verify the screening results of medical centres through improving their access to the GCC guidelines, which should be made available to all OEPs.
21. Strict measures should be taken against those who are involved in preparing fake medical certificates and other documents needed for migration.
22. National/international agencies and other concerned groups like the Joint UN Team's Working Group on HIV and Migration should arrange country-wide and provincial seminars to bring on board the important stakeholders of various contact points of migrant workers as well as media. These seminars should lead to the development of

concrete policy and intervention recommendations on ensuring HIV prevention, treatment, care and protection of current and intending migrants and their families.

23. The level of coordination among international agencies and the concerned Government sectors should be enhanced and concrete/visible steps should be taken to ensure humane reintegration of migrant workers being deported for HIV and other health reasons.
24. An active mechanism regarding monitoring, evaluation, and follow-up of training and other activities and implementation status of the recommendations from the various national/international workshops/seminars and research studies should be put in place. This should be done though a Memorandum of Understanding between the BE&OE with federal and provincial health authorities.