Health Vulnerabilities of Migrants from Pakistan

Baseline Assessment

IOM, Pakistan
August 2015

International Organization for Migration (IOM)

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
FGD	Focus Group Discussion
GAMCA	Gulf Cooperation Council Approved Medical Centres Association
GCC	Gulf Cooperation Council
HIV	Human Immunodeficiency Virus
INGO	International Non-Governmental Organization
ILO	International Labour Organization
IOM	International Organization for Migration
KII	Key Informant Interview
NGO	Non-Governmental Organization
PKR	Pakistani Rupee
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
WHA	World Health Assembly
WHO	World Health Organization

EXECUTIVE SUMMARY

Aims: This study aimed to understand the health vulnerabilities of departing and returnee migrants in Pakistan in order to inform policy and programme development regarding the health of migrants in South Asia. It was conducted as part of the IOM project, *'Strengthening Government's Capacity of Selected South Asian Countries to address the Health of Migrants through a Multi-sectoral Approach'* that was implemented in Bangladesh, Nepal and Pakistan from 2013 to 2015.

Methodology: The study population consisted of departing and returnee migrants (those preparing to leave and those residing in the country of origin for no longer than twelve months following a period of emigration or work) and their spouses in Pakistan. The study employed a mixed-methods approach. For quantitative data collection, interviews were conducted using a structured questionnaire, while qualitative data was collected through Key Informant Interviews (KII) with relevant government, international organizations and community-based organizations and Focus Group Discussions (FGD) with returnee migrants and their spouses. A multi-stage cluster sampling technique was used for the quantitative sampling. Qualitative participants were recruited through snowball and network recruitment. Research tools were pre-tested and translations of the tools into Urdu and Pashto languages were validated. Informed consent was sought from all the study respondents and participants before incorporating them under this study.

Results: This study interviewed 400 respondents for the survey, consisting of 200 departing and 200 returnee migrants. Only five female respondents were interviewed. More than 80 per cent of respondents were under 35 years of age, and approximately half of the migrants were married. Almost one-third did not attend formal education or attended below primary school level while 29 per cent reached secondary school. About half of them could read Pakistani but with difficulties and 13 per cent could not read at all. The most common profession was labourer (32%), followed by construction worker (20%), and technician (18%). The Middle East was the intended destination region for 77 per cent of departing migrants, and the most recent region of work for 85 per cent of returnee migrants. Saudi Arabia was the most popular country for departing migrants, and Dubai for returnee migrants. Relatives (48%) and friends (31%) were the main sources of assistance during the pre-departure migration phase. The majority of respondents specified that the highest burden was taking care of financial arrangements. Only 14 per cent of migrants reported that they ever had sex. About 45 per cent did not provide information on their sexual activity. Lower numbers of sexual partners within this time were reported; 42 per cent had had one partner and 32 per cent between two and five within the past six months. Spouse was the most frequently identified sexual partner. Condom use appears to be highest during sex with a casual acquaintance or sex worker, with 29 and 23 per cent always using condoms respectively. However, due to the high proportion of missing responses, particularly among those who had reported sex with a spouse or friend in the last 6 months, comparing condom use between partners is difficult. Only 4 per cent of returnee migrants reported a history of forced sexual intercourse. However, 17 per cent of migrants knew of peers who had been sexually abused abroad.

General medical treatment was widely available in the community, identified by 77 per cent of all migrants. Other specific services were however less available, such as maternity care, dental care, optical care, and mental health-care services. When asked about specific curative health services, medicine provision and diagnosis were the most frequently identified available services in their communities, while Sexually Transmitted Infection (STI) management was the least available (6%).

Both preventative and curative services were mostly provided by community government centres, followed by private services and district government centres. More than half (58%) found health care in Pakistan to be unaffordable or difficult to afford, while 34 per cent of migrants found health care to be easily affordable or affordable. 64 per cent of respondents felt that they could use the public health facilities any time, 32 per cent were satisfied while 16 per cent were unsatisfied with the health services. About a half (51%) of migrants expressed that they faced difficulties accessing health-care services, citing the unavailability of doctors (55%), unaffordable costs (52%), long distances to health-care centres (28%), and inconvenient operating times (22%) as the main barriers. Regarding access to health care while abroad, 16 per cent of all returnee migrants had heard of places where migrants can access medical care and treatment, with the majority of these specifying government organizations. About 75 per cent of returnee migrants perceived health care abroad to be easily affordable or affordable. Among those who sought health care, the most common form of health-care financing was out of pocket payments, with 56 per cent of migrants paying for their own health care. A further 30 per cent had their health care financed by insurance, although this is slightly under the 37 per cent of migrants who had insurance abroad. About a quarter of all migrants expressed that they had faced difficulties accessing health care in their destination country. Among these individuals, the main barriers consisted of language barriers (48%), lack of information (32%), unaffordable costs (31%) and discrimination due to migration status (31%).

During the time of field work, 44 per cent of all selected respondents of the study (n=176) had a health check-up: 31 per cent of departing migrants and 58 per cent of returnee migrants. According to the Bureau of Immigration, more than 90 per cent would go for the Pre departure medical check as most of the migrants go to the Middle East and do medical under the Gulf Cooperation Council Approved Medical Centres Association (GAMCA). The most popular locations of the pre-departure medical check-up were GAMCA approved centres in the capital cities. As an aggregate measure, 69 per cent those who underwent a pre-departure health examination stated that all three protocols namely explaining the test, acquisition of consent and sharing of results, had been followed by the health provider. Only 5 per cent of migrants had received a pre-departure health orientation or training. Approximately half of returnee migrants believed it was necessary to have a health check-up after arrival in their home country, however just over a quarter of returnee migrants had actually had one. Among those who did not have a health check-up after their return home, more than half attributed this to perceived insusceptibility. The findings also showed that Pakistani migrants were particularly vulnerable to occupational hazards, and mental health. The majority of migrants perceived themselves not to be at risk of Tuberculosis, HIV, STIs or Hepatitis C. However approximately a third of migrants reported not knowing their risk, which suggests poor understanding of these diseases.

The quality of health services in Pakistan was generally perceived to be unsatisfactory among the participants in the focus group discussion. Geographical, economic, administrative, and communication barriers limit accessibility to health care in Pakistan. There were no preventive, screening, curative, palliative, or psychosocial government services targeting the migrant population, and that inbound migrants are not entitled to public health services. The GAMCA is the exception: The majority of migrants have pre-departure health examinations facilitated by GAMCA, and some key informants noted that GAMCA sometimes offers health promotion and education services to those migrants who present for the check-ups. Key informants highlighted a particular need for information on how to access health care while abroad. None of the key informants were aware of the International Guidelines and frameworks related to health of migrants or any other evidence-based country policy framework.

Recommendations: The major recommendations from the study include the need for the Government of Pakistan to improve health infrastructure, including migrant-specific health services such as psychosocial counselling. The Government should develop a regulatory mechanism to effectively monitor the activities of private health providers, recruiting agencies, and medical testing centres. More pressure should be applied to employers and recruitment agencies to ensure they provide or finance fair, equitable, comprehensive, and acceptable health services, including pre-departure medical examination and health orientations, as well as health care in the destination country. Television and radio should be harnessed for effective health communications. Underlying this, the Pakistani Government should ratify global migration related conventions, to incorporate health as an essential and "non-negotiable" component in the bilateral agreements. They should implement migrant-friendly services through participatory and transparent planning that is inclusive of migrant and local health provider representatives, and harnesses the guidance and comparative advantages of relevant NGOs.

CHAPTER ONE

INTRODUCTION

1.1 PROJECT BACKGROUND

This study among Pakistani migrants is part of the IOM project *"Strengthening Government's Capacity of Selected South Asian Countries to Address the Health of Migrants through a Multi-sector Approach"*. It is implemented in Bangladesh, Nepal and Pakistan. The three objectives of the project were:

1. To conduct an in-depth assessment among the three South Asian countries to assess health vulnerabilities of migrants, including their access to health and other social services, a mapping of governments' responses to address these vulnerabilities, and to come up with recommendations for action;
2. To support a regional consultation involving the three primary target countries and countries that implemented a similar project before, such as Sri Lanka and Thailand, to discuss best practices and agree on success factors to develop a migration health agenda at national level for the target countries;
3. To support the Ministries of Health of Bangladesh and Nepal, and the Ministry of Human Resource Development of Pakistan to develop strategic action plans to address the health of migrants using a multi-sectoral approach.

The project responds to the recommendations from the Regional Dialogue on the Health Challenges for Asian Migrant Workers (July 2010), the Dhaka Declaration (April 2011) and the World Health Assembly (WHA) Resolution 61.17 (May 2008) and assists key migration affected countries in South Asia to implement global and regional commitments and comprehensively address multi-faceted migration related health challenges.

From 1971 to 2013, over 7 million Pakistani migrant workers have sought employment abroad through the Bureau of Emigration, 96 per cent of which have migrated to countries in the Gulf Cooperation Council (ILO, 2014). In 2013, a total of 609,478 individuals migrated to the top six receiving countries, Saudi Arabia, the United Arab Emirates, Oman, Bahrain, Qatar and Kuwait (ILO, 2014). A further 3.5-4.0 million Pakistanis are thought to migrate per year, often temporarily, through undocumented channels (UNDP, 2010). The health impacts and social consequences resulting from outbound migration flows are substantial and not well explored. Given the likelihood that migration trends will continue to increase in Pakistan, improved knowledge of the migration and health related challenges that Pakistan faces is needed in order for the key government ministries to understand the importance of supporting migrants, in order to reduce health disparities and ensure better health outcomes for all categories of migrants.

In many South Asian countries, governments have not kept pace with the growing challenges of migration related health concerns, whether it is inbound, internal or outbound migration. The adoption of the WHA Resolution 61.17 on the "Health of Migrants" in 2008 calls upon Member States to develop and promote migrant sensitive health policies and practices. It calls upon the WHO and other relevant organizations, such as IOM, to encourage inter-regional and international cooperation and promote the exchange of information and dialogue among Member States, with particular attention to strengthening health systems (WHA, 2008).

Since 2008, there have been a number of high-level regional meetings and commitments in South and South East Asia to operationalize and implement the WHA Resolution. In July 2010, the Regional Dialogue on the Health Challenges for Asian Labour Migrants was held in Bangkok, bringing

together government representatives from thirteen Member States[1] from the Departments of Labour, Foreign Affairs and Health. During this dialogue delegates discussed and agreed upon a number of recommendations to tackle the health of Asian labour migrants at national, bilateral and regional level. In April 2011, at the Colombo Process[2] Fourth Ministerial Consultation for Asian Labour Sending Countries in Dhaka, the Dhaka Declaration was adopted. It included the recommendation to "promote the implementation of migrant-inclusive health policies to ensure equitable access to health care and services as well as occupational safety and health for migrant workers" (Dhaka Declaration, 2013).

This report presents and discusses the findings of the data collected on the health vulnerabilities of departing and returnee migrants and the health policy regarding migrants in Pakistan have been collected and analysed.

1.2 PURPOSE OF STUDY

The overall aim of this study was to contribute to the general understanding of the health vulnerabilities of departing and returnee migrants in Pakistan to inform the development of evidence policies, services and programmes that respond to migration related health challenges.

Specifically, the objectives of the study were to:

1. To assess the migration related health vulnerabilities of departing and returnee migrants in Pakistan.
2. To determine the availability and accessibility of health services, quality of health services, and barriers to accessing health services among migrants in their country of origin and destination.
3. To provide recommendations to the government and other stakeholders to support policy development on health aspects of migration and programme development.

1.3 RESEARCH METHODOLOGY

1.3.1 Study design

This study employed a mixed-methods approach, undertaking both quantitative research through questionnaire-aided interviews, and qualitative data collection using semi-structured Key Informant Interviews (KII) and Focus Group Discussions (FGD). Based on the findings of the literature review, both qualitative and quantitative methods of data collection were developed to conduct this study. This study was carried out among departing and returnee migrants in several districts, as well as the capital city of Pakistan.

1 *Attending Member States were Bangladesh, Cambodia, China, India, Indonesia, Lao People's Democratic Republic, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Thailand and Viet Nam.*

2 *The Colombo Process is an informal and non-binding, regional consultative process of the following Member States: Afghanistan, Bangladesh, China, India, Indonesia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand and Viet Nam. The Colombo Process is dedicated to discussing issues of migration.*

1.3.2 Study area

Seven areas were chosen, of which four were within the migrant-dense province Khyber Pakhtunkhwa.

a) **Peshawar District**, the capital of Khyber Pakhtunkhwa province: urban and rural areas of Chamkini and Phando (Khyber Pakhtunkhwa province)

b) **Swabi District**: rural villages Tarakai, Shera Ghwand, Kernal Sher Kaly and Kalu Kh (Khyber Pakhtunkhwa province)

c) **Nowshera District**: rural areas and semi urban areas of Pabbi and Jalozai village (Khyber Pakhtunkhwa province)

d) **Lower Dir District**: Bilambat, Khaal, Talaash and Chakdar town (Khyber Pakhtunkhwa province)

e) **Hangu District**: Hangu city and Tall town (Khyber Pakhtunkhwa province)

f) **Islamabad city**, the federal capital of Pakistan

g) **Rawalpindi city** (Punjab province)

1.3.3 Sampling scheme

A purposive sampling technique was used. Several clusters were selected covering almost an equal number of clusters for departing and returnee migrants. Clusters of returnee migrants were selected through the use of literature, previous experience in the area, and a preliminary survey prior to data collection. Within identified, migrant prone areas, recruitment agencies, government migration management institutions, and health examination centres were visited. Migrants were either approached for interview, or they provided their addresses for off-site interviews at another time.

Recruitment agencies and clinics for mandatory health examinations were regarded as single clusters for departing migrants. They were selected using a list of recruitment agencies and health examination centres available from Bureau of Emigration & Overseas Employment, Government of Pakistan and Gulf Coordination Council. From the list, the required number of clusters was selected using the Probability Proportionate to Size (PPS) method, and respondents, primarily migrant workers, were randomly selected from the selected clusters. If departing migrants were not available in a certain cluster, snowball sampling was used to draw more respondents from health examination centres.

1.3.4 Participant selection and eligibility criteria

Quantitative research

This study interviewed 400 respondents for the survey, consisting of 200 departing and 200 returnee migrants. Only five female respondents were interviewed. Irrespective of age, gender, labour category and length of migration, the following eligibility criteria applied: departing migrants had to be in or have completed the process of signing a contract, applying for a visa, and/or undergoing a mandatory health examination prior to departure. Those who planned to migrate but had not yet taken definitive steps to do so were excluded. Returnee migrants had to have returned to Pakistan within the last twelve months.

Qualitative research

Several KII and FGD were conducted with relevant stakeholders. This included health service providers, migration and health officials, government officials, employment and training officials, academic experts, NGO officials working with migrants, departing, returnees, and cross border migrants, as well as spouses of migrants. Available FGD participants were randomly selected from the clusters selected for the quantitative survey during quantitative data collection. Participants for KII were selected at random to include relevant stakeholders, such as health service providers, migration and health officials, relevant government officials, manpower, employment and training officials, NGO officials working with migrants and relevant academic experts.

Table 1: Quantitative and Qualitative sample respondents

Target Groups	Method	Sample Size	Comments/ Distribution
Migrants (departing and returnee)	Quantitative survey	400 respondents	200 departing migrants 200 returnee migrants
Migrants (departing and returnee)	Focus Group Discussion	4 FGDs (33 respondents)	2 FGDs with returnee migrants (8 + 9 participants per group) 2 FGDs with departing migrants (9 + 7 participants per group)
All major stakeholders	Key Informants Interview	16 KIIs	5 recruitment agency managers (Jan Express overseas employment promoters, GAMCA, Universal Travels, Marwat Manpower Ltd., Overseas employment promoters of Pakistan) 1 medical centre representative 7 managers and doctors representing development agencies (UNHCR, WHO (x2), IOM, FAO, UNDP, ILO) 1 Deputy Director of Public Health from MOH 1 CEO of Comprehensive Health and Education Forum International Islamabad 1 Migration Officer from the Department of Migration Islamabad

1.3.5 Research tool development

Design, pre-testing and training

The research tools were developed by the Regional Researcher, based in Dhaka, Bangladesh, in consultation with the IOM teams in the Regional Office for Asia and the Pacific in Bangkok, and in the Country Offices in Pakistan, Nepal and Bangladesh. Field researchers were recruited in Pakistan. The field researchers translated the tools into Urdu and Pashto languages. Pre-testing of the questionnaire was conducted in Peshawar and Lower Dir Districts to assess its validity and to determine the appropriateness of the translation and database design. Pre-testing was conducted in several households of returnee migrants and at recruitment centres with departing migrants in selected sample areas. The questionnaire was finalized based on the results of this piloting.

A three-day training session for field researchers was conducted prior to the data collection period. The training included both theoretical and practical sessions, as well as detailed discussions on each question in the questionnaire. Mock interviews and FGD sessions were also held during the training.

1.3.6 Data collection

Six study teams were deployed to the field for quantitative data collection, consisting of four enumerators and one supervisor each. Two student teams were deployed for the qualitative field data collection, and each team consisted of a supervisor, interviewer and note taker. Care was taken to ensure interviews were conducted in privacy and proper rapport was established with respondents. In some cases, repeated visits were required to break down barriers. Twenty per cent of the quantitative interviews were supervised and incomplete surveys were re-done where possible.

A central data collection coordinator supervised the overall data collection activities. The National Consultant was responsible for organizing logistics for the survey teams and quality control teams under his/her jurisdiction. He also implemented the overall monitoring and supervision of fieldwork. Comprehensive records were kept in a computerized database which differentiated between individual field researchers to enable effective monitoring and field management. The IOM Data Protection Principles and Research Guide were provided to the National Consultants for their ready reference.

1.3.7 Data management and analysis

Quantitative data

Field supervisors coded the questionnaires and entered data using Microsoft Excel. 30 per cent of the completed questionnaires were checked and validated. Data was then transferred into SPSS, cleaned, labelled, and checked for internal consistency. Data analysis consisted of basic cross tabulations to create frequency tables and graphs. Differences between returnee and departing migrants, age groups, and professions were presented where appropriate. In some cases, statistical methods, including Chi-square tests and logistic regression, were used for bivariate and multivariate analysis.

Qualitative data

Interviews were transcribed and translated prior to analysis. The material was then explored thematically, and trends were identified according to specific categories. Categorization and sub-categorization of data was continued until all relevant themes were identified and labelled. Standard and systematic qualitative data analysis techniques were carried out, such as grounded theory or

content, narrative or comparative analysis. The framework of analysis and codes for the qualitative findings were provided by the Regional Researcher, and analysis was carried out manually.

1.3.8 Ethical considerations

Ethical approval was sought from the Health Service Academy under Ministry of National Health Services Regulation and Coordination in Pakistan. Informed consent, through a generic form incorporated at the beginning of all study tools, was sought from all study participants before participating in data collection. The study team also followed WHO and UNAIDS guidelines for generating data on HIV/AIDS and other infectious diseases (UNAIDS, 1997).

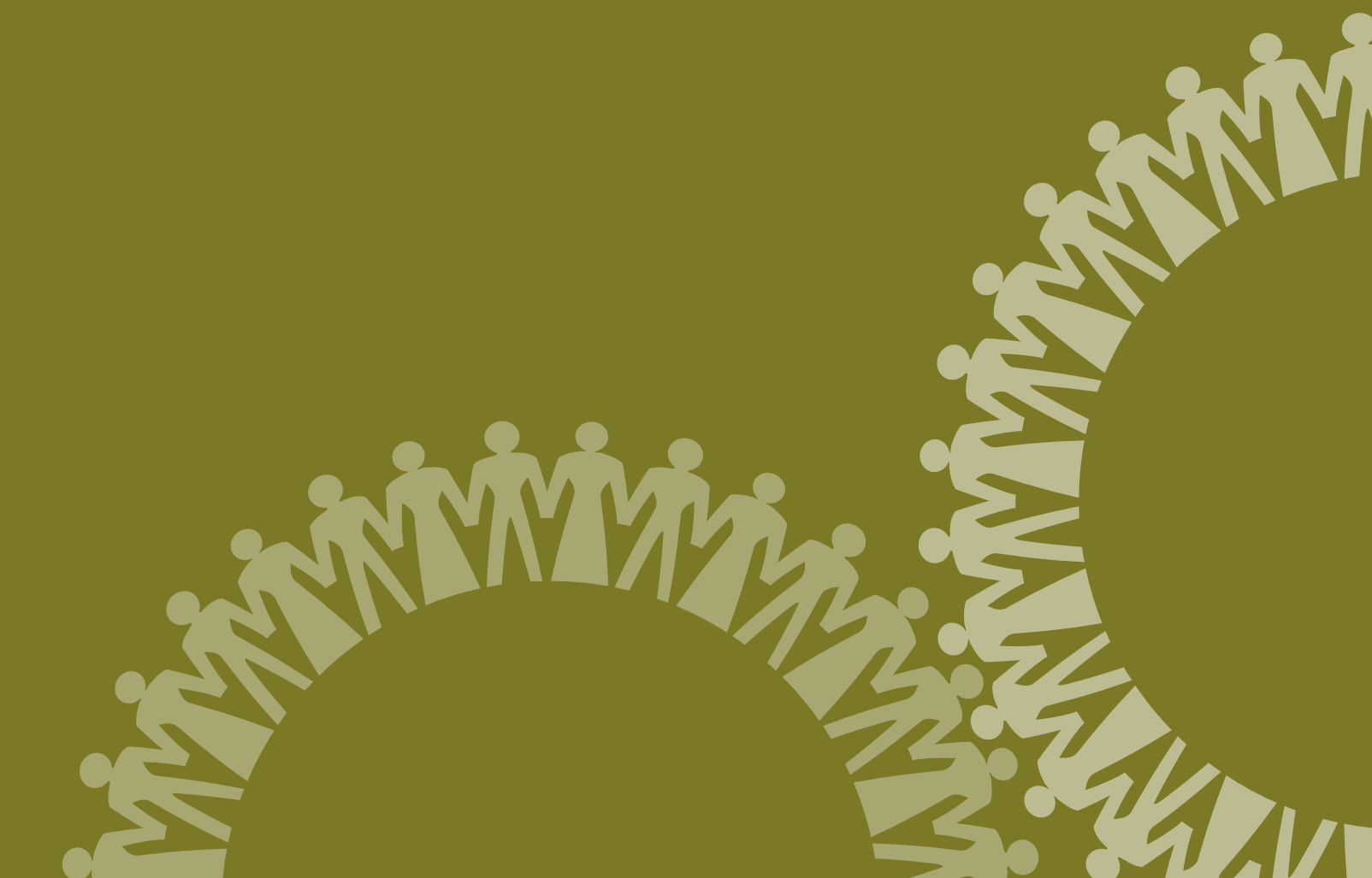
1.3.9 Study limitations

There were various obstacles that prevented access to departing migrants, which limited the recruitment of the desired number of respondents. It was also very difficult to find female migrants, and the findings are thus not necessarily representative of the migration experience of women in Pakistan. Furthermore, this study does not capture the experiences of undocumented migrants from Pakistan while living abroad.

There is risk of response bias, particularly with regard to sensitive topics such as sexual behaviour. Some variables missed more than 20 per cent of responses. The lack of discussion and probing in the quantitative survey poses a limitation, and indicators concerning the health knowledge of respondents, for example, may be underestimated.

CHAPTER TWO

LITERATURE REVIEW



2.1 LABOUR MIGRATION IN PAKISTAN

Pakistan has a population of approximately 190 million making it the seventh most populous country in the world (CIA, 2014). From 1971 to 2013, over 7 million Pakistani migrant workers have sought employment abroad through the Bureau of Emigration, 96 per cent of which have migrated to countries in the Gulf Cooperation Council (ILO, 2014). In 2013, a total of 609,478 individuals migrated to the top six receiving countries, Saudi Arabia, United Arab Emirates, Oman, Bahrain, Qatar and Kuwait (ILO, 2014). A further 3.5-4.0 million Pakistanis are thought to migrate per year, often temporarily, through undocumented channels (UNDP, 2010).

Approximately 63 per cent of Pakistan's migrating population is below the age of 25 years (CARAM Asia, 2007). Labour migration out of Pakistan predominately involves unskilled male workers, the majority of whom work in construction. According to UN DESA (2013), within Asia, 42 per cent of migrants are women. In Pakistan, however, women only constitute 0.12 per cent of the total migrant population; women seeking employment abroad are typically skilled, taking up professions such as health, finance, beauty, and fashion design in developed countries. Religious and social values, however, prevent women from taking advantage of opportunities abroad in occupational sectors that require less or no skill (ILO, 2014). The Government of Pakistan encourages the migration of women abroad for foreign employment in any sector. This highlights an area for substantial growth and improvement.

Remittances are a major pull factor for migration out of Pakistan, amounting to USD 17 billion in 2014 (World Bank, 2014), approximately 6.7 per cent of the GDP (World Bank, 2013). Costs to send remittances have been declining, making it more feasible for migrants sending remittances back to their country of origin. In Pakistan in 2013, remittances increased by 16.6 per cent and remittance rates are expected to continue to grow robustly, especially in South Asia.

2.2 HEALTH SYSTEM IN PAKISTAN

Pakistan operates a multi-tiered, mixed health system. It consists of public and private providers including NGOs. The health system at federal level is highly fragmented following the dissolution of the Ministry of Health and the downgrade of responsibilities to the provincial Departments of Health.

Pakistan allocates only 3.1 per cent of gross domestic product (GDP) to health expenditure (World Bank, 2012). As a result of underfunding of public facilities, many are obligated to rely upon health care provided by the private sector, which operates largely for profit and charges high fees for consultations and medication (Rehman et al., 2014; Shaikh et al., 2011).

In Pakistan there also exist large disparities between provision of health services in urban and rural settings. Shortage of health-care staff such as health managers, nurses, paramedics and skilled birth attendants in rural areas highlight a strong imbalance in health resource allocation.

2.3 HEALTH VULNERABILITIES OF PAKISTANI MIGRANT POPULATIONS

Migrants often work in environments that expose them to risk factors for communicable and non-communicable diseases. The combination of migrant status and belonging to an ethnic minority has also been frequently associated with impaired health and poorer access to health services

(WHO, 2010a). Furthermore, migrants are more exposed to social disadvantage and exclusion and face a multitude of barriers to accessing health care (WHO, 2010b). Due to their frequent mobility and lack of legal status, language barriers, as well as cultural and religious factors access to health services is often difficult, inconsistent or unavailable. Vulnerabilities experienced by migrants are also related to factors such as gender, age and ethnicity (WHO, 2010b).

Migrants from Pakistan are predominantly male under the age of 25 years. This population is typically illiterate with minimal knowledge of pertinent health issues (CARAM Asia, 2007). Furthermore, the poor and often exploitative conditions under which migrants travel, live and work increase their risk of exposure to infectious diseases such as HIV and Tuberculosis (TB) (UNDP, 2008).

HIV in Pakistan manifests as a concentrated epidemic among key populations, including injecting drug users, men who have sex with men and sex workers (Khan and Khan, 2010). Migrants have also been found to be a group at risk of heightened HIV prevalence. This can be linked to the typical demographics of Pakistani migrants who are primarily young unskilled males with a low knowledge of HIV, STIs or the importance of safe sex practices (AIDS Data Hub, 2009). Separation from spouses and family increases the vulnerability of migrant men to engage in risk taking behaviours, such as purchasing commercial sex. In a 2008 study conducted by UNDP found that 86 per cent of respondents had limited or no knowledge of safe sex practices and 82 per cent of migrants had sexual relations with female sex workers during their period of migration. At the time of publication, Pakistan has no policy regarding HIV/AIDS and migrants.

Pakistan is also a high Tuberculosis-burden country, with an estimated TB incidence of 231 per 100,000 population and a case detection rate of 64 per cent for all types of TB (WHO, 2013). In Pakistan, health efforts are continually hampered by weak health programming, socioeconomic inequities in access to services, natural disasters, social resistance, recent controversies surrounding health interventions, and conflict.

Furthermore, the migration process can impact the mental health of migrants. In a study of Pakistani migrants in Canada, it was found that negative mental health outcomes were associated with high levels of acculturative stress, lower sense of coherence and low perceived social support, among others (Jibeen and Khalid, 2010).

2.4 POLICY AND MIGRATION HEALTH IN PAKISTAN

While the Emigration Ordinance was adopted in Pakistan in 1979, it was not until 2010 that a National Migration Policy was formed. In 2008, the Ministry of Overseas Pakistanis was also formed in an effort to streamline migration-focused initiatives and improve services for overseas Pakistanis, including housing, education and health-care schemes, and facilitate the rehabilitation of returnee migrants. According to Emigration Rule 27, all workers recruited for employment abroad are required to receive a pre-departure orientation and briefing along with the overseas employment promoter or authorized representative. Additionally, any individual travelling to Gulf Cooperation Council (GCC) countries on a work visa is required to undergo a mandatory health examination and be certified as medically fit by one of the 20 GCC-Approved Medical Centres Association (GAMCA) screening centres in Pakistan. However, in a UNDP study of migrant women to Arab States, 83 per cent of respondents did not undergo pre-departure orientation from any government department (UNDP, 2008).

Within South Asia, Pakistan is the second largest migrant sending country making necessary sound and effective migration policy that supports overseas workers, especially women and youth (ILO, 2014). Pakistan has yet to ratify important migration related conventions such as the ILO Conventions 97 and 143. Furthermore, Pakistan has also yet to establish effective migration policy that addresses issues related to migrants' health. Failure to establish and implement policy addressing migrants' issues makes the position of migrants even more precarious and potentially jeopardizes general public health in Pakistan.

CHAPTER THREE

STUDY FINDINGS

3.1 QUANTITATIVE RESEARCH

3.1.1 Characteristic of study population

Demographic profile

In this study, 400 migrant respondents (200 departing, 200 returnee) were interviewed for the quantitative survey. Only five female respondents were interviewed. More than 80 per cent of respondents were under 35 years of age, and approximately half of those sampled were married. The majority of respondents had acquired some form of education. 18.5 per cent had a primary level education, 29 per cent of respondents had acquired secondary school education and nearly 20 per cent had tertiary level education. A quarter had no history of formal education (Table 2).

Table 2: Study population demographics

	Total		Departing		Returnee	
	%	n	%	n	%	n
Gender						
Men	98.8%	395	99.0%	198	98.5%	197
Women	1.3%	5	1.0%	2	1.5%	3
Age						
Less than 25	35.0%	140	47.5%	95	22.5%	45
25 to 35	46.3%	185	39.5%	79	53.0%	106
36 to 50	16.0%	64	13.0%	26	19.0%	38
Above 51	2.8%	11	0.0%	0	5.5%	11
Marital status						
Never married	47.3%	189	53.0%	106	41.5%	83
Married	50.8%	203	45.0%	90	56.5%	113
Widowed/ Divorced/ Separated	2.0%	8	2.0%	4	2.0%	4
Education						
No formal education	25.2%	101	26.0%	52	24.5%	49
Below primary	7.5%	30	6.0%	12	9.0%	18
Primary	18.5%	74	14.5%	29	22.5%	45
Secondary	29.0%	116	29.0%	58	29.0%	58
College/university	19.8%	79	24.5%	49	15.0%	30
Literacy among those with primary education or less (ease of letter-writing)						
Easily	38.1%	85	37.6%	41	38.6%	44
With difficulty	48.0%	107	51.4%	56	44.7%	51
Not at all	13.0%	31	11.0%	12	16.7%	19
Number of people in family						
1 to 3	7.8%	31	6.0%	12	9.5%	19
4 to 6	26.5%	106	28.5%	57	24.5%	49
Above 6	65.8%	263	65.5%	131	66.0%	132
Total		**400**		**200**		**200**

The median income amongst all migrants was just under 20,000 PKR (approx. 200 USD), and the most common profession was Labourer (32%), followed by construction worker (20%), technician (18%), domestic worker (10%), and agricultural worker (6%). Fifteen per cent of migrants worked in other unspecified occupations. Although nearly two thirds of migrants had a family size of more than six people, 95 per cent had three or fewer earning members in the family.

Migration profile

The Middle East was the intended destination region for 77 per cent of departing migrants, and the most recent region of work for 85 per cent of returnee migrants. 30 per cent of departing migrants named the United Arab Emirates as their destination of choice, followed by 25 per cent of respondents intending to migrate to Saudi Arabia. 39 per cent of returnees were returnees from the United Arab Emirates; 19.5 per cent were returnees from Saudi Arabia.

The most frequently stated planned and actual time spent abroad was between one and two years (48% of departing and 39% of returnee migrants respectively), however returnee migrants appeared to spend slightly more time abroad than departing migrants intended to (Table 3) (p=0.042).

Table 3: Planned and actual time spent abroad for work, as % of departing and returnee migrants

	Departing		Returnee	
	%	n	%	n
Time spent abroad	**Planned**		**Actual**	
Up to 12 months	18.5%	37	17.0%	34
12 to 24 months	48.0%	96	38.5%	77
24 to 48 months	21.0%	42	25.0%	50
More than 48 months	12.5%	25	19.5%	39

Relatives (48%) and friends (31%) were the main sources of assistance during the pre-departure phase, 20 per cent of respondents relied upon themselves for support and twelve per cent received support from recruitment agencies (Figure 1). There was little difference between departing and returnee migrants.

Migrants faced many challenges throughout the migration process. The most frequently mentioned challenge was arranging finances for migration (75.5% of respondents), followed by bribes to the authorities (20%). Also mentioned were facing discrimination (11%) and abuse (7%), and completing the health examination (4%) (Figure 2). More departing migrants than returnees indicated that they faced no challenges throughout the migration process, however, this difference was minimal (11% versus 13% respectively).

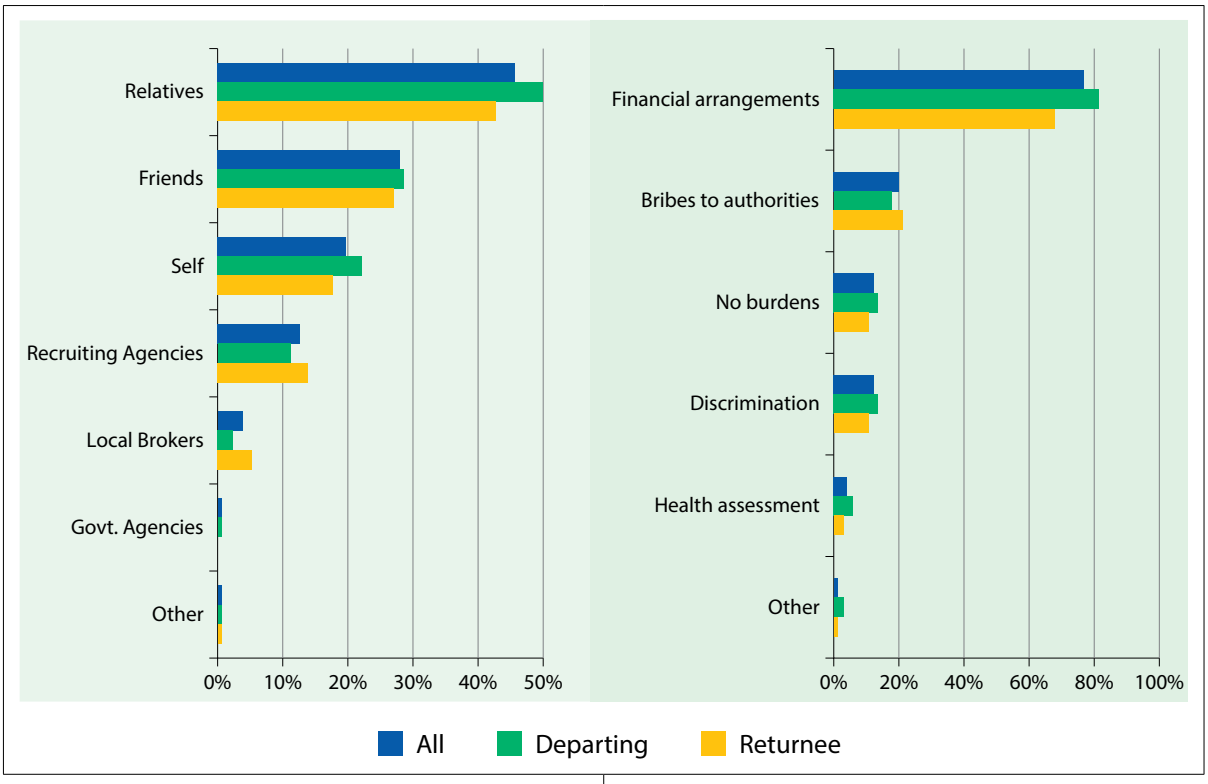


Figure 1: Sources of assistance during the pre-departure migration process, as percentage of departing and returnee migrants who specified each source

Figure 2: Burdens during the pre-departure migration process, as percentage of departing and returnee migrants who specified each burden

As for the reasons for return, personal reasons was the most frequently specified reason for return (38% of returnee migrants), followed closely by coming for leave (33%) and the end of contract (17%). Personal reasons and leave were the only ones reported by the three female respondents. The majority (76%) of returnee migrants reported having completed two to three trips abroad, and 81 per cent expressed their intention to work abroad again. See Table 4 for full details.

Table 4: Reasons for return and history of mobility among male and female returnee migrants

	Total		Men		Women	
	%	n	%	n	%	n
Reasons for return						
Personal reasons	37.5%	75	37.6%	74	33.3%	1
Coming for leave	33.0%	66	32.5%	64	66.6%	2
End of contract	16.5%	33	16.8%	33	0	0
Pushed back (deported)	5.0%	10	5.1%	10	0	0
Political unrest	4.5%	9	4.6%	9	0	0
Early termination of contract	3.5%	7	3.6%	7	0	0
Other	2.0%	4	4.6%	4	0	0
Number of past trips for work abroad						
2 – 3 times	77.5%	155	77.2%	152	100.0%	3
4 – 5 times	15.0%	30	15.3%	30	0.0%	0
More than 5 times	7.5%	15	7.6%	15	0.0%	0

	Total		Men		Women	
	%	n	%	n	%	n
Intention to work abroad again						
Yes	80.5%	161	80.2%	158	100.0%	3
No	19.5%	39	19.8%	39	0.0%	0
Total		**200**		**197**		**3**

3.1.2 Health risks and vulnerabilities

Health profile and health-care seeking behaviour

In the survey, 96 per cent of all migrants reported to ever have fallen ill, and 42 per cent had fallen ill in the past six months. Almost all (90%) of returnee migrants had been sick in the country of destination, including all three women that were included in the sample. The most frequently experienced illnesses whilst abroad consisted of minor health problems (27%), followed by hypertension (21%) and mental illnesses (17%) (Figure 3); 38 per cent of respondents who had been ill did not specify the type of illness.

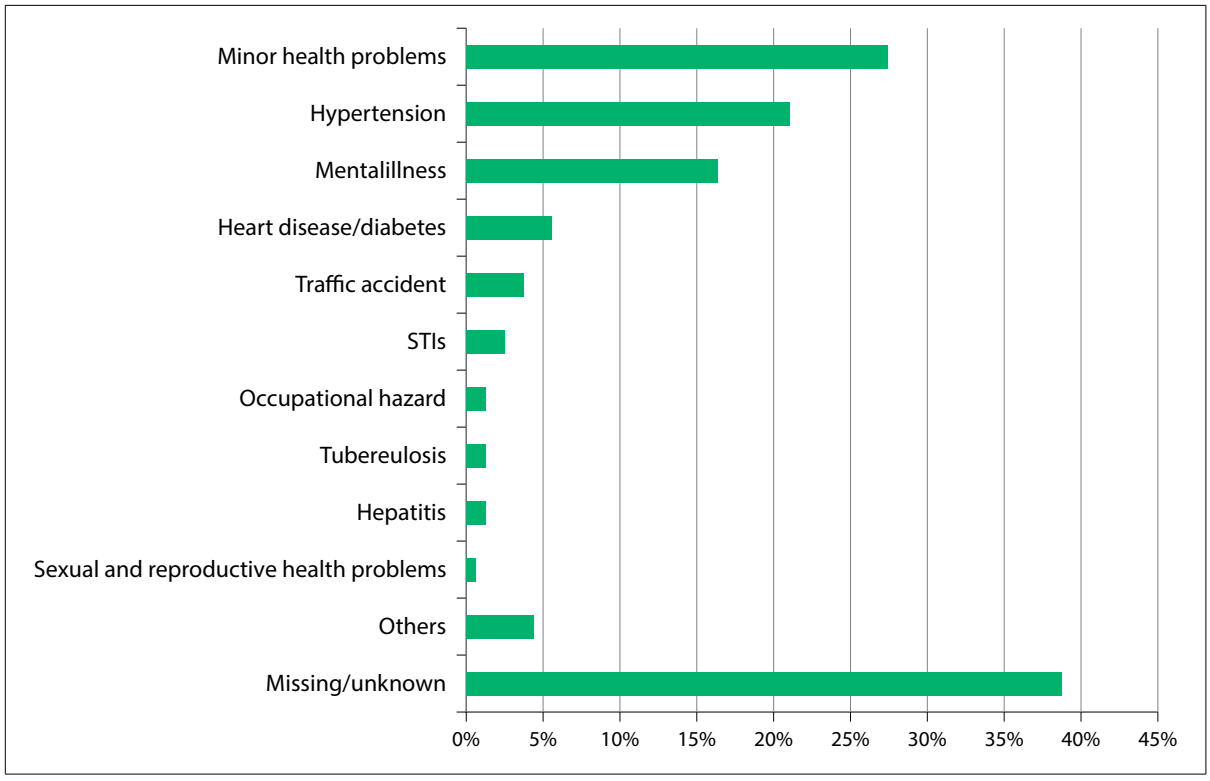


Figure 3: Illnesses experienced in the destination country, as % of returnee migrants who fell ill

When asked about specific conditions, occupational hazards and mental health problems were reported by 23 per cent and 19 per cent of returnee migrants respectively. Occupational hazards appeared particularly common among those working in agriculture. Only five respondents reported a history of STI, all male respondents.

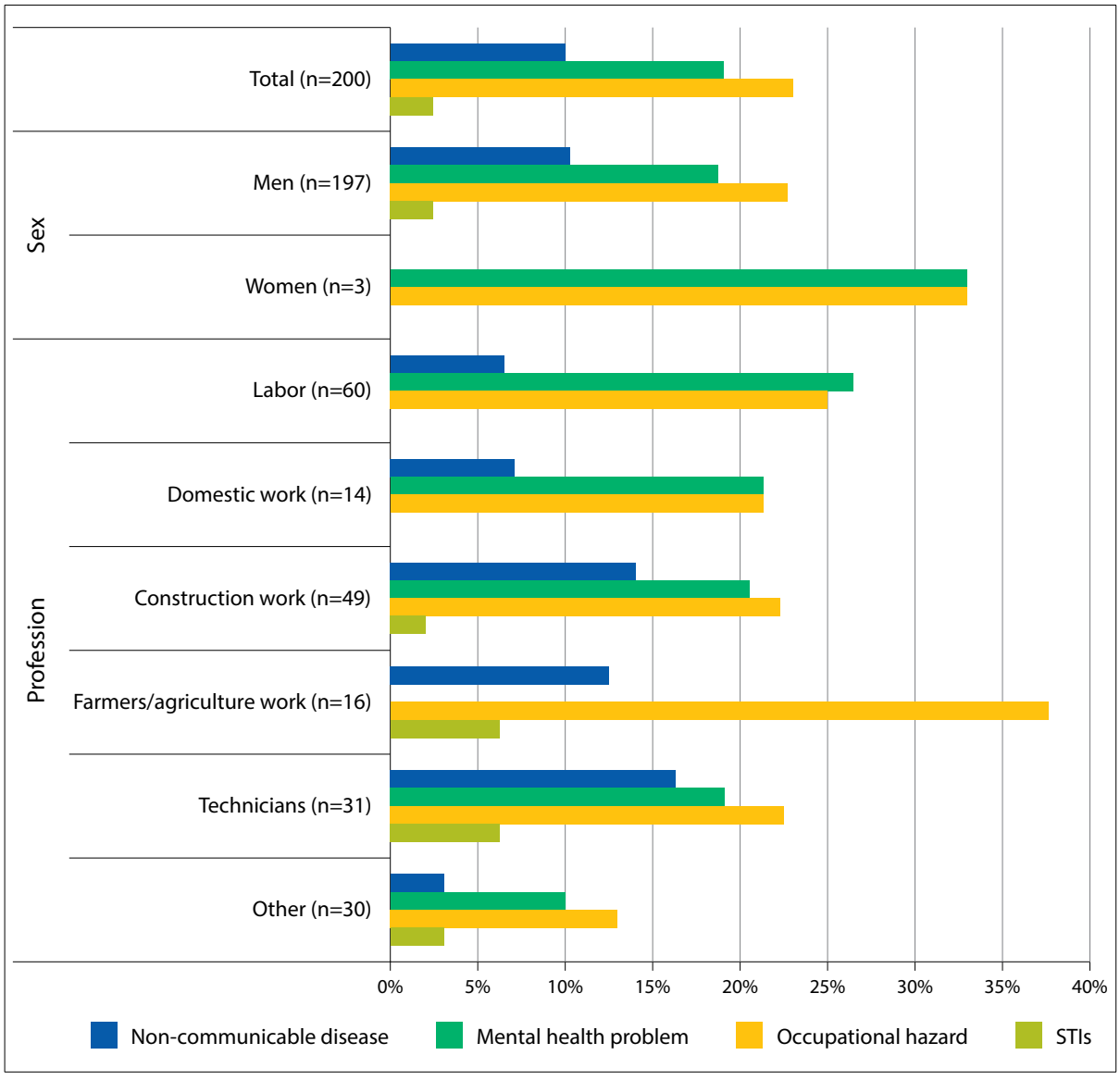


Figure 4: Per cent of migrants who have a history of a non-communicable disease, mental illness, occupational hazard, or STI, by sex and profession

Health-care seeking was over 85 per cent for STIs, occupational hazards, and mental health problems. Twenty per cent (4 of 20) had sought health care due to a non-communicable disease (Figure 4). Of those that did seek advice or treatment, half approached health providers and a quarter mentioned seeking advice from friends or relatives. Less frequently mentioned were shops or pharmacies, traditional healers, and employers.

Sexual Behaviour and condom use

Condom use appears to be highest during sex with a casual acquaintance or sex worker, with 29 and 23 per cent of respondents respectively reporting always using a condom (Figure 5). Condom use with a spouse was inconsistent. However, due to the high proportion of missing responses, particularly among those who had reported sex with a spouse or friend in the last six months, comparing condom use between partners is difficult.

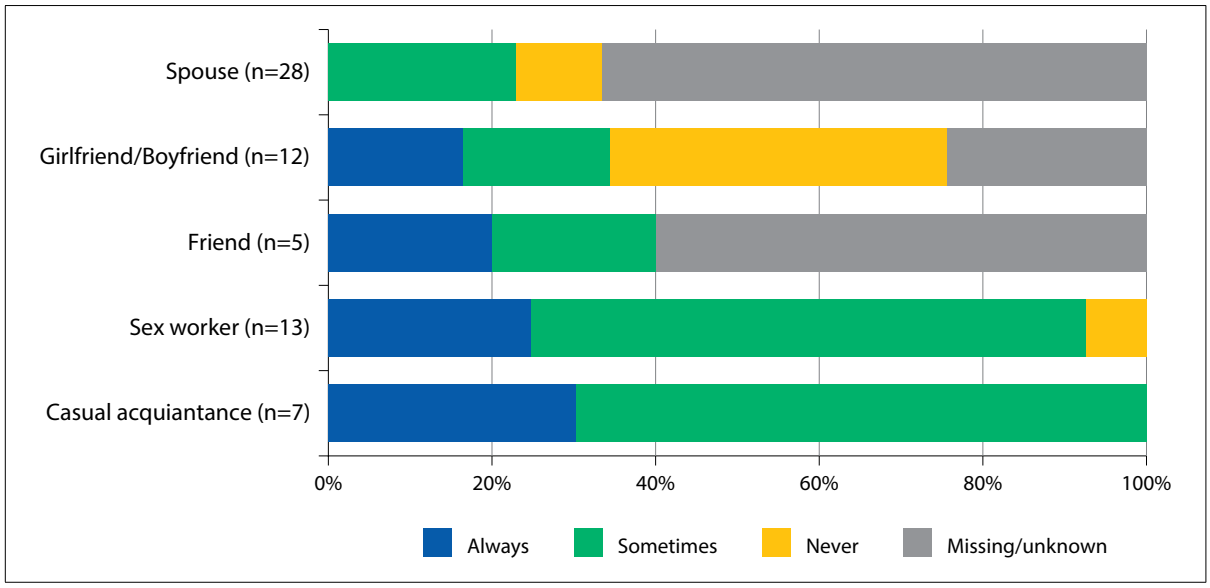


Figure 5: Respondents that always, sometimes, and never use condoms when having sex with specific partners, among those who had been sexually active in the past 6 months

There is some indication that reasons for condom use differed depending on the type of sexual partner. For example, five out of six of respondents who reported always or sometimes using a condom with a spouse gave pregnancy prevention as the primary reason; in the same category no respondents indicated condom use for the purpose of preventing sexually transmitted infection (Table 5). Among those respondents who reported sexual intercourse with a sex worker, prevention of STIs or HIV was the primary reason for condom use. This data however is not conclusive as there were low responses in all categories, and furthermore, this question was not asked to those who had sex with a girlfriend or boyfriend.

Table 5: Reasons for condom use among those who reported 'always' or 'sometimes' using a condom in the past 6 months, by partner type

	Spouse		Friend		Sex worker		Casual acquaintance	
Prevent pregnancy	83.3%	5	50.0%	1	25.0%	3	0.0%	0
Prevent STI/STD	0.0%	0	0.0%	0	41.7%	5	0.0%	0
Prevent HIV	0.0%	0	50.0%	1	83.3%	10	14.3%	1
N/A	16.7%	1	0.0%	0	8.3%	1	0.0%	0
Missing/unknown	0.0%	0	0.0%	0	0.0%	0	85.7%	6
Total		6		2		12		7

Trust in one's partner was the most common reason reported for not using a condom at last sexual intercourse (57%) (Figure 6). Poor condom availability, lack of knowledge of condoms, partner preference, and lack of preparation prior to sexual intercourse were also cited reasons.

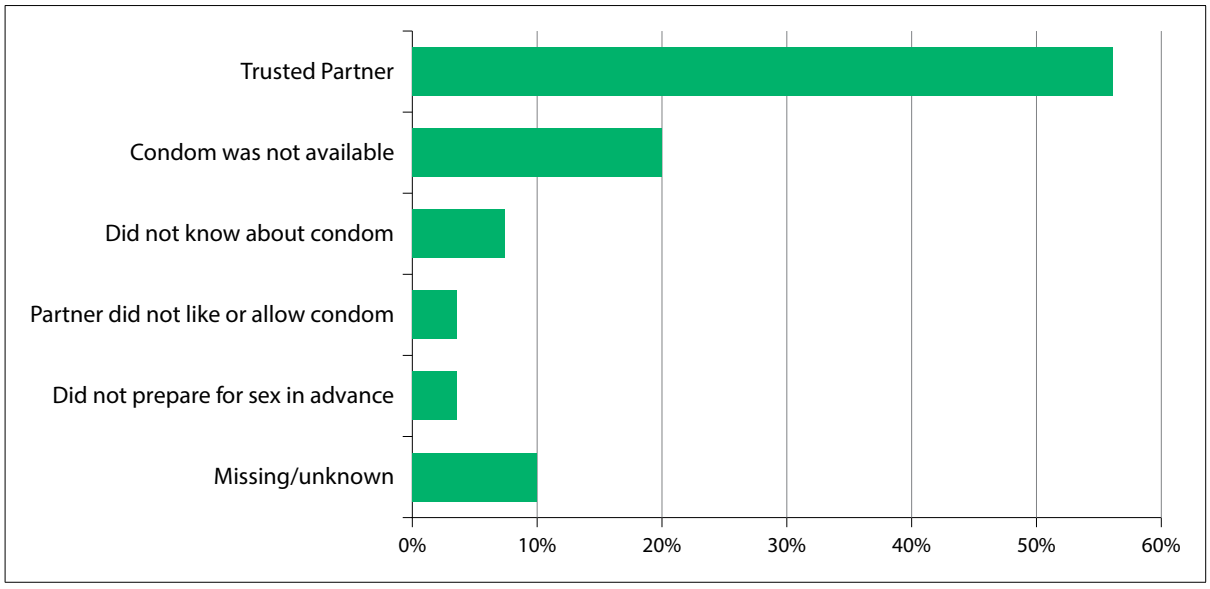


Figure 6: Reasons for not using a condom

About 16 per cent of returnee migrants report having sex in the country of destination; the majority had between two and five sexual partners. Commercial sex workers were the most frequently reported partner type, followed by girlfriend/boyfriends, friends, and casual acquaintances (Figure 7).

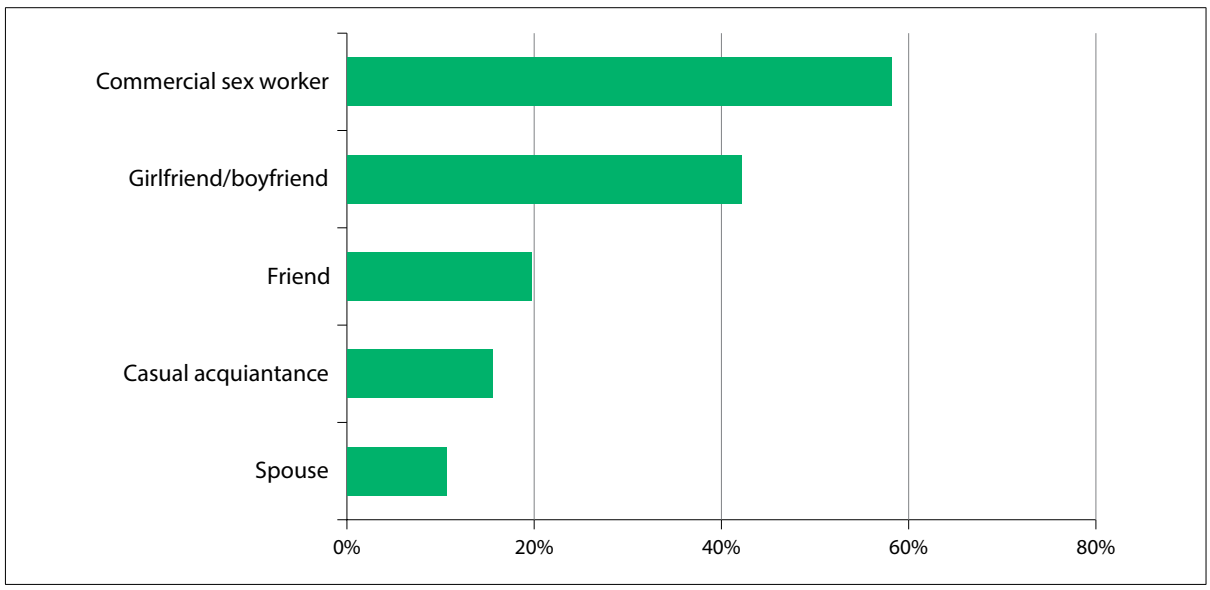


Figure 7: Sex partners in the country of destination (n=31)

Spouses were the least common sex partners among returnees, identified by only three of 31 migrants that had sex in the country of destination. Condom use at last sexual intercourse was highest with spouses and commercial sex workers (>60%), followed by casual acquaintances and friends. Data pertaining to condom use with girlfriend/boyfriend was not recorded (Figure 8).

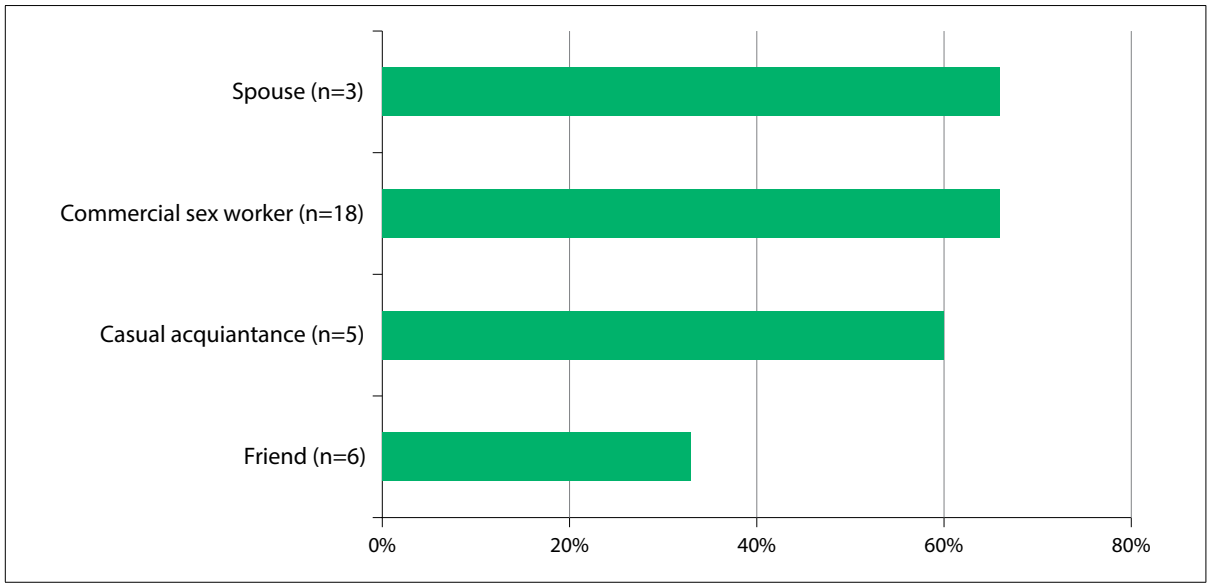


Figure 8: Returnee migrants who used a condom at last sex in the country of destination country (n=31)

Sexual violence in country of destination

Only 4 per cent of returnee migrants reported a history of forced sex, although 17 per cent of migrants knew of peers who had been victims of sexual abuse in the country of destination. Among them, the most commonly identified perpatrators were recruitment agents, followed closely by colleagues. Friends and employers were also mentioned.

Substance abuse

Twenty-three per cent of respondents reported having used drugs in the past twelve months; alcohol and hashish were the main substances used. Patterns were very similar among departing and returnee migrants. Of those who had history of drug use, 8.6 per cent (n=8) had injected drugs.

3.0.3 Knowledge of health risks and prevention including HIV/AIDS

General health knowledge

Fifty-five per cent of returnee migrants believed that diseases can be transmitted from migrants to partners and other family members. Of these respondents, 90 per cent identified HIV/AIDS as an example; just over 50 per cent identified Tuberculosis, and roughly 40 per cent identified STIs and malaria.

HIV/AIDS knowledge

When asked specifically about HIV/AIDS, just under two thirds had heard of HIV, while 74 per cent were familiar with AIDS. Of those who had heard of AIDS, over 90 per cent were aware that HIV could be transmitted through unprotected sex and from sharing needles. Far fewer respondents were aware of mother-to-child transmission, particularly via breast-feeding. More than 55 per cent identified sex with a commercial sex worker as a risk factor for HIV transmission (Figure 9). There were few reports of HIV misconceptions, save for the false belief that sharing a toilet with an HIV positive person is a method of disease transmission.

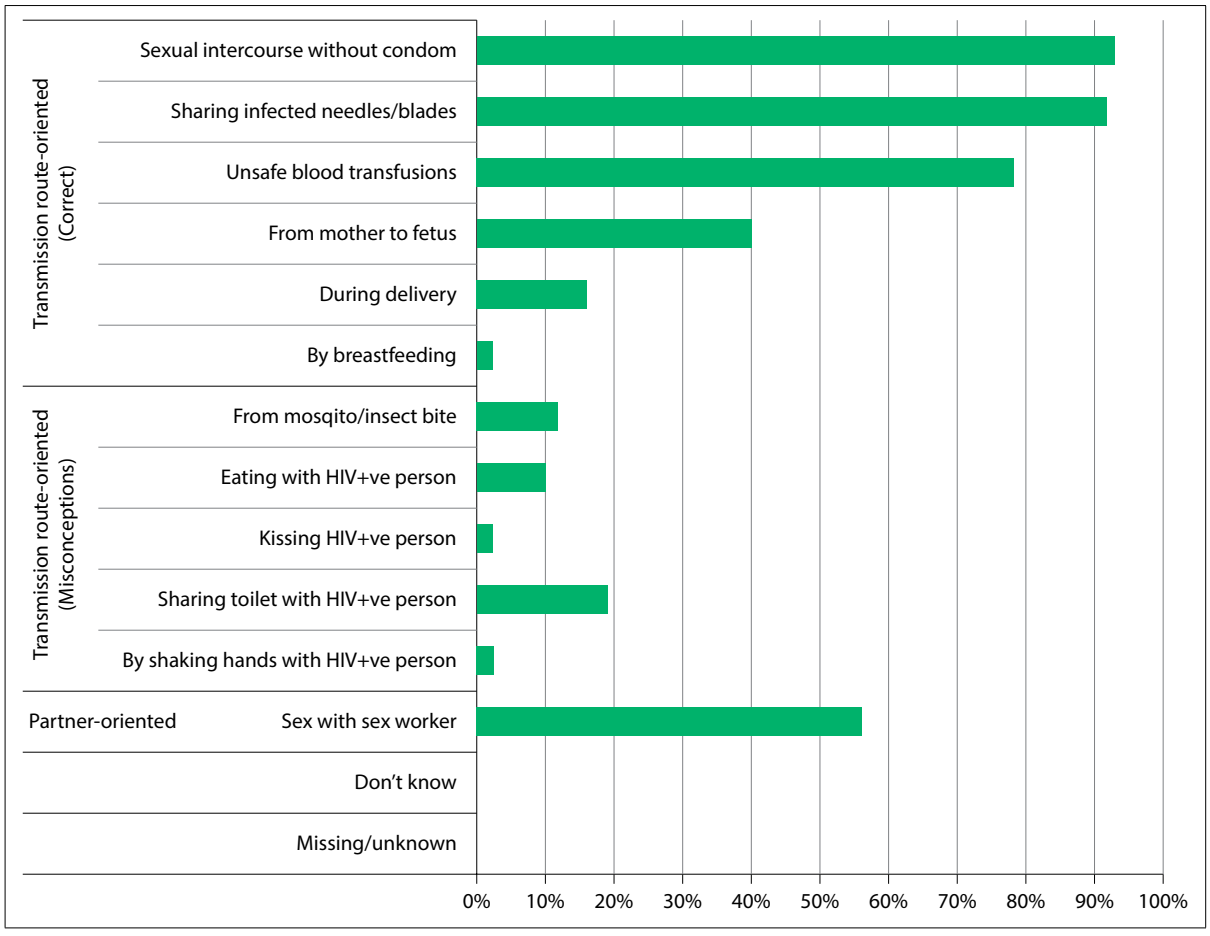


Figure 9: Reported causes of HIV transmission, among migrants familiar with AIDS

Perceived risk of contracting infectious diseases

The majority of migrants perceived themselves to not be at risk of Tuberculosis, HIV, STIs or Hepatitis C. However, approximately a third of migrants reported not knowing their risk, which suggests poor understanding of these diseases. Testing history was below 40 per cent for Tuberculosis, around

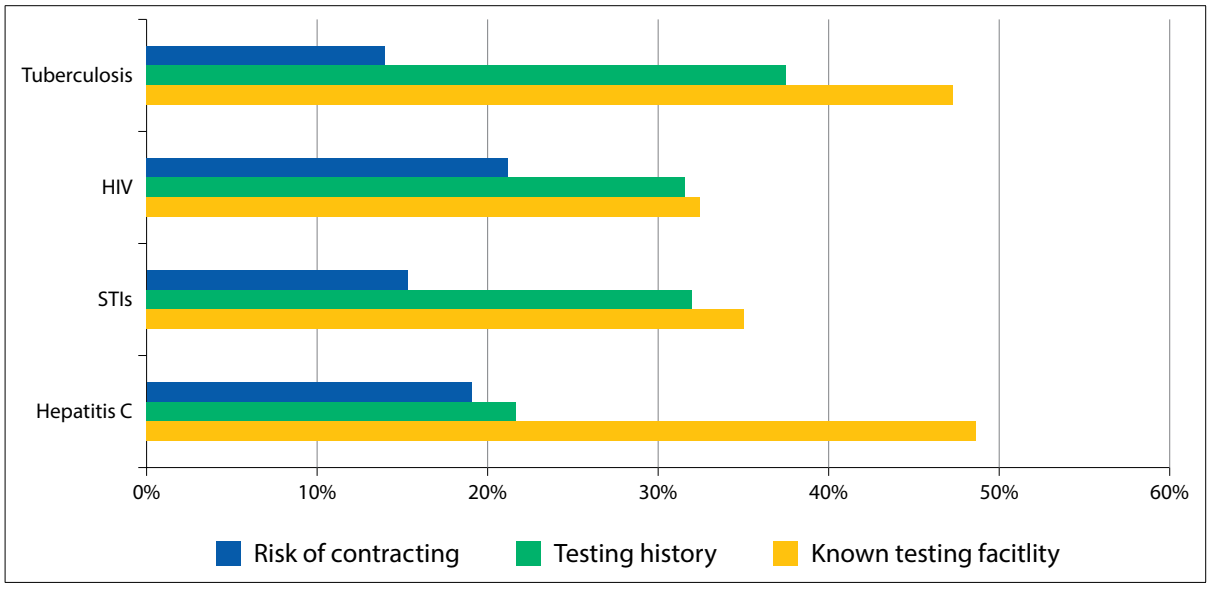


Figure 10: Perceived risk, test history and knowledge of testing facilities for Tuberculosis, STIs, HIV and Hepatitis C (n=200)

30 per cent for HIV/STI and just above 20 per cent for Hepatitis C. About a third of respondent knew where to receive HIV/STI testing, and less than half of respondents were aware of facilities that performed Hepatitis C and Tuberculosis testing (Figure 10).

Pre-departure health orientation

Only 5 per cent of migrants (3% of departing; 8% of returnees) had received a pre-departure health orientation (Figure 11). More migrants with farming or agricultural occupations reported receiving a pre-departure health orientation.

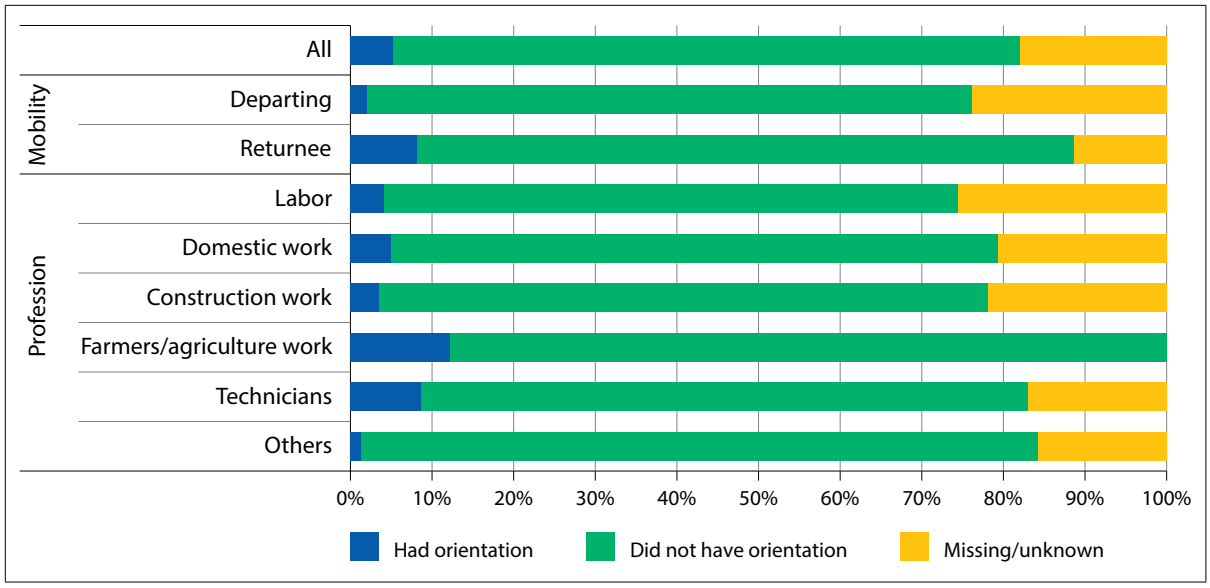


Figure 11: Respondents who received a pre-departure health orientation, by mobility and profession

Orientations most often covered general health, cited by 57 per cent of migrants who attended an orientation, followed by HIV/AIDS (48%), physical abuse and exploitation (38%), as well as occupational hazards (33%) (Table 6). Employers or recruitment agencies were the primary providers of pre-departure health orientations (52%), followed by government organizations (23%).

Table 6: Health topics discussed during health orientations, as % of all, male and female migrants who underwent a health orientation

	Total (n=21)		Men (n=6)		Women (n=15)	
	%	n	%	n	%	n
General health*	57.1%	12	66.7%	4	53.3%	8
HIV/AIDS*	47.6%	10	50.0%	3	46.7%	7
Physical abuse and exploitation*	38.1%	8	50.0%	3	33.3%	5
Occupational hazards	33.3%	7	0.0%	0	46.7%	7
TB*	33.3%	7	33.3%	2	33.3%	5
Rights of migrants**	28.6%	6	16.7%	1	33.3%	5
Sexual harassment**	23.8%	5	33.3%	2	20.0%	3
STIs**	14.3%	3	16.7%	1	13.3%	2
Mental health**	9.5%	2	0.0%	2	13.3%	2

*More than 20% missing data. **More than 50% missing data.

3.0.4 Accessibility and perceived quality of health services and health seeking behaviour

Health-care seeking behaviour

Of those migrants who had a history of illness in Pakistan, 70 per cent had sought health care during their last episode of illness. The majority (62%) of those who sought health care had visited a public health-care provider, 44 per cent sought care from a private health-care provider and 12 per cent from a traditional healer. Village quacks, shops, pharmacies, friends or relatives, and homeopaths were sparsely mentioned (<4% each) (Table 7).

Table 7: History of health-care seeking and health providers

	Total		Men		Women	
	%	n	%	n	%	n
History of illness in Pakistan						
Yes	95.8%	383	96.2%	380	60.0%	3
No	4.3%	17	3.8%	15	40.0%	2
Total		400		395		5
History of health-care seeking among those with history of illness in Pakistan						
Yes	70.0%	268	69.7%	265	100.0%	3
No	30.0%	115	30.3%	115	0.0%	0
Total		**383**		**380**		**3**
Location of medical consultation among those who have sought health care in Pakistan						
Public health provider	61.9%	166	61.5%	163	100,0%	3
Private health provider	44.0%	118	44.5%	118	0.0%	0
Traditional healer	11.9%	32	11.7%	31	33.3%	1
Village quack/ shop/ pharmacy	3.4%	9	3.0%	8	33.3%	1
Friends/ relatives	2.6%	7	2.6%	7	0.0%	0
Homeopathy	3.7%	10	3.8%	10	0.0%	0
Other	0.0%	0	0.0%	0	0.0%	0
Missing/ unknown	0.4%	1	0.4%	1	0.0%	0
Total		**268**		**265**		**3**

Post-arrival medical check-up

Approximately half of returnee migrants believed it necessary to have a medical check-up following return to their country of origin, however just over a quarter of returnees actually received one.

Among those who had, the majority chose to do so within three months of their return, most often at provincial and district level government facilities. A general health check-up was the most frequently reported type of health check-up received (82%), however only 46 per cent reported having an HIV test, and 20 per cent and 19 per cent reported receiving STI and TB tests respectively .

Among those who did not receive a medical check-up following return to country of origin, more than half attributed this to perceived insusceptibility. Other specific reasons included the inconvenience of the check-up (14%), un-affordability (8%), as well as inaccessibility (6%).

Health-care accessibility in Pakistan

General medical treatment was widely available in the community as identified by 77 per cent of all migrants. Other specific services, such as maternity care, dental care, optical care, and mental health services, however, were less available (Table 8).

Table 8: Health-care services available in the community, as % of all, male, and female migrants who identified each health-care service

	Total (n=400)		Men (n=395)		Women (n=5)	
	%	n	%	n	%	n
Medical treatment	76.5%	306	77.0%	304	40.0%	2
Maternity care/antenatal checks	26.5%	106	26.6%	105	20.0%	1
Dental care	25.0%	100	24.3%	96	80.0%	4
Lab tests	23.8%	95	23.3%	92	60.0%	3
Medical check-up	23.0%	92	22.8%	90	40.0%	2
Optical care	14.8%	59	14.4%	57	40.0%	2
X-ray	11.8%	47	11.6%	46	20.0%	1
Other treatment or unknown	9.3%	37	9.4%	37	0.0%	0
Mental health/psychological treatment	7.3%	29	7.3%	29	0.0%	0
Physiotherapy	4.5%	18	4.3%	17	20.0%	1
MRI	3.8%	15	3.5%	14	20.0%	1
Other	2.3%	9	2.3%	9	0.0%	0
Missing	0.0%	0	0.0%	0	0.0%	0

When questioned about specific preventative health-care services, the majority (63%) of respondents indicated that primary health care was available in their community. Maternal and child health (41%), health education (41%) and family planning (32%) were other available services mentioned (Table 9). More than 20 per cent of respondents, however, could not verify whether or not these services were actually available.

Table 9: Preventive health-care services available in the community, as % of all, male, and female migrants who identified each preventive health-care service.

	Total (n=400)		Men (n=395)		Women (n=5)	
	%	n	%	n	%	n
Health education*	41.0%	164	40.8%	161	60.0%	3
Primary health care*	63.8%	255	63.8%	252	60.0%	3
HIV/STI testing*	6.3%	25	6.3%	25	0.0%	0
Family planning*	31.3%	125	31.4%	124	20.0%	1
Maternal and child health*	41.0%	164	41.3%	163	20.0%	1

*More than 20 per cent missing data.

When asked about specific curative health services, provision of medication was the most frequently identified available service in their community, while STI management was reported as the least available. Again the response rate was below 80 per cent for these questions (Table 10).

Table 10: Curative health-care services available in the community, as % of all, male, and female migrants who identified each curative health-care service.

	Total (n=400)		Men (n=395)		Women (n=5)	
	%	n	%	n	%	n
Diagnosis*	62.5%	250	62.8%	248	40.0%	2
Surgery*	10.0%	40	9.9%	39	20.0%	1
Medicine*	64.0%	256	63.8%	252	80.0%	4
STI management*	5.8%	23	5.8%	23	0.0%	0
HIV*	42.3%	169	42.5%	168	20.0%	1

*More than 20 per cent missing data.

Both preventive and curative services were mostly provided by community government centres, followed by private services and district government centres (Table 11).

Table 11: Providers of preventive and curative health-care services in the community, as % of all, male and female migrants who identified each provider.

	Preventive services						Curative services					
	Total		Men		Women		Total		Men		Women	
	%	n	%	n	%	n	%	n	%	n	%	n
Govt. centre at community level	47%	187	47%	187	0%	0	51%	203	51%	201	40%	2
Private	39%	156	39%	154	40%	2	41%	164	41%	160	80%	4
Govt. centre at district level	36%	144	36%	141	60%	3	41%	162	40%	160	40%	2
NGO	15%	60	15%	59	20%	1	20%	81	21%	81	0%	0
Govt. centre at sub-district level	4.5%	18	4%	17	20%	1	8%	30	7%	29	20%	1
Others	1%	5	1%	5	0%	0	7%	29	7%	29	0%	0
Missing/unknown	12%	49	12%	49	0%	0	3%	12	3%	12	0%	0

Note: percentages do not add to 100% due to multiple choices

The majority of migrants faced financial difficulties accessing health care in Pakistan: 58% found health care in Pakistan to be unaffordable or difficult to afford, while 34% of migrants found health care to be easily affordable or affordable (Figure 12).

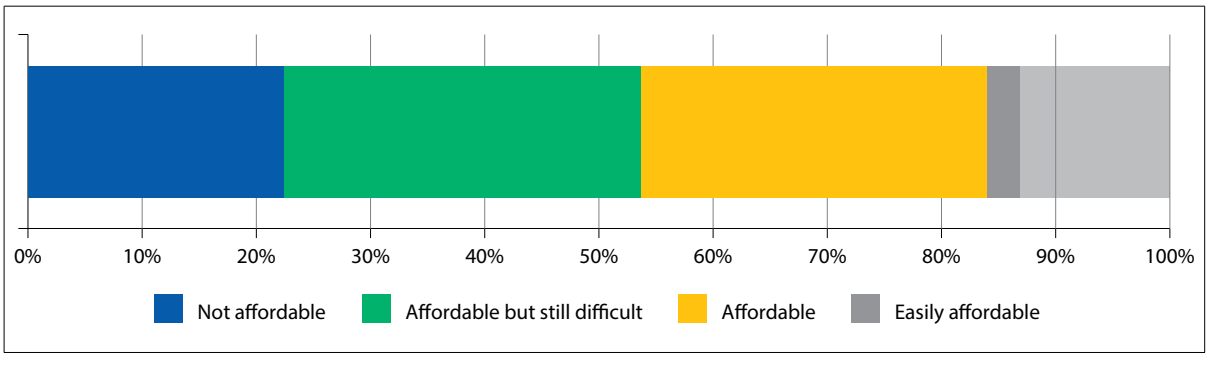


Figure 12: Perceived affordability of health-care in the community among all migrants

Sixty-four per cent of respondents felt that they could use the public health facilities any time, and expressed moderate satisfaction with health facilities in their community; 32 per cent were satisfied while 16 per cent reported they were unsatisfied.

Just over half (51%) of migrants expressed that they faced difficulties accessing health-care services, citing the unavailability of doctors (55%), unaffordable costs (52%), long distances to health-care centres (28%), and inconvenient operating times (22%) as the primary barriers (Figure 13).

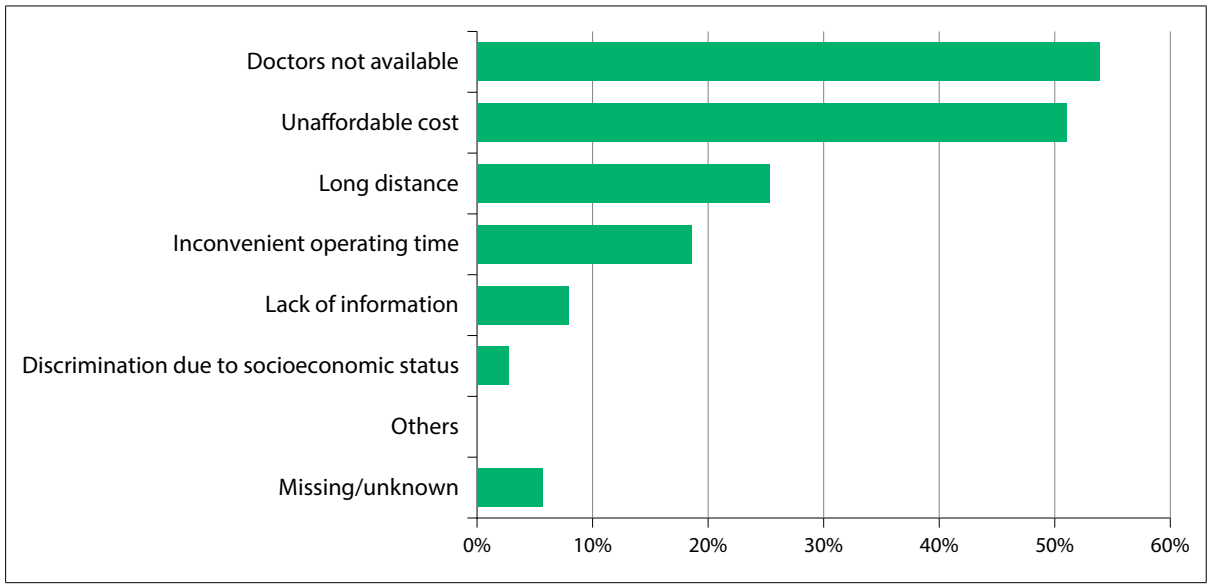


Figure 13: Main barriers faced by migrants accessing health care in the country of origin (n=202)

Health-care accessibility in the country of destination

About 75 per cent of returnee migrants perceived health-care abroad to be easily affordable or affordable, while 21 per cent found it to be unaffordable or difficult to afford. A further 6 per cent did not know or did not provide an answer (Figure 14).

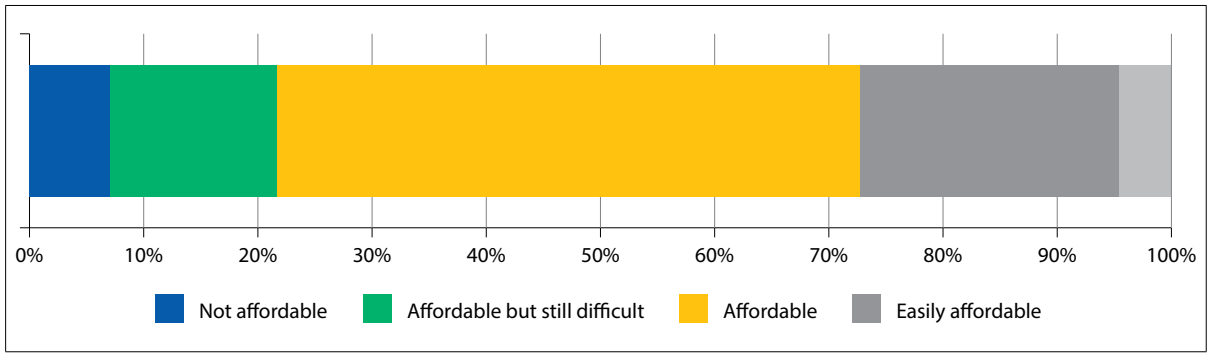


Figure 14: Perceived affordability of health care in the destination country among returnee migrants

Among those who sought health care, the most common form of health-care financing was out-of-pocket payments, with 56 per cent of migrants paying for their own health care. A further 30 per cent had their health care financed by insurance, although this is slightly under the 37 per cent of migrants who had insurance abroad. Employers fully or partly paid for 12 per cent of returnee migrants (Table 12).

Disaggregated by profession, domestic workers and labourers covered the greatest amount of health-care costs using person income (75% and 67.7% respectively). However, each employment group was small in size, which makes it difficult to draw conclusions.

Table 12: Financers of migrant health care in country of destination among returnee migrants who sought health care, by sex and profession

	Total	Fully paid by employer		Partially paid by employer		Self-paid		Insurance		Missing	
		%	n	%	n	%	n	%	n	%	n
Sex											
Men	113	8.0%	9	4.4%	5	56.6%	64	27.4%	31	3.5%	4
Women	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	100.0%	1
Profession											
Labour	31	6.5%	2	3.2%	1	67.7%	21	12.9%	4	9.7%	3
Domestic work	4	0.0%	0	25.0%	1	75.0%	3	0.0%	0	0.0%	0
Construction work	36	5.6%	2	2.8%	1	41.7%	15	50.0%	18	0.0%	0
Farmer/agriculture	10	10.0%	1	0.0%	0	60.0%	6	30.0%	3	0.0%	0
Technicians	20	10.0%	2	5.0%	1	65.0%	13	10.0%	2	10.0%	2
Other	13	15.4%	2	7.7%	1	46.2%	6	30.8%	4	0.0%	0
Total	**114**		**9**		**5**		**64**		**31**		**5**

Friends or relatives were the prominently reported sources of support or accompaniment when seeking health care abroad (68%); the second most common response was "no support or accompaniment" (14%). About 13 per cent of migrants who sought health care were supported by their employer/agency.

When asked about free services from specific providers, 47 per cent of all returnee migrants stated that they were offered free services from government centres. Less than 10 per cent stated that they had been offered free services from NGOs or private providers, however, the response rate was lower than 50 per cent for these questions.

In the study, 85 per cent of respondents felt that they could use the public health services in their destination country. About 60 per cent of returnee migrants expressed that they were very satisfied or satisfied with health-care facilities in the country of destination. Only 1.5 per cent of all migrants expressed dissatisfaction. The response rate for this question was 71 per cent. About a quarter of all returnee migrants expressed that they had faced difficulties accessing health care in the destination country. Among these individuals, the primary deterrents consisted of language barriers (48%), lack of information (32%), unaffordable costs (31%) and discrimination due to migration status (31%) (Figure 15).

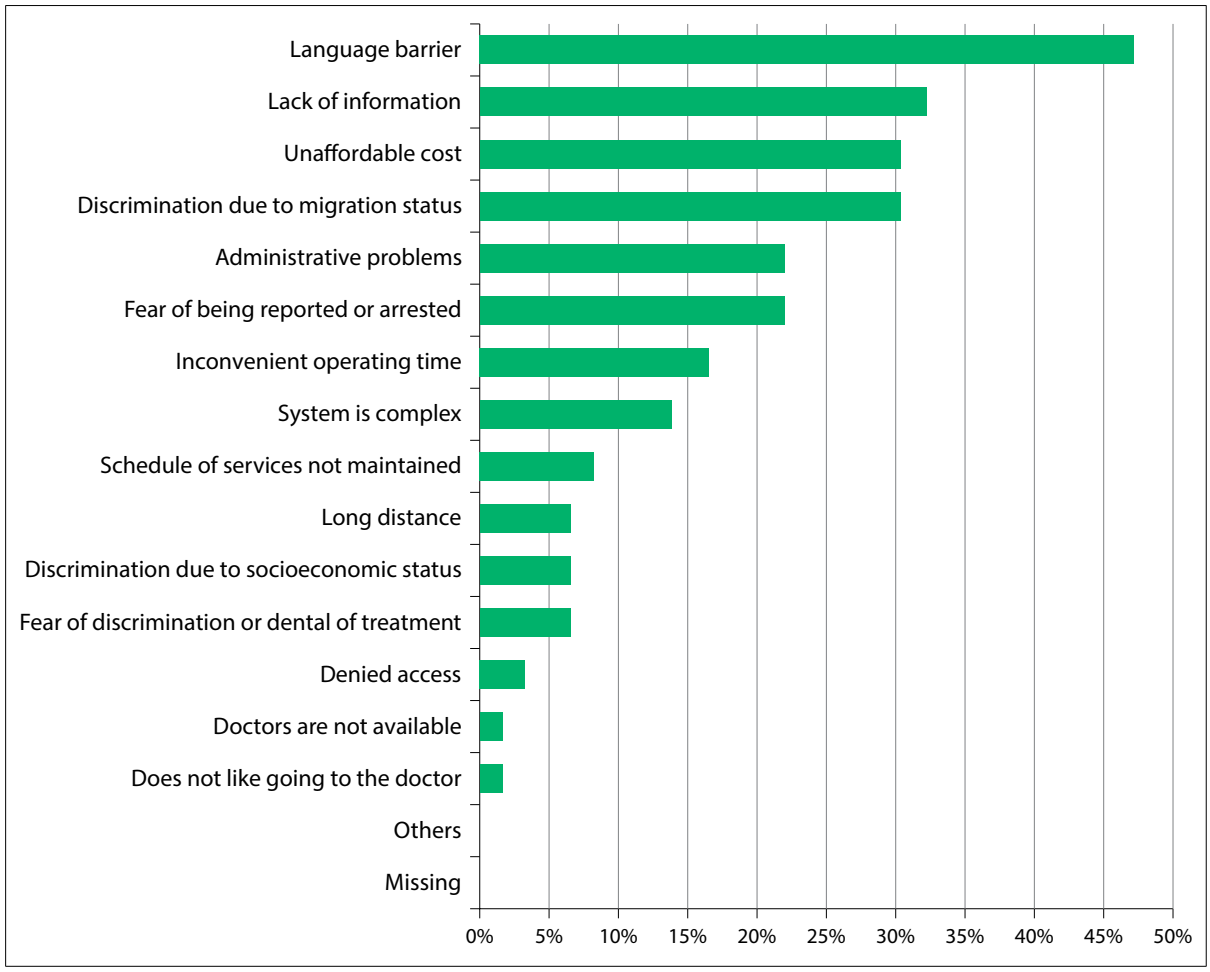


Figure 15: Main barriers faced by migrants accessing health care abroad, among returnee migrants who expressed facing difficulties (n=59)

Mandatory health examination prior to departure

During the time of data collection, 44 per cent (n=176) of respondents had received a mandatory health examination: 31 per cent of departing migrants and 58 per cent of returnee migrants. According to the Bureau of Immigration, more than 90 per cent of migrants are expected to undergo a mandatory health examination, as those migrants traveling to the Middle East require GAMCA approval. The most popular location to acquire mandatory health examinations were GAMCA approved centres in capital cities. Most migrants with history of a health examination prior to departure recalled receiving a general health check-up, and the most specific test received was a TB test (29%), followed by a HIV test (30%) and STI test (15%). Two women reported having a mandatory health examination, one of whom specified a general health check-up at a provincial government centre and another who had an unspecified test at a district government centre (Table 13).

Table 13: Sources and procedures of mandatory health examinations prior to departure (GAMCA approved), by sex

	Total		Men		Women	
	%	n	%	n	%	n
Source/location of pre-departure medical tests						
Govt. Centre at district level	29.0%	51	28.7%	50	50.0%	1
Govt. Centre at provincial level	21.6%	38	21.3%	37	50.0%	1
Employer/Agency	19.9%	35	20.1%	35	0.0%	0
Govt. Centre at capital	14.2%	25	14.4%	25	0.0%	0
NGO	8.0%	14	8.0%	14	0.0%	0
Others	6.8%	12	6.9%	12	0.0%	0
Procedures during pre-departure health examination						
General health check-up	83.5%	147	83.9%	146	50.0%	1
TB test	32.4%	57	32.8%	57	0.0%	0
HIV test	29.0%	51	29.3%	51	0.0%	0
STI test	14.8%	26	14.9%	26	0.0%	0
Other	4.5%	8	4.6%	8	50.0%	1
Missing	4.5%	8	4.6%	8	0.0%	0
Total		**176**		**174**		**2**

The patient experience when receiving blood tests was generally positive: the large majority (75%) of patients were asked for consent, were explained about the nature of the text and received their results. As an aggregate measure, 69 per cent those who underwent a mandatory medical test prior to departure stated that all three protocols had been followed by the health provider (Figure 16).

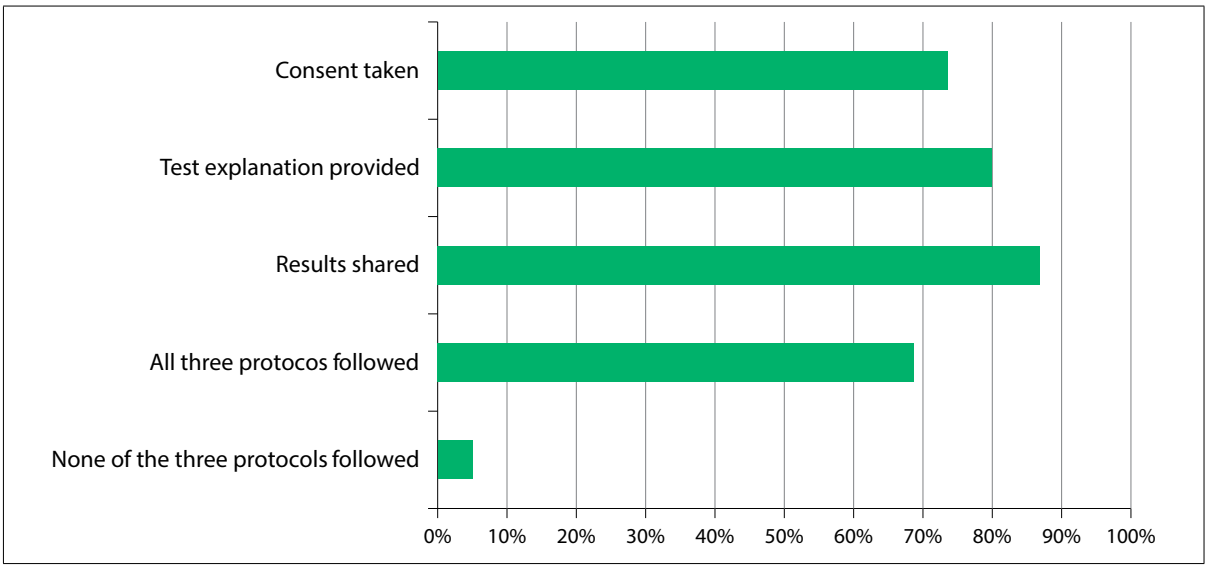


Figure 16: Respondents who underwent a mandatory health examination prior to departure and who were asked for consent, were given an explanation of the test and were provided test results

The study findings show that 18 per cent of mandatory health examinations prior to departure were free of charge, however 90 per cent of health examinations that were not free of charge were financed by migrant employers (Table 14).

Table 14: Respondents who underwent free mandatory health examinations and financiers of non-free health examinations

	Total		Men		Women	
	%	n	%	n	%	n
% of migrants who underwent a free mandatory health examination						
Yes	17.6%	31	17.8%	31	0.0%	0
No	77.3%	136	77.0%	134	100.0%	2
Missing/unknown	5.1	9	5.2%	9	0.0%	0
Total		**176**		**174**		**2**
Financers of mandatory health examinations for migrants who did not undergo free examinations						
Employer	90.4%	123	91.0%	122	50.0%	1
Self	8.1%	11	7.5%	10	50.0%	1
No response	1.5%	2	1.5%	2	0.0%	0
Total		**136**		**134**		**2**

Access to health information and communication

Access to media in Pakistan

Television proved to be the most accessed form of media (Figure 17), viewed by 85 per cent of respondents, 68 per cent of which viewed every day. Radio was less popular, generally listened to by 65 per cent of respondents, 40 per cent of which listened daily. Newspaper was read by 30 per cent of migrants every day, and 37 per cent of migrants accessed the internet.

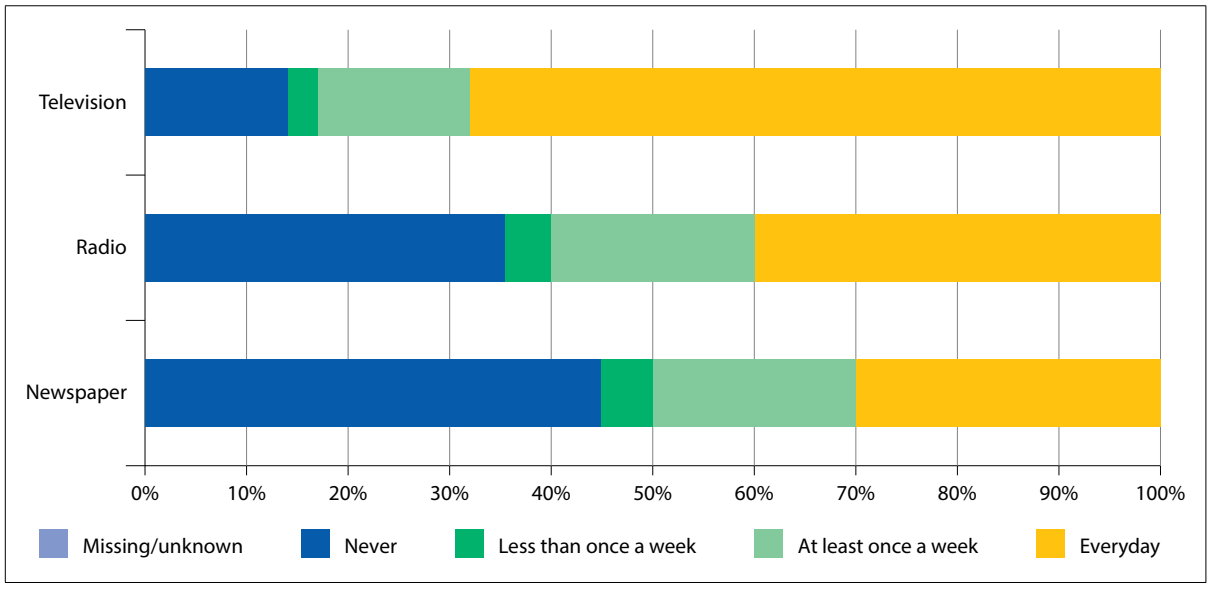


Figure 17: Frequency of access to various forms of media among all respondents (n=400)

Men, younger age groups (less than 36 years), as well as construction workers and technicians accessed the most television, while domestic workers appeared to access the least (Figure 18).

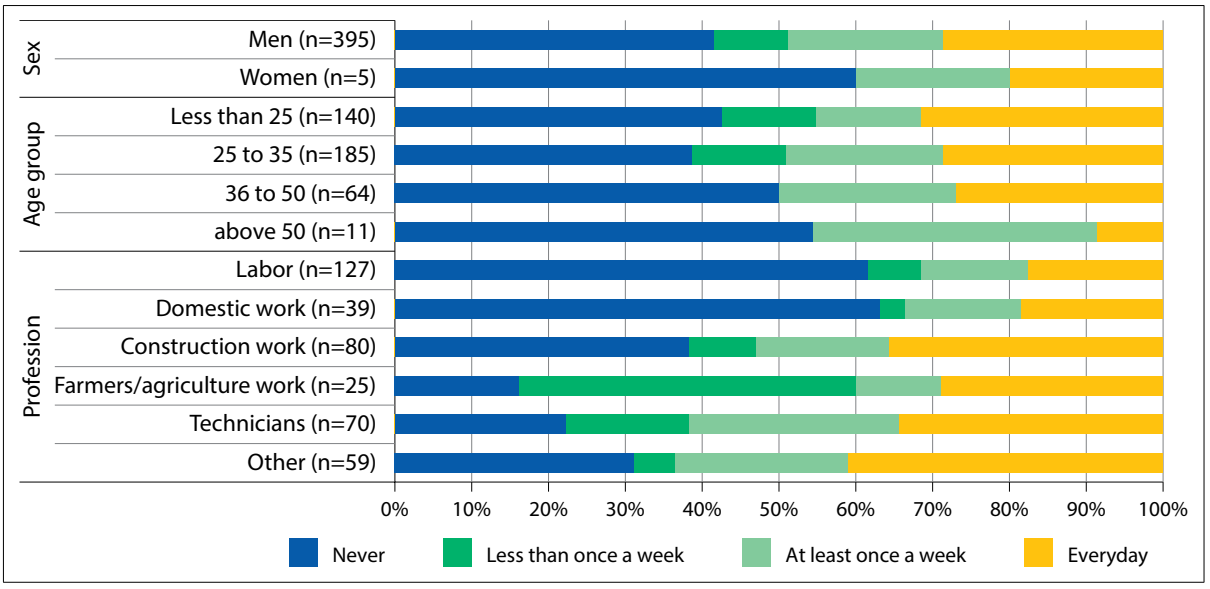


Figure 18: Frequency of access to various forms of media among all respondents, by sex, age group, and profession

Sources of health information in the country of origin

Television, radio, newspaper, and educational institutions or peers were the most important sources of health information among all respondents (Figure 19). Other popular sources included health providers, homeopaths (*Kabiraj/hakim*), and billboards or posters. Departing migrants appeared to have more access to health information from most media compared to returnee migrants. These patterns were reinforced when migrants were asked their preferred method of health information dissemination; 86 per cent preferred television. Radio and newspaper were the most preferred methods following television (Figure 20).

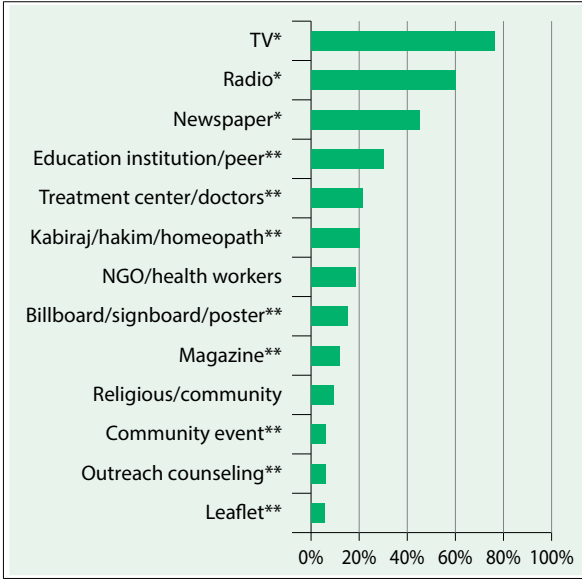


Figure 19: Main sources of health information (n=400)

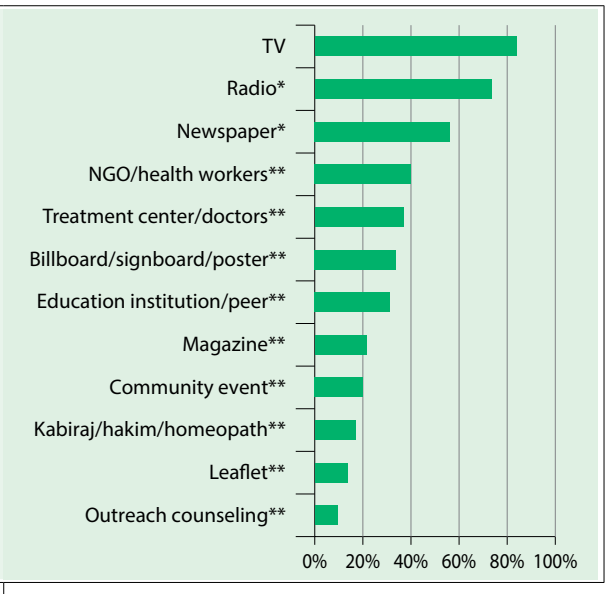


Figure 20: Preferred methods for health information dissemination (n=400)

Fifteen per cent of migrants (23% returnees; 8% departing) had received health related communication materials from health providers in Pakistan (Table 15). Among those, 61 per cent stated that the materials were easily understandable or understandable, while 20 per cent found the materials understandable with some difficulties. No respondents reported that the materials were not understandable.

Table 15: History of receiving health communication materials from health providers in Pakistan

	Total		Departing		Returnee		Men		Women	
	%	n	%	n	%	n	%	n	%	n
Received health communication materials										
Yes	15.0%	60	7.5%	15	22.5%	45	14.7%	58	40.0%	2
No	45.5%	182	44.5%	89	46.5%	93	45.6%	180	40.0%	2
Don't know	27.0%	108	27.0%	54	27.0%	54	27.1%	107	20.0%	1
Missing/unknown	12.5%	50	21.0%	42	4.0%	8	12.7%	50	0.0%	1
Total		**400**		**200**		**200**		**395**		**5**
Ease of understanding										
Easily understandable	5.0%	3	6.7%	1	4.4%	2	5.2%	3	0.0%	0
Understandable	66.7%	40	66.7%	10	66.7%	30	67.2%	39	50.0%	1
With some difficulties	20.0%	12	13.3%	2	22.2%	10	20.7%	12	0.0%	0
Missing/unknown	8.3%	5	13.3%	2	6.7%	3	6.9%	4	50.0%	1
Total		**60**		**15**		**45**		**58**		**2**

Health topic of primary interest was HIV/AIDS followed by STIs, Tuberculosis, Malaria, and mental health for both departing and returnee migrants (Figure 21).

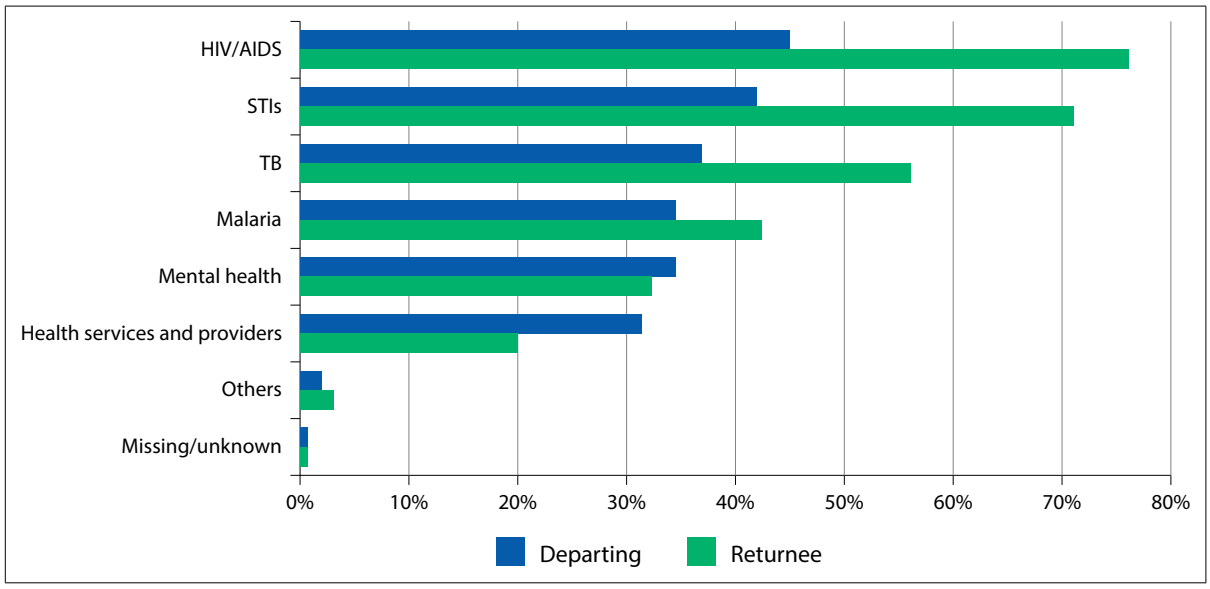


Figure 21: Health topics respondents would like to receive more information about, as % of departing and returnee migrants

Sources of health information in country of destination

In the country of destination television was once again the primary source of health information, identified by 62 per cent of returnee migrants (Figure 22). This was followed by friends or relatives (58%), radio (34%), health providers (24%), and billboards or posters (22%). When asked of the preferred method of health information dissemination, respondents selected television as the primary preferred method followed closely followed by newspaper, radio, health providers, and friends or relatives (Figure 23).

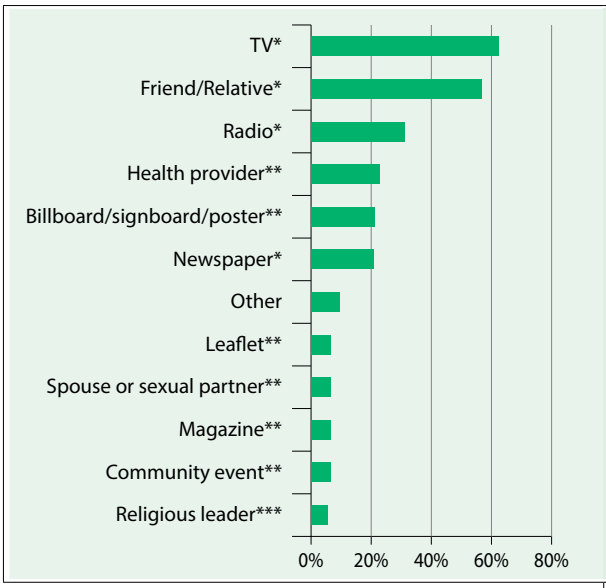


Figure 22: Main sources of health information among returnee migrants

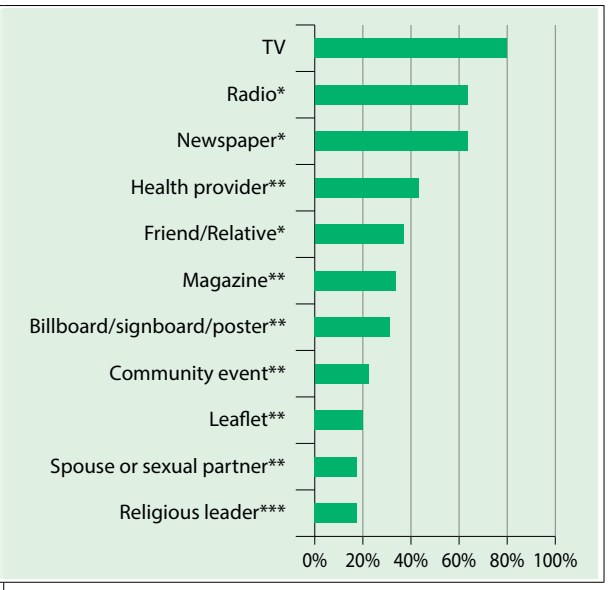


Figure 23: Ideal channels for migration health information identified by returnee migrants

A quarter of migrants reported receiving health-related communication materials from health providers or facilities in the country of destination (Table 16). However 30 per cent could not recall if they had. Among them, 59 per cent had not received heath materials in their own language. 45 per cent of migrants reported having difficulties understanding the content, while just over half found the materials easily understandable or understandable.

Table 16: Provision of health communication materials in country of destination

	Total		Men		Women	
	%	n	%	n	%	n
Migrants who have received health materials from health providers/facilities						
Received health materials	25.5%	51	23.6%	50	3.3%	1
Did not receive health materials	42.5%	85	42.1%	83	66.7%	2
Do not know	29.0%	58	29.4%	58	0.0%	0
Missing/unknown	3.0%	6	3.1%	6	0.0%	0
Total		**200**		**197**		**3**
Migrants who received health materials (language)						
In their own language	39.2%	20	40.0%	20	0.0%	0
Not in their own language	58.8%	30	58.0%	29	100.0%	1
Do not know	2.0%	1	2.0%	1	0.0%	0
Missing/unknown	0.0%	0	0.0%	0	0.0%	0
Ease of understanding						
Easily understandable	15.7%	8	16.0%	8	0.0%	0
Understandable	37.3%	19	38.0%	19	0.0%	0
With some difficulties	45.1%	23	44.0%	22	100.0%	1
Missing/unknown	2.0%	1	2.0%	1	0.0%	0
Total		**51**		**50**		**1**

Sources of HIV/AIDS information

The majority of respondents indicated television as their primary source of information on HIV/AIDS, followed by radio, newspaper, and friends or relatives (Figure 24).

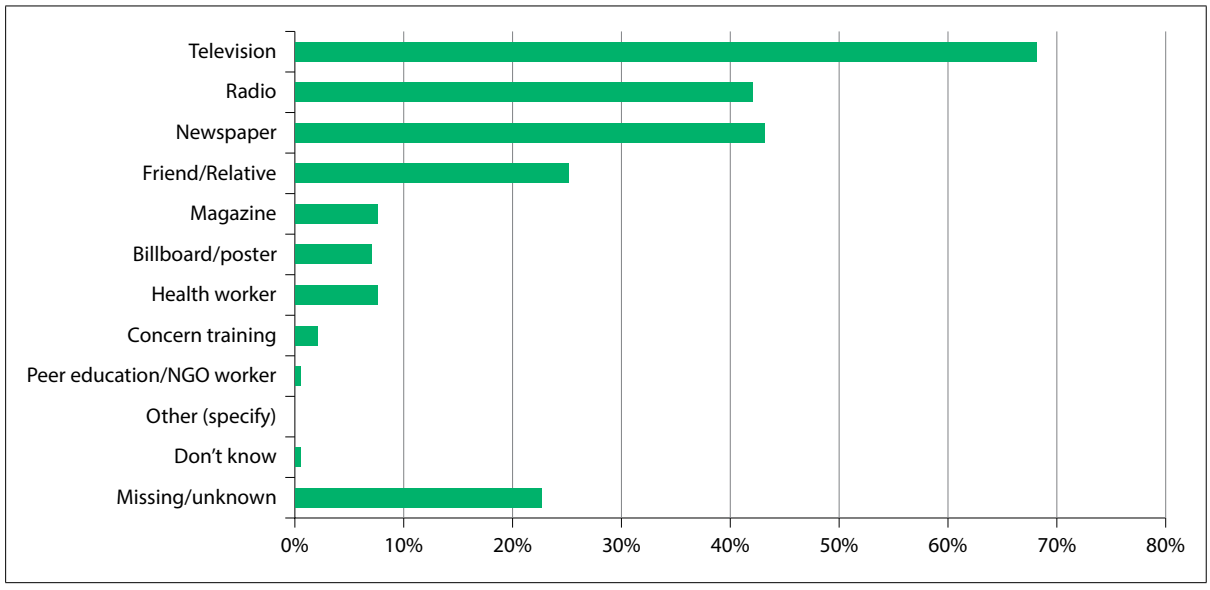


Figure 24: Health topics respondents would like to receive more information about, as % of departing and returnee migrants

3.1 QUALITATIVE RESULTS

3.2.1 Health risks faced by migrants and their dependents

The majority of migrants, particularly those working in labour, described difficult working environments. FGD respondents employed as truck drivers complained of having to drive long distances alone, increasing their risk of accidents. Other FGD participants noted that employers or recruitment agencies do not provide treatment or support on the job, and there were reports of migrants being forced to continue working despite being ill. Only when the health condition is severe, such as losing consciousness, will an individual be taken to hospital.

Key informants explained that the health conditions of outbound migrants have a strong economic, social and cultural impact on their family members, due to reduced income and risk of social exclusion when ill. The vulnerabilities of migrants and their families may be further exacerbated by unsympathetic host government policies. Specifically, FGD respondents expressed disapproval of the deportation policies often experienced in countries of destination, often imposed in the case of severe or prolonged illness, which they considered unjust and financially overwhelming. In the case of death, all airlines except for Pakistan International Airlines charge for three seats to repatriate remains to the country of origin.

1.1.2 Health-care seeking behaviour and post-return medical check-up

Health-care seeking in both Pakistan and countries of destination is limited by the costs earlier described, rooted in geographical, financial and administrative barriers. Additionally, one key informant noted that individuals may be less likely to seek health care or return for follow up due to socio-cultural barriers, namely a fear of being viewed negatively by health-care workers or other

society members that in turn links to "shyness" and conservatism. As noted by some key informants, communication barriers and poor health awareness are further barriers to health-care seeking, as the majority of migrant labourers are illiterate or have not received education beyond primary school level.

As a result of these barriers, key informants pointed out that migrants do not typically opt for non-essential health services. Reinforcing this, FGD participants noted that health-care seeking behaviour is typically low unless enforced.

> "When we depart to the destination country we did our medical test (mandatory health examination) here… there is no such rule or regulation requiring a medical check-up for migrants when they return to their home country."
>
> *FGD respondent*

However, when ill, several migrants agreed that they preferred to return home to seek health care, due both to the lower costs as well as to the fewer administrative requirements in Pakistan, including the lack of regulations on medical prescriptions.

> "Health treatment in the destination country is very expensive; therefore we often come to Pakistan for treatment."
>
> *FGD, Labour migrant*

To encourage health-care seeking, one key informant suggested that employers allocate a budget for medical check-ups for migrant employees.

3.2.3 Knowledge of health risks and prevention

The majority of FGD participants did not know about HIV and other communicable diseases like Hepatitis C. Indeed, health information for migrants is limited in Pakistan, and user-friendly and culturally sensitive health communication materials for migrants abroad are not available. As expressed by both key informants and FGD participants, the main sources of knowledge on migration health services and programmes for migrants are thought to be travel agencies, overseas agencies, medical test centres, relatives and friends. As the majority of outbound labour migrants in Pakistan are illiterate, respondents suggested that posters and billboards, banners, television advertisement, radio, and social media should be used to communicate health information. In addition to these sources, FGD respondents indicated that information on health-related topics should be disseminated at airports and passport offices. FGD respondents also suggested that free brochures and emergency numbers should be provided to all migrants.

3.2.4 Pre-departure orientation

FGD respondents stated that there is no pre-departure training conducted in Pakistan or country of destination. They felt it should be the responsibility of the state to provide any training, seminars or workshops on health for migrant populations, and that the government has failed to do so. It was also suggested that training should be provided in airports and passport offices prior to departure, as it will not be available in destination countries. Key informants highlighted a particular need for information on how migrants can access health care while abroad.

3.2.5 General health services in Pakistan

The quality of health services in Pakistan was generally perceived to be unsatisfactory. Participants of the Focus Group Discussion pointed to low quality medication, unreliable government hospitals, the lack of a quality assurance system for laboratories, and poorly trained and under-qualified health and laboratory staff. Timeliness of test result delivery in the public sector was considered to be poor by all key informants. Key informants also expressed that the attitudes and behaviours of health professionals in the government sector towards migrants are unsatisfactory, and comparably better among private providers. Participants noted a need for culturally sensitive counselling services and improved logistic facilities within the region, such as emergency transportation.

Geographic, economic, administrative, and communication barriers limit accessibility to health care in Pakistan, and were identified by the majority of research participants. Climate and weather-related factors, long distances and difficult terrain present an obstacle for remote populations. Fees for private health services were considered unreasonable among key informants and FGD respondents. FGD participants added that the booming private health-care sector functions as a "business", with profit-making prioritized over patient welfare.

Organizational and administrative barriers manifest as time consuming procedures such as registration, waiting lines, and Zakat[3] paperwork, further compounded by low literacy and language barriers leading to poor patient understanding of such procedures.

Respondents identified not requiring prescriptions for certain procedures and medications as one positive feature of Pakistan's public health system.

3.2.6 Migrant focused services in Pakistan

Key Informant Interviews (KII) and Focus Group Discussion (FGD) respondents expressed that there are no preventive, screening, curative, palliative, or psychosocial government services targeting migrant populations, and that inbound migrants are not entitled to public health services. The GAMCA, however, is an exception: The majority of migrants are facilitated by GAMCA for mandatory health examinations prior to departure,[4] and some key informants noted that GAMCA sometimes offers health promotion and education services to those migrants who present for an examination. Five key informants, however, were unaware of these additional GAMCA services.

Some NGOs provide migrant-specific health services, however their scope is limited; three key informants noted that they were aware of NGOs that only provide services to Afghan refugees, and another respondent stated that NGO services are specific to situations related to political asylum. Additionally service provision by NGOs is not well-known; six of the 16 key informants were unaware that NGOs provided such services.

To address these issues, key informants suggested that a facility like GAMCA should be provided in each major city, testing fees should be minimized, and migrants should be encouraged to test on a regular basis. Respondents also suggested that there should be regular training and capacity building sessions for health-care professionals, as well as regular staff meetings with both medical and migration staff to encourage exchange of knowledge and mutual integration of ideas and

3 *Zakat is a tax levied as almsgiving for the relief of the poor, however as explained by FGD participants, an individual cannot benefit from Zakat unless the appropriate forms have been signed and approved, which can be subject to further delays.*

4 *The required tests for GAMCA centres includes; physical examination, Chest X-ray, HIV test, HBs Ag, anti-HCV, VDRL, Urine test, stool examination, Malaria test, and micro-filariasis test.*

practices. It was suggested that a separate department for migrants should be established in hospitals offering free or subsidized services for migrant groups.

3.2.7 Accessibility and perceived quality of health care in the country of destination

FGD respondents, particularly those within the group consisting mainly of labour migrants, remarked on the inequity of health services and discrimination faced by migrants when seeking health care in the country of destination.

> "Quality treatment is only available for permanent residents. Migrants are treated in an unequal manner in the destination country."
>
> *FGD, Labour migrant*

FGD respondents also considered health care abroad to be costly, as high as "four-fold those of Pakistan". They explained, however, that assistance is provided in the case of emergencies or accidents in destination countries, unlike in Pakistan.

Health-care affordability abroad can be supplemented via a health card that entitles the holder to free or subsidized health care. Health cards are issued by governments for migrants in select countries. FGD respondents however reported difficulties associated with the health card; the process of obtaining the cards is subject to extensive delays, and coverage schemes may only cover designated hospitals, which may be inconveniently located and difficult to access.

Key informants indicated a need for a of continuum care, made possible through a registration or tracking system to monitor and promote the health of migrants throughout the entire migration process.

3.2.8 Mandatory health examination prior to departure

Mandatory health examinations prior to departure are conducted in Pakistan, but they are poorly regulated. Respondents of the quantitative survey described the examinations as consisting of Hepatitis B and C, HIV, Tuberculosis, Malaria and Typhoid tests. According to FGD participants, laboratory staff are poorly trained and under qualified, and bribes are often made to obtain certificates of medical fitness. Key informants further indicated that health certificates expire within three months, adding a further administrative burden for migrants in countries of destination.

3.2.9 Higher level and multi-sectoral coordination

Key informants were asked about their awareness of policy issues relating to the health of migrants. No respondents were aware of the International Health Regulation World Health Assembly (WHA) Resolutions 57.19 and 58.17 (2005) and the World Health Assembly Resolution 61.17 (2008); nor were they aware of the recommendations from the Regional dialogue on health challenges for Asian migrant workers (2010), the Dhaka declaration (2011) or any other evidence based-country policy framework.

CHAPTER FOUR

DISCUSSION OF FINDINGS

4.1 MIGRATION PROFILE

The population of this study was predominantly male, with only five female respondents. More than 80 per cent of respondents were under 35 years of age, and approximately half were married. The majority of respondents had acquired some form of education. One quarter had no history of formal education.

The majority of returnee migrants in the sample spent between one and three years abroad, a time period long enough to become established and require health-care services. Data suggests that migrants spent a longer time abroad than they originally intended to, however this may be due to confounding by age.

The majority of migrants had experienced difficulties during the migration process mostly related to finances but also due to poor and discriminatory treatment. Several studies support these findings, with the exploitation of migrants, particularly in the Middle Eastern region, having been extensively documented. This finding is important as the primary destinations of Pakistani migrants are countries in the Middle East. The severity of these problems is not determinable from the available data, however it appears that difficulties experienced did not deter returnee migrants from working abroad multiple times and intending to do so again.

Friends and relatives of migrants were the primary sources of assistance during the pre-departure migration phase. Only 10 per cent of respondents indicated that recruitment agencies provided assistance. This indicates that there is great potential for employers and recruitment agencies to increase the amount of assistance provided to migrants.

4.2 HEALTH RISKS AND VULNERABILITIES

Migrants included in this study tended to generally be in good physical health. One in two reported experiencing illness within the past 6 months, which most frequently was described as minor health problems. Roughly 10 per cent of respondents had experienced conditions related to stress, such as hypertension and mental health problems. The severity of these mental illnesses is unknown, but literature has shown that depression and anxiety tend to be more frequent and more severe among economic migrants compared to the general population. This is due to factors such as cultural bereavement and the loss of social structures. Despite this, it is positive that mental issues were recognized and identified as health issues even when unprompted.

Migrants were more likely to report a history of occupational hazards when prompted compared to when unprompted. Due to missing data and small sample sizes, patterns are difficult to derive, however the higher frequency of occupational hazards among agriculture workers and labourers is consistent with the physical risks faced by those in the primary sector. Effort should be made to ensure that employment or insurance policies cover those most at risk of occupational hazards.

A surprisingly low proportion of migrants reported sexual activity; monogamy with a spouse was the norm among respondents. However, data collected is skewed by a large percentage of no responses, likely due to the culturally sensitive nature of the topic.

There was, however, a notable amount of sexual risk taking, with more than 20 per cent of those sexually active male respondents engaging in commercial sex, as well as reported infrequent condom use with all partners. While it is not possible to directly compare rates of change, it is apparent that

the choice of sexual partner type did change dramatically, with commercial sex partners becoming the most frequently reported partner type abroad. Condom use was highest with these partners at 64 per cent, indicating risk for possible disease transmission.

Substance abuse among this group of migrants was low (23%). Substances used were predominantly hashish and alcohol. Of those who had a history of drug use there was a minimal number who had injected drugs (n=8).

Few migrants reported sexual violence; the true percentage may be higher, however, due to underreporting. The percentage of migrants that knew of someone else having experienced sexual abuse (17%) may be low compared to other studies, but given the seriousness of sexual abuse and exploitation, this still requires urgent attention. In particular, the fact that agents and colleagues were the main perpatators of such acts highlights the need for increased transparency and fair treatment within the recruiting and working environments.

4.3 HEALTH-CARE SEEKING BEHAVIOUR

Perceived insusceptibility appeared to be the primary barrier to seeking health-care services, leading to low uptake of preventative medical check-ups but high uptake of curative services. For example, one third of all respondents had received a STI test, and 85 per cent of those who already had an STI had sought medical care.

Health-care seeking determined by subjective susceptibility to illness is problematic. Respondents appear to underestimate their health risks as a result of an overestimated good health status. This is well documented among young and able individuals, as well as among those with poor knowledge of health issues. One third of migrants reported not knowing whether or not they were at risk of Tuberculosis, HIV, STIs, or Hepatitis C. It is universally recognized that preventive health-care seeking behaviors must be promoted to optimize health and minimize global health expenditure. Improved health awareness is thus required to promote recognition of health risks and uptake of health examination activities.

It must be acknowledged that the high rate of health-care seeking among those respondents with history of illness also applied to those suffering from mental health problems. Awareness of mental health and the validity of seeking health care for mental health related illness thus appears reasonably high among respondents, which is notable given the tendency to overlook mental health.

After perceived insusceptibility, health-care accessibility and affordability were the primary barriers to health-care seeking. These factors could partly explain why only half of those who intended to receive a post-return medical check-up actually attended one. This suggests the need for improved health capacity and coverage of hard-to-read populations, particularly within the public health system.

Health-care seeking behavior decreased while abroad. This is often expected due to the challenges of accessing health infrastructure as a migrant, and is discussed in further detail below.

4.4 HEALTH-CARE QUALITY AND ACCESSIBILITY IN THE COUNTRY OF ORIGIN AND DESTINATION

Health-care accessibility was lacking in respondents' communities in Pakistan. The range of available health-care services was varied greatly and coverage was limited. For example, only 64 per cent of migrants reported primary health care services available in their community, and just over 40 per cent reported health education services. Less than two thirds of respondents felt they could access public health facilities, sixteen per cent expressed dissatisfaction with the health system, and one in two expressed barriers accessing health care that were largely related to poor health infrastructure, such as unavailable doctors, long distances to clinics, and inconvenient operating times. Financial difficulties were also a major problem to accessing health-care services in Pakistan.

Interestingly, health service accessibility and affordability increased substantially in countries of destination; 85 per cent expressing that they could access public health services, 30 per cent expressed experiencing problems accessing health care, and 2 per cent expressed dissatisfaction with the health system abroad. Instead of infrastructural problems, barriers to health-care access in countries of destination were largely related to difficulties with social integration, including language barriers, discrimination, and lack of information.

This data suggests better quality health-care infrastructure abroad compared to that in Pakistan; few returnee migrants cited distance or doctor availability as barriers to health care in destination countries. Health cards provided by employers most likely further enabled accessibility, despite the associated delays as limitations. The difference may also be attributable to the move from under-resourced rural communities in Pakistan to resource-plenty urban areas in destination countries. This highlights the need to improve Pakistan's health-care quality to meet international standards.

However, there still remains much room for improvement to health-care accessibility abroad. Social barriers suggest the need to minimize prejudice towards migrants and take measures to promote assimilation, including the provision of comprehensive information about available health services. Furthermore, financial barriers were mentioned be respondents. Given that only 12 per cent of employers covered health-care costs and only 37 per cent of migrants had any form of insurance, improving access to health-care financial support and schemes could work to ensuring equitable access to health care in destination countries.

4.5 MANDATORY HEALTH EXAMINATION PRIOR TO DEPARTURE

Less than two thirds of returnee migrants had had undergone a mandatory health examination prior to departure. This is notable considering that the majority of migrants had migrated to the Middle East where certification of good health by GAMCA is typically required for migrants to obtain work permits.

The data suggests adequate adherence to the internationally recognized SOPs of informed consent and results sharing. There still exists much room for improvement; approximately one third of migrants had not experienced any of the three protocols during their health examination. Respondents also perceived examinations to be of poor quality and reported bribery associated with falsified certificates of medical fitness. As local government facilities, and not employers or recruitment agencies, were both the primary location for mandatory health examinations and the worst performers in terms of patient experience, the capacities of these facilities in particular should be targeted.

The financial contributions of respondents for health examinations were minimal; 9 out of 10 migrants reported that their employer financed their mandatory health examination. This behaviour on behalf of the employer is commendable and should be continued.

4.6 HEALTH KNOWLEDGE AND SOURCES OF INFORMATION

Health knowledge was limited among respondents, with just over one half able to explicitly recognize that disease can be transmitted by close physical contact. While HIV was the most frequently identified infectious disease, approximately one in four respondents were unfamiliar with HIV. Among those who had heard of HIV, the large majority had practical knowledge of prevention, such as the importance of protected sex. However, a handful respondents exhibited misconceptions, and few were aware of mother to child transmission. This provides evidence for the need for extensive health education, specifically addressing common misconceptions. Among stakeholders, poor knowledge of international standards and conventions regarding migration health indicates the lack of pressure or commitment to improving migrant health services, which needs to be addressed.

Television was the most important communication channel for migrants, followed by the radio and newspaper. These types of media were frequently accessed, and were identified as both actual and ideal sources of general health information, as well as disease specific information such as HIV. The data also suggests that health providers have great potential to deliver health messages, as they were identified more often as ideal than actual sources of health information.

Health communication strategies must consider the quality and effectiveness of health materials through various communication media. This is particularly the case when using printed media, given the risk of language barriers and disadvantage to illiterate groups.

Almost a half of returnee migrants had difficulties understanding health materials provided abroad, which can be explained by the fact that two thirds of returnee migrants did not receive health materials from health providers in their own language. Language, however, is not the only factor; even in Pakistan, one fifth of migrants reported difficulties understanding health materials.

More appropriate and evidence-based health communication is required in Pakistan, while use of effective visuals, multi-lingual health materials should be employed in countries of destination to disseminate health information. Furthermore, the potential of informal migrant networks must be further utilized as friends or relatives were the second largest source of health information among returnee migrants.

Pre-departure health orientations provide an additional platform to promote health awareness among migrants, particularly those with reduced access to general media while in the destination country. The data suggest that domestic workers in particular have reduced access to sources of media, which may reflect the documented human rights violations of domestic workers in Gulf countries. Equipping migrants with information prior to departure, on both health and rights, would allow migrants increased control of their own health and living circumstances. Despite Emigration Rule 27 that states pre-departure orientations should be provided to all migrants, only five per cent of respondents reported having received one. This gross underachievement needs to be ameliorated by stricter enforcement of this Rule.

CHAPTER FIVE

RECOMMENDATIONS

The following recommendations have been made following the World Health Assembly Resolution on the Health of Migrants Global Operational Framework. Improvements to migrant health can be achieved through both health infrastructure developments within in Pakistan, as well as improved employer or agency support and social integration while abroad. The definition of migrant health needs to be universally recognized to include not only infectious diseases but also chronic conditions and mental health concerns.

These improvements can only be attained through bilateral and national multi-sectoral commitments both in Pakistan and in destination countries. Migrants should be active players in the improvement of their own health and in the services they use. They should be equipped with the necessary information to be aware of their health and to effectively utilize and pay for services. Listed below are the gaps in effective migration health and applicable recommendations.

5.1 MONITORING MIGRANT HEALTH

Health research of migrants concentrates predominantly on newly arrived migrants and is communicable disease focused. However, given the increases in migration flows, the duration of stay and diversity of migrant populations there is great need for expanding migrant health monitoring efforts. Research of migrant health should include social and economic risk factors, as well as health throughout the migration process and long term effects of migration beyond first generation migrants.

1. More research is needed to understand the female experience of migration;
2. More comprehensive research on the sexual behaviour of migrants throughout the migration process would be useful to understanding their risks of STIs/HIV;
3. Research should be undertaken to consider destination country-specific migrant experiences to enable custom interventions for Pakistani migrants;
4. More research should examine the health status of cross-border and irregular Pakistani migrants, who are not frequently covered in current literature;
5. Regional research should be undertaken to identify key indicators that are acceptable and useable across the region; and to identify the techniques of promoting the inclusion of migration variables in existing censuses, national statistics, targeted health surveys and routine health information systems, as well as in statistics from sectors such as housing, education, labour and migration.

5.2 POLICY AND LEGAL FRAMEWORKS

Policy and legal frameworks that fail to take into account the health needs of migrants negatively impact migrants' right to health and inevitably their overall well-being. Policy should be aimed at improving the health of migrants and must consider the interdisciplinary nature of the topic. Countries and communities involved in the migration cycle must harmonize their efforts, support and maintain policy that complies with international standard to ensure that the rights of migrants are upheld.

1. The Government of Pakistan should ratify the major migration related conventions: Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and UN Protocol to Prevent, Suppress and Punish Trafficking in Persons. Pakistan should also ratify the two ILO conventions specific to migration: Migration for Employment Convention (Revised), 1949 and Migrant Workers (Supplementary Provisions), 1975. Ratification of these conventions would demonstrate Pakistan's commitment to protect the rights of migrants;
2. Bilateral agreements between Pakistan and migrant receiving countries should include the health of migrants as an essential and "non-negotiable" component;
3. Pakistan's HIV policy should be developed to specifically include migrants as a key population;
4. Interactions should take place in the form of discussions, meetings and conferences with representations from government, private agencies, NGOs/INGOs and migrants to develop comprehensive policy and implementation mechanism enabling migrants to access health care abroad free of discrimination. In particular, specific steps should be taken to limit discrimination in the health-care environment, such as implementing no-tolerance policies;
5. Through a progressive empowerment model, field-level health workers migrants should be informed of and engaged in the planning, implementation and oversight of migrant-friendly health services, and health systems should facilitate an ongoing dialogue with migrant communities and their representatives. Migrants should be included in these dialogues as interpreters, intercultural mediators and educators in outreach programmes, and those with health professional credentials from other countries can be supported to re-qualify and enter practice.

5.3 MIGRANT SENSITIVE HEALTH SYSTEMS

Health systems have been challenged to provide services inclusive of migrants throughout the migration process. In addressing the health needs of migrants, the public health approach should ensure that the health rights of migrants are upheld; disparities in access and health status should be avoided; excess mortality and morbidity should be reduced; and the negative impact of the migration process are minimised. The aim of migrant sensitive health systems is to incorporate the needs of migrants so as to facilitate their access to health services in the countries of origin, transit and destination.

1. Recruitment agencies and employers should take on increased responsibility for the well-being of migrants, particularly concerning health-care financing and providing pre-departure orientations;
2. A system involving a third-party, overseeing authority should be developed, or stricter regulations should be applied to ensure recruitment agencies or employers adhere to their commitments in terms of health insurance and labour contracts;
3. Pakistan should continue to invest in improved health infrastructure and health provider capacity, particularly targeting district and provincial public health facilities, which are in particular need of improved quality of care. Activities should include;
    a. Provision of training and disseminating guidelines to ensure implementation of SOPs such as informed consent, test result sharing, and post-test counselling;

b. Increasing health-care accessibility in rural areas;

c. Implementing universal health coverage;

4. Pakistan needs to develop a regulatory mechanism to effectively monitor the activities of private health providers, recruitment agencies, and medical testing centres;

5. Integration of migrant health into the health-care system and recognition of migrants as a particular group with their own health risks and needs should be promoted through capacity building sessions as well as regular staff meetings with both medical and migration staff to encourage exchange of knowledge and best practices;

6. The private health sector should become more patient-friendly and should face increased regulations by the government of Pakistan to reduce out-of-pocket expenditure;

7. A registration or tracking system should be established for Pakistani migrants and coordinated with the health systems of receiving countries to enable a continuum of care for Pakistani migrants while abroad;

8. Popular media, particularly television and radio, should be used to spread health messages targeting migrants. These programmes should also be made available in health facilities to supplement print materials;

9. Health providers should be harnessed for improved health education. Improved health materials should be developed, using effective content and language.

10. Through these means, migrants should be provided comprehensive and practical information on:

- o Specific health issues, including relevant communicable diseases such as HIV, TB, and hepatitis, occupational hazards, mental health problems, including those related to sexual violence, as well as the validity of seeking health care for these conditions;
- o Availability of health care and health insurance;
- o The importance of condoms and demanding use;

11. Employers and recruitment agencies should ensure that migrants, especially those seeking domestic work, have access to comprehensive pre-departure orientations which feature health information tailored to the destination country. Content should be standardized and should encompass general health check-ups, immigrant rights and access to health care in the destination country, as well as specific diseases and conditions related to their work, including comprehensive information on HIV/AIDS, Tuberculosis, mental health, and sexual violence.

5.4 PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

Sound management of migration requires collaboration and cooperation at the global, regional, inter-regional and national levels, as well as with sectors and institutions involved in the migration process. Specifically alliances with and engagement of civil society organizations and the private sector are integral to ensure migrants health rights are upheld and that they have sustained access to health services in countries of origin, transit and destination.

1. Interactions should occur in the form of discussions, meetings and conferences with representations from government, private agencies, NGOs/INGOs and migrants to establish a comprehensive policy and implementation mechanism relating to addressing the health vulnerabilities of migrants;
2. The Government of Pakistan should take initiatives of interministerial coordination between stakeholder agencies, especially Ministry of Population Welfare, Ministry of Labour and Ministry of National Health Services, Regulation and Coordination to facilitate the foreign employment process. The Human Rights Commission and the National Commission of the Status of Women should also be included in this national level broader coordination to strengthen monitoring mechanisms of health rights of migrants.

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