Access to Healthcare, Insurance Provision and Health Status of Sri Lankan Migrant Domestic Workers

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Publisher:
Centre for Women's Research (CENWOR)
225/4, Bernard Soysa Mawatha (Kirula Road), Colombo-5, Sri Lanka.
Tel: 94-11-2369530, 94-11-2502153, 94-11-2368965
Email: cenwor@slt.lk
ULR: www. cenwor.lk

Printed by:
Karunaratne & Sons (Pvt) Ltd.
No.67, UDA Industrial Estate, Katuwana Road, Homagama.

ISBN : 978-955-8610-69-5

Acknowledgements

This report, and the research on which it is based, would not have been possible without the co-operation, advice, help and support of many people.

We would like to thank the International Migration Initiative of the Open Society Foundations for their generous funding of the project. Further, from the inception of the idea of this project through all stages of its implementation, and up to the very end including the production of the report and dissemination, we have benefitted enormously from the excellent guidance and support provided by Elizabeth Frantz, Senior Program Officer for the Open Society International Migration Initiative.

The project co-ordination and fieldwork in Sri Lanka were made possible through the dedicated involvement and hard work of several members of CENWOR. We owe a particular debt of gratitude to Anula Maddumabandara and Chandra Mudugamuwa, who recruited all the interviewees among migrant domestic workers, and undertook in-depth qualitative interviews with them, and with local stakeholders. We are extremely grateful to the Project Co-ordinator, Indrani Hewagama for managing and supervising the fieldwork and collection of information for the report in Sri Lanka; to the Information Officer, Savithri Hirimutugoda, for her unwavering efforts in locating source material relevant to the report; and to the IT Manager, Vathany Narendran, for providing expert help at various stages of the project and for undertaking formatting of the report. We would also like to thank Leelangi Wanasundera for editing the report, and members of the CENWOR Steering Committee (Swarna Jayaweera, Agnes Mendis, Leelangi Wanasundera, Ramani Jayatilaka and Priyani Soysa) for providing oversight of the project in Sri Lanka.

At various stages of the project - planning, research, analysis and writing - we received invaluable advice and help from colleagues in academic, international organisation and civil society sectors. Among these, we would particularly like to thank Sarah Spencer, Xiang Biao, Ben Gidley and Vicky Kingsman (COMPAS, University of Oxford), L. K. Ruhunage (Consultant in Labour Migration, Sri Lanka), Francis Solomantine (Centre for Human Rights and Development), Ray Jureidini (Institute for Migration Studies, Lebanese American University), Linda al-Kalash (Tamkeen Fields for Aid, Jordan), George Naufal (Public Policy Research Institute, University of Texas A&M), Finn Goldner (National Health Insurance Company, Qatar), Susan Martin and Abbie Taylor (Institute for Study of International Migration, Georgetown University), Mike Collyer (Sussex Centre for Migration Research, University of Sussex), Erwin Puhawan (Kanlungan Centre Foundation, Philippines) and Marla Asis (Scalabrini Migration Center, Philippines).

We are very grateful for the participation, and time given to the project, of stakeholders from the State, International Organisations, and Non-governmental and Civil Society Organisations who were interviewed in Sri Lanka and in the GCC countries, Jordan and Lebanon, and those stakeholders who attended the workshop on emerging findings in Colombo in April 2015 and provided very useful input and comments. The research on which this report is based would not have been possible without the participation of the migrant domestic workers whose narrated life and work histories lie at the centre of this report. We owe an enormous debt of gratitude to them for sharing their experiences with us and we hope we have done justice to the stories they wanted us to tell and to the recommendations for changes in rights for migrant domestic workers that they sought.

Hiranthi Jayaweera, Elizabeth H. Shlala & Centre for Women's Research

October 2015

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Abbreviations

ADD	Abu Dhabi Dialogue
CERD	Convention against All Forms of Racial Discrimination
DHA	Dubai Health Authority
GAMCA	GCC Approved Medical Centres Association
GCC	Gulf Cooperation Council
GCE A/L	General Certificate of Education (Advanced Level)
GDP	Gross Domestic Product
HAAD	Health Authority of Abu Dhabi
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
ILO	International Labour Organization
IOM	International Organization for Migration
KWD	Kuwaiti dinar
MFEPW	Ministry of Foreign Employment Promotion and Welfare
MoH	Ministry of Health
MoU	Memorandum of Understanding
MoUs	Memoranda of Understanding
NGOs	Non Governmental Organisations
NLMP	National Labour Migration Policy
NMHP	National Migration Health Policy
NSSF	National Social Security Fund
NVQ	National Vocational Qualification
OWWA	Overseas Workers Welfare Administration
SEHA	Abu Dhabi Health Services Company
SLBFE	Sri Lanka Bureau of Foreign Employment
STDs	Sexually Transmitted Diseases
UAE	United Arab Emirates
VAT	Value Added Tax
WDO	Women Development Officer
WHA	World Health Assembly
WHO	World Health Organization
WPS	Wage Protection System

Executive Summary

Overview

Provisions to ensure access to healthcare are failing Sri Lankan women who migrate for domestic work, both in their own countries and abroad. There are serious gaps and anomalies in relation to health in the current Sri Lankan policy framework for migrant domestic workers. Power imbalances between migrants and their employers create a massive obstacle to their ability to receive care and to access justice in receiving countries.

Women domestic workers form around two fifths of total outgoing Sri Lankan migrant workers annually, with nearly all going to Kuwait, Saudi Arabia, Jordan, the United Arab Emirates (UAE), Qatar, Lebanon, Bahrain and Oman. Despite family poverty being the main driver of their migration and despite their low wages overseas, domestic workers' remittances form a very significant part of Sri Lanka's foreign exchange earnings. While there is much documentation of the violations of human rights and lack of labour rights of Sri Lankan overseas domestic workers, particularly in Gulf States, relatively little attention has been paid so far to their health and barriers in access to healthcare. This report examines the health experiences of Sri Lankan domestic workers throughout the entire migration process. It includes the impact of the Sri Lankan labour migration governance framework relevant to health, as well as the impact of receiving country policies and employer practices on migrants' access to healthcare and health status. The report makes recommendations for improvements in both policy and practice that may lead to better health and realisation of human rights for Sri Lankan migrant domestic workers.

Primary research was conducted through in-depth qualitative interviews with 40 returned migrants, and 20 first time pre-departure migrants who had been through training, medical testing and registration procedures. The participants were purposively selected in two districts in Sri Lanka, Kalutara and Kurunegala, in which a significant number of migrant domestic workers originate. Interviews were also undertaken with key stakeholders in national and local government in Sri Lanka, recruitment agencies, medical testing centres, international organisations represented in Sri Lanka, trade unions involving domestic workers, and civil society organisations working around rights of migrant workers; and with labour migration and health experts in the UAE, Kuwait, Jordan and Lebanon.

Key findings

There are gaps and anomalies in the Sri Lankan governance framework around health of migrant domestic workers in both origin and destination countries. Most significantly the compulsory welfare insurance scheme operated by the Sri Lankan Bureau of Foreign Employment (SLBFE) excludes coverage of important health areas and conditions for which many domestic workers need support given the lack of enforcement of their employment rights and entitlements in receiving country households. Lack of coverage includes medical expenses within receiving countries, illness and injury sustained in escaping from abusive work situations, and sexually transmitted diseases such as HIV. The period of insurance coverage is limited to two years and can only be extended by re-registering with the SLBFE, a requirement that can be difficult if not impossible for migrants remaining overseas for longer periods to fulfil. Among the migrants interviewed for this report, the majority did not have full information about their entitlements under the insurance scheme, and very few had tried to make claims or obtained compensation despite the fact that many had endured injuries or illnesses as a result of poor working conditions or accidents abroad.

Most women interviewed had signed a 'standard' employment contract at the SLBFE prior to migration, but some had also signed a second contract with the employer on arrival, which had less favourable employment terms. According to the accounts of interviewees, they were compelled to endure employer violations of many of the health-related provisions in the contract such as adequate rest times and food, limitations on working hours, and humane treatment generally. The findings on health fit in with broader evidence from other studies pointing to the impact of a lack of systematic and effective monitoring of employer compliance with contract terms exacerbated by the absence of national labour law coverage of domestic work in most of the destination countries.

There are other weaknesses in the design and implementation of the Sri Lankan governance framework relevant to health as revealed through interviews with migrants as well as health professionals and other stakeholders. Women reported having medical tests conducted and reports provided to agencies without their consent. Those returning from work abroad with known physical and mental health problems did not receive adequate long-term care. Sri Lankan embassies in receiving countries provided limited oversight, preventative strategies and support. The women interviewed also did not seem to benefit a great deal from the support of civil society organisations at any of the stages of the migration process, instead relying on colleagues, friends and family for information and help.

Physical and mental health challenges for both the interviewees and members of their families were present prior to migration, arising for the most part from levels of poverty that meant basic family needs were not met. Migrants knowingly leveraged or traded their health through multiple cycles of migration for poorly regulated and gruelling work predominantly in an attempt to meet family economic, social and health needs. Poor working and living conditions in receiving countries and lack of health support - for instance sick leave - led to significant deterioration of their health. Interviewees most often reported musculoskeletal injury from heavy lifting and carrying and respiratory difficulties and eye damage from the use of chemical cleaning agents. The pre-departure training they received encouraged them to take and use home remedies and practice mindfulness and prayer as preventative and curative strategies rather than seek justice for inhumane treatment. Access to medical treatment, although stipulated in the employment contract, was in practice provided at the discretion of employers, and interviews revealed cases of serious neglect. Isolation, and worry about family health and wellbeing in Sri Lanka compounded negative experiences of work and life in employers' households. Return to Sri Lanka, while sometimes a joyful relief, often did not allay health worries and financial anxieties. In some cases, the existence of physical and mental health problems remained undetected through a pattern of re-migration and circular migration.

Recommendations

Recommendations in this report are mainly directed towards the Sri Lankan government and the SLBFE. While there is an urgent need for policy and practice reform in the treatment of migrant domestic workers in GCC countries, Jordan and Lebanon, many actions can be taken by Sri Lanka to improve the health of domestic workers. As the migration infrastructure is state controlled significant change can be achieved through state action.

- *Health insurance.* Examine and address serious gaps and anomalies relating to health coverage of migrant domestic workers in the existing SLBFE insurance scheme. This could be done for example through expanding the current insurance provisions to include healthcare in receiving countries, thus reducing domestic workers' dependence on employers. The way in which health insurance can be funded requires serious consideration to ensure that the cost of premiums is not borne by the workers.

- *Employment contract.* Press for a revised employment contract similar to that between the Philippines and some Gulf countries, which includes requirements for employers to provide more comprehensive healthy working and living conditions to domestic workers in private homes. As the current Chair of the Colombo Process, Sri Lanka should advocate for receiving country governments to monitor and enforce employer adherence to the terms of the employment contract to provide necessary healthcare in a timely manner.

- *Medical testing.* Regulate and monitor pre-departure medical testing practices in testing centres to ensure that women's privacy, dignity, and confidentiality are maintained as set out in the National Labour Migration Policy, and to ensure their right to access their medical reports. Systemic pathways of referral should be set up for women detected with health problems at testing stage.

- *Psychological health.* Implement the action point in the National Migration Health Policy to meet both the mental and physical health needs of returning migrants, through long term follow up after return. A confidential psychological assessment for returnees co-ordinated by the Ministry of Health working with local hospitals and health professionals is desirable.

- *Pre-departure training.* As part of pre-departure training programmes provide clear and detailed information to women on separate health provisions listed in the employment contract and in the SLBFE welfare insurance scheme, and on healthcare entitlements according to policies and health systems in different receiving countries. In all three cases, information given should include redress mechanisms in the case of violations by employers, recruitment agents and Sri Lankan officials. Pre-departure training provided by the SLBFE and other SLBFE regulated providers should be conducted in safe, hygienic, comfortable, relaxed environments where the expressed needs of trainees are respected.

- *Embassies and consulates.* Extend the creation of accessible Migrant Resource Centres associated with all embassies and missions in destination countries, following the Philippines welfare assistance model, and disseminate information about these to migrant domestic workers. Use modern technology to collect and provide information necessary to keep contact with migrants so that they can easily communicate with Labour Attaches in embassies if they have problems.

- *SLBFE board.* Enable and/or increase the representation of migrant workers on the SLBFE board and Sri Lankan migrant resource centre advisory groups in receiving countries. This would allow recognition of the agency and decision-making capacity of migrant domestic workers within difficult circumstances in both sending and receiving contexts, and ensure their voice is heard in policy making and implementation processes at local, national and international levels.

- *Domestic Workers' Convention.* Sri Lanka should ratify and implement the ILO Domestic Workers' Convention (C.189) applicable to local domestic workers. This would enable more leverage internationally and regionally, to ensure the health and labour rights of women migrating for domestic work abroad.

A full list of actionable recommendations is contained in the Conclusion to this report in Chapter 7.

CHAPTER 1

Introduction, Objectives and Background

1.1 Introduction

This report draws attention to the health[1] of a specifically vulnerable section of the migrant population in Sri Lanka: women migrating for domestic work in the Gulf Cooperation Council (GCC)[2] countries, Jordan and Lebanon. In many of these countries, and in Sri Lanka, domestic work is performed outside the scope of national labour laws, and therefore workers are excluded from national minimum wages, limits on working hours, occupational safety and health measures, and social security schemes (International Labour Office 2013). The nature of domestic work can have a negative impact on health; hours are typically long and determined by ad hoc employer demands, and there is no oversight of health and safety in private homes. Academic studies, reports of civil society/human rights organisations, and media accounts have documented violations of the human rights of Sri Lankan migrant domestic workers. However there is a lack of systematic evidence in any detail specifically on health and access to healthcare, resulting in a knowledge gap. It has been noted that even globally the health of migrant domestic workers is a relatively neglected research area (Malhotra et al. 2013). Around 17.5 per cent of complaints to the Sri Lanka Bureau of Foreign Employment (SLBFE) in 2012 made by women migrant workers - the majority domestic workers and mainly with reference to labour receiving countries in the Gulf and nearby countries - was on 'sickness', the second largest category after 'non-payment of wages' (SLBFE 2012).[3]

In this report we present evidence across the entire migration process on the health status and barriers to access to healthcare of migrant domestic workers, and gaps and discrepancies in the provision of health protection for them.[4] The evidence is from primary qualitative research with pre-departure and returned migrants and a range of relevant stakeholders in Sri Lanka and the United Arab Emirates (UAE), Kuwait, Lebanon and Jordan. On the basis of this evidence, and a review of relevant policies and practices of government, regional and international organisations, as well as best practices relating to migrant domestic workers in other countries in the Asian region, the report makes recommendations towards protecting and promoting migrant domestic workers' health throughout the migration process. This is the first study to focus specifically on the health of Sri Lankan migrant domestic workers. It provides a particular emphasis on the role of the sending country in relation to health issues in the entire migration process - pre-departure, in receiving countries, and return - within human rights, gender rights and social justice frameworks.

[1] We use the WHO definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. [Online] Available from: http://www.who.int/about/definition/en/print.html [Accessed: 07th July 2015].

[2] The GCC countries are Saudi Arabia, Kuwait, the United Arab Emirates, Qatar, Bahrain, and Oman.

[3] Women have been making up around half of all outgoing migrant workers over the past few years but four fifths of complaints filed by migrant workers in the Sri Lanka Bureau of Foreign Employment (SLBFE) in 2012 were from women (SLBFE 2012).

[4] Our primary focus is the health of the migrant workers and policies and procedures pertaining to this, rather than that of their families. There is significant research focus at present directly on the latter – for example, pertaining to the wellbeing of children 'left behind' (see Wickramage et al. 2015). However, we show later in the report how in the domestic workers' own accounts family health is inextricably linked with their own health.

1.2 Objectives

The objectives of the project were:

1) To examine the governance framework around health that applies to Sri Lankan women who migrate as domestic workers to the GCC countries, Jordan and Lebanon, across the entire migration process (pre-departure, destination context, and on return), in particular, to examine gaps and anomalies in the framework around health protection and to identify barriers to providing effective and comprehensive health insurance,
2) To examine the impact of *not* having (or inadequate) health insurance and of other barriers in access to and uptake of healthcare before migration, in destination countries and on return to Sri Lanka, on healthcare seeking behaviour and health status of migrant domestic workers,
3) To situate the evidence from the primary research in the context of policies, programmes and impact in the region relating to the health of women migrant domestic workers, and
4) To impact on taking the policy and practice agenda forward on health protection for migrant domestic workers by making concrete recommendations to stakeholders who formulate and implement policies relating to migrant domestic workers.

The overall objective of this project was to produce and share knowledge that will contribute to informed policies and best practices that will improve the health of a key category of Sri Lankan overseas migrants.

1.3 Sri Lankan women migrating for domestic work: patterns and developments over time

Women form a large proportion of Sri Lankan migrant workers and have done so over the past few decades. In 2012, 282,331 people left for foreign employment and women made up around half (49 per cent) of all departures although there has been a gradual decrease of the female share of departures since the mid-1990s, when three quarters of departures were made up by women (SLBFE 2012). Disaggregation of the 49 per cent female share of outgoing migrant workers shows that 42 per cent migrated as 'housemaids'. Stated slightly differently, domestic workers made up 86 per cent of all outgoing women migrant workers in 2012. Further, 96.7 per cent of Sri Lankans migrating as 'housemaids' went to Kuwait, Saudi Arabia, Jordan, the United Arab Emirates (UAE), Qatar, Lebanon, Bahrain and Oman, with Kuwait and Saudi Arabia being the two largest receiving countries (ibid).

Sri Lankan women who migrate as domestic workers to the GCC derive from a particular local socio-demographic context. However, there is no official national or district level data on the backgrounds of these women. In general, female participation in the labour force in Sri Lanka is low compared to that of men. According to the 2013 Labour Force Survey annual report[5], among the working age population in Sri Lanka (age 15 and over) the labour force participation rate of women is less than half of that among men - 35.6 per cent of women compared to 74.9 per cent of men (Department of Census and Statistics 2014a). At the same time, among those who are in the labour force (i.e. economically active), women have an unemployment rate double that of men - 6.6 per cent compared to 3.2 per cent. It appears that women are disproportionately migrating overseas for work, given that women form around 35 per cent of the labour force in Sri Lanka but nearly half of migrant workers. Also, for those who are economically active, unemployment may be a key driver in migration.

[5] Data from the 2013 Labour Force Survey annual report is used as the 2014 annual report was not available online at the time this report was completed.

It can be suggested that many of the women who migrate abroad as domestic workers are employed in low income activities in the informal sector, between migration episodes and on return (Rathnayake et al. 2010; Jayaweera & Dias 2011). Around 61 per cent of the total labour force, and about 56 per cent of women in the labour force, were in the informal sector in 2013 (Department of Census and Statistics, 2014a). The 'employment status' of 21 per cent of women was classified as 'contributing or unpaid family workers' in the agriculture sector chiefly and also in family enterprises in the industry and services sectors compared to only three per cent of the men in the labour force (ibid). Some women who migrate may be classified as economically inactive. In particular, in 2013 around 62 per cent of economically inactive women were 'engaged in housework' (ibid). There is very little systematic information available on local domestic workers, who are also in the informal sector and may represent a feeder category for migrant domestic workers.

Studies of migrant domestic workers in Sri Lanka have shown that the main reason for the overseas migration of women as domestic workers is their attempt to escape from poverty (Ukwatta 2010; Gamburd 2000; Kottegoda et al. 2013). Both liberalisation of economic policies in the late 1970s in Sri Lanka that encouraged labour migration and the increasing demand for domestic workers in households in Gulf countries that were becoming more affluent fed the growing trend for women to migrate for low-skilled, low-paid contractual work in these countries. Remittances, both in the past and now, are key to successive Sri Lankan governments' endorsement of this large supply of female migrants despite their vulnerability to exploitative recruitment practices at origin and poor working conditions and lack of rights in destination countries. In 2012 private remittances constituted 61.3 per cent of total earnings from export in Sri Lanka, overtaking garment and tea export. Remittances from the 'Middle East' made up 57.4 per cent of total private remittances. This percentage has fluctuated between 56 per cent and 60 per cent since 1997 (SLBFE 2012).

The Sri Lanka Bureau of Foreign Employment Act No. 21 of 1985 led to the setting up of the Sri Lanka Bureau of Foreign Employment to provide a regulatory framework for migrant workers including registration of approved employment agencies, providing pre-departure training for migrant workers, and maintaining a compulsory welfare insurance scheme for migrants. Over the past quarter of a century there have been a series of policies and practices to attempt to tackle some of the many shortcomings of this regulatory framework in the light of cumulative evidence of the violations of the rights of migrant domestic workers throughout the entire migration process. The amendments to the Foreign Employment Act mainly set a compulsory registration fee for workers going overseas (1994) and tightened regulations on foreign employment agencies (2009) (Gunasinghe 2011).

Local civil society organisations are concerned that while the Act promotes migration it does not protect rights of the workers. Also while Sri Lanka has ratified the 1990 International Convention on the Protection of All Migrant Workers and Members of their Families (ICMW), some commentators point out that as a labour sending country some of the conditions pertaining to the rights and protection of migrant workers have not been enshrined in law or policy. Of direct or indirect relevance to health, these include lack of effectiveness of bilateral agreements with labour receiving GCC countries and Jordan and Lebanon (none of which has ratified the convention) on humane employment conditions and social security measures, and lack of proper accountability of services provided by labour attaches and welfare officers in Sri Lankan embassies in destination countries (Iredale et al. 2005). In general it has been commented that labour sending countries in the region do not want to place too much emphasis on migrant rights for fear that access to labour markets in the receiving countries may be curtailed as a result (Ruhs 2013).

Nevertheless there is increasing awareness within the Sri Lankan government, international organisations such as the International Labour Organization (ILO) and the International Organization for Migration (IOM) working in Sri Lanka, and civil society organisations at national and local levels,

about the importance of improving the labour market conditions and health of workers migrating overseas for low-skilled jobs. In the last few years two, migration-related, national policies have been launched - the National Labour Migration Policy (2008) and the National Migration Health Policy (2013) (see Chapter 2). Concrete mechanisms are being set up to address issues around implementation of the framework to reduce exploitative and abusive practices across the whole migration process.

Over time there has been a shift to more local (particularly district level) implementation of policy around pre-departure, and re-integration of returning migrants, mainly as a measure to address exploitative practices by unlicensed sub-agents and the protection of children left behind (see Chapter 5). The relevance and implications of the current governance framework for the health of domestic workers will be considered later in the report.

1.4 Plan of report

Chapter 2 broadly sets out the existing international, regional and national sending country policy frameworks that apply to the health of migrants with a focus on domestic workers. Chapter 3 explores receiving country regulatory frameworks on migrant health and that of domestic workers, focusing in detail on specific countries and including receiving country stakeholder interviews. Chapter 4 provides the key socio-demographic characteristics and migration motivations of the migrant domestic workers who were interviewed. Chapters 5 and 6 discuss the main findings of the primary research on health: Chapter 5 focuses on migrant and Sri Lankan stakeholder interviewee perspectives on the governance and institutional framework surrounding health; Chapter 6 relates to the migrants' experiences and views on their health status and access to healthcare. Both chapters cover the entire migration process of the domestic workers: pre-departure, destination country context, and return. The final chapter summarises the key findings of the study and sets out recommendations arising from these for improving health protection for migrant domestic workers, with reference also to other practices in the region.

CHAPTER 2

International, Regional and Sri Lankan Policy Frameworks on Migrant Health

This chapter considers international, regional and Sri Lankan national policy frameworks on health of migrants within which responses from migrant domestic workers who were interviewed need to be viewed.

2.1 International frameworks

The right to health, including for migrants in all countries, is enshrined in international human rights instruments. Article 25 of the Universal Declaration of Human Rights (UDHR) declares that each person has a right to health including social conditions important for health and well-being, access to healthcare and social security. The International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises that all people irrespective of nationality and legal status should have an equal opportunity to enjoy the 'highest attainable standard of physical and mental health' (Article 12) as well as 'safe and healthy working conditions' (Article 7). Among Gulf States, only Bahrain, Jordan, Lebanon and Kuwait have ratified the ICESCR (Gunaratne 2014). However, all GCC countries as well as Jordan and Lebanon have ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (United Nations General Assembly 1979), which incorporates equal access to healthcare services for men and women (Article 12) and the protection of health and safety at work (Article 11). All these countries have also ratified the International Convention against all Forms of Racial Discrimination (CERD)(United Nations General Assembly 1965) including on the basis of national or ethnic origin, incorporating 'the right to public health, medical care, social security and social services' (Article 5). Sri Lanka has ratified all these conventions.

More directly, the World Health Assembly's 2008 resolution on health of migrants called for member states to promote migrant-sensitive health policies and equitable access to health promotion and care for migrants.[6] There is a recognition in this resolution and in subsequent global consultations and dialogue that health outcomes for migrants have multiple determinants including those outside the health system - e.g. labour market, housing, immigration rules; but progress, particularly involving inter-sectoral and inter-state policy and action, has been slow (Mosca et al. 2013; IOM 2012; Zimmerman et al. 2011). Challenges to the health of migrants are identified at pre-departure, travel, destination country and return stages and involve cross-cutting determinants such as migrants' age, gender, educational and socio-economic background, legal migration status, as well as institutional and employer practices around recruitment and occupational conditions, and health and welfare support in receiving countries and in countries of origin.[7] There is a call for health in the UN post-2015 Development Agenda to go beyond the promotion of universal healthcare coverage for migrants to include and address the migration process itself as a social determinant of health with inherent barriers to achieving a right to health for migrants (Mosca et al. 2013).

ILO pursues a thematic strategy on migrant domestic workers in line with the ILO Director General's call for a Fair Migration Agenda 2014 building on the International Labour Conference's adoption in

[6]World Health Assembly (2008) *Health of Migrants* [Online] 61st, 24th May (WHA61.17). Available from: http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R17-en.pdf [Accessed: 31st May 2015].
[7]UN Human Rights Council (2009) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* [Online] Geneva, United Nations Office of the High Commissioner for Human Rights (A/HRC/23/41). Available from: http://daccess-dds-y.un.org/doc/UNDOC/GEN/G13/135/98/PDF/G1313598.pdf?OpenElement [Accessed: 7th August 2015].

2011 of the Domestic Workers Convention (No.189)[8] and Domestic Workers Recommendation (No. 201),[9] which were historic in setting minimum standards of protection for all domestic workers globally. In stipulating decent work for domestic workers the convention sets requirements binding on states to ensure that each worker has 'the right to a safe and healthy working environment'; contracts, working conditions and social security protection 'that are not less favourable than those applicable to workers generally'; and access to legal redress mechanisms in the face of abusive and fraudulent institutional and employer practices. Importantly, Recommendation No. 201 specifically sets out conditions for medical testing: including providing information to the domestic workers on public health and disease concerns underpinning need for testing, ensuring privacy and confidentiality of testing, and highlighting that 'that no domestic worker is required to undertake HIV or pregnancy testing, or to disclose HIV or pregnancy status'.[10] The earlier General Comment 1 of The International Convention on the Protection of the Rights of All Migrant Workers and Member of their Families (ICMW) applied health-related recommendations specifically to migrant domestic workers at different stages of the migration process.[11] While the ICMW has been ratified by Sri Lanka (see Chapter 1) but not by the GCC and Jordan and Lebanon, significantly none of these countries or Sri Lanka has yet ratified the Domestic Workers' Convention.

2.2 Regional frameworks

Alongside or following the 2008 World Health Assembly (WHA) resolution on the health of migrants there have been several regional dialogues in Asia between labour sending and/or receiving countries which either directly related to, or included, an aim for a better common understanding of the main health challenges of intra-regional migration and recommendations to improve the health and access to justice of migrant workers (Calderon et al. 2012). These include the *Colombo Process*, set up in 2003 and the *Abu Dhabi Dialogue* (ADD), set up in 2008. The Colombo Process brought together 11 labour-sending countries including Sri Lanka to co-operate on issues arising from contract labour migration. Most recently this was through the ministerial meeting held in Bangladesh in 2011 when the *Dhaka Declaration* was adopted. This declaration contains the recommendation to address 'the specific needs and concerns of vulnerable groups of migrant workers, especially women, domestic workers, low-skilled and low-wage workers' and also echoes the WHA resolution in the recommendation 'to promote the implementation of migrant inclusive health policies to ensure equitable access to healthcare and services' and incorporates occupational health and safety for migrant workers.[12] Sri Lanka assumed the Chair of the Colombo Process in 2013 and is seemingly keen to also strengthen dialogue and co-operation with countries of destination for labour migrants in the region, particularly through the ADD. An IOM report pointed out that since

[8]International Labour Organization (2011) *C189-Domestic Workers' Convention, 2011 (No. 189).* [Online] Geneva. Available from: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:2551460 [Accessed: 7th August 2015].

[9]International Labour Organization (2011) *R201-Domestic Workers Recommendation, 2011 (No. 201). Recommendation concerning decent work for domestic workers*.[Online]. Available from:http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:R201 [Accessed: 7th August 2015].

[10]Ibid.

[11]United Nations Committee on Migrant Workers (2011). *General Comment No. 1 on Migrant Domestic Workers*. [Online] Available from: http://www.right-to-education.org/sites/right-to-education.org/files/resource-attachments/CMW_General_Comment_1_2011.pdf [Accessed: 31st May 2015].

[12]Global Leadership Meeting on Population Dynamics in the context of the Post-2015 Development Agenda (2013) *Dhaka Declaration*. [Online] Dhaka. Available from: https://www.iom.int/files/live/sites/iom/files/What-We-Do/docs/Dhaka-Declaration.pdf [Accessed: 31st May 2015].

2005, 10 of the 11 countries had signed bilateral agreements or MoUs with key destination countries (Agunias et al. 2011).

The ADD is a collaborative platform of both receiving and sending countries in the region including the Gulf States, aimed at creating a broader common base to improve policies and practices with regard to temporary labour mobility between countries.[13] 'Conditions that promote health and well-being and insurance protection' are specifically mentioned as an area identified for co-operation together with promoting standard employment contracts for migrant workers. One of the key current areas for development through synergy between Colombo Process countries and destination countries within the ADD is ethical labour recruitment practices including ensuring the protection of workers' rights and welfare.[14] However regional dialogue between governments such as that covered in this section has been criticised for 'engaging more in rhetoric about protection of migrant domestic workers than in reform' (Human Rights Watch 2010a, p.24). Real collective bargaining capacity of labour sending countries is limited by the power of receiving countries to set the terms of recruiting migrant workers with individual sending countries (Ruhs 2013; Jones 2015).

2.3 Sri Lanka national framework

As mentioned in Chapter 1 there are two main national policies that have been introduced in Sri Lanka in recent years that have direct relevance for the health, access to healthcare, and health protection of migrant domestic workers throughout the entire migration process.

2.3.1 National Labour Migration Policy

The National Labour Migration Policy (NLMP) was developed by the Ministry of Foreign Employment Promotion and Welfare (MFEPW) together with the ILO, and was launched in 2008. Its stated objective is 'to promote migration in conditions of freedom, dignity, security and equity' with a focus on good governance of labour migration, protection and empowerment of migrant workers and their families, and linking migration and development processes. It was formulated in line with the provisions of the ICMW, the 2006 ILO Multilateral Framework on Labour Migration, and several national labour policies including the 2006 National Policy for Decent Work. However, implementation of rights-based measures for migrant workers appears to have been slow so far. The main output appears to be an operational manual for the labour sections of Sri Lankan diplomatic missions to strengthen the services they offer in labour-receiving countries.[15] In keeping with the aim of the policy to 'promote skilled migration' the pre-departure training provided by the SLBFE to domestic workers is now designated to be at National Vocational Qualification (NVQ) Level 3 (see Chapter 5).[16] The Ministry is also apparently in the process of drawing up a Sri Lanka Employment Migration Act but it is not clear when this will be presented to parliament and whether it is more about incoming migrants.[17]

[13]International Organization for Migration (2012) *Abu Dhabi Dialogue*. [Online] Available from: https://www.iom.int/abu-dhabi-dialogue [Accessed: 10th May 2015].
[14]Mangala Randeniya (2014) Our mission on behalf of 'Rata Viriwo'. *Daily News* 12th September, p. 20.
[15]Ministry of Foreign Employment Promotion and Welfare (2009) *National labour migration policy for Sri Lanka*. [Online] Colombo. Available from: http://www.ilo.org/dyn/migpractice/migmain.showPractice?p_lang=en&p_practice_id=27 [Accessed: 18th February 2015].
[16]Stakeholder interview, 26th August 2014 – Expert involved in formulation of the NLMP.
[17]Stakeholder interview, 26th August 2014 – Expert involved in formulation of the NLMP. Also personal communication with ILO official, Colombo, 17th February 2015.

An analysis of the health aspects of the labour migration policy reveals the following actions proposed (MFEPW 2008):

- Monitoring health impacts of migration and creating awareness among migrants about possible health risks,
- Pre-departure health testing to be regulated to ensure dignity, privacy and confidentiality,
- Pre-departure training to include information on health tests, health issues while in service, and access to health services abroad,
- Inclusion of HIV awareness in pre-departure training,
- Psychological counselling to be included in pre-departure training and counselling to be available on demand in destination countries,
- MoUs and bilateral agreements with receiving countries to include provisions for protecting workers' physical, mental and health rights and dealing with contract violations,
- Setting up migrant worker resources centres in diplomatic missions headed by labour attaches and supported by welfare officers and including shelter, medical and legal services,
- Ensuring safe repatriation of workers in emergency situations including relating to sudden and serious health and safety issues.

It has been pointed out that while emphasis on counselling and monitoring health impacts of migration is present in the policy, there is less focus on diseases other than HIV/AIDS and its risks, and insufficient information about available health services in destination countries and upon return. Further where the health situation of a worker disqualifies them from migrating, there is no proposal for a follow-up system to enable the worker to deal with the health issues (Centre for Applied Research and Training 2012). However most of the action points above resonate with recommendations and action points adopted in Colombo Process country dialogues with each other and with receiving countries in the region. Later in this report we will consider whether there has been progress on the above actions, as revealed in the interviews with migrants and stakeholders.

2.3.2 *National Migration Health Policy*

The Ministry of Health in collaboration with IOM developed the National Migration Health Policy (NMHP) and it was launched in September 2013. It is a first attempt to specifically address the health needs of Sri Lankan outgoing, incoming and internal migrants and their families, and is aimed at advancing the World Health Assembly's 2008 resolution on health of migrants which, as stated above, calls for member states to promote migrant-sensitive health policies and equitable access to health promotion and care for migrants. It contains 'policy responses and a detailed action plan of strategies and actions to address needs' (Ministry of Health 2013). The policy states Sri Lanka's commitment to several international and regional policy declarations over the past few years including adoption of the *Dhaka Declaration* recommendation to ensure equitable access to healthcare and services as well as occupational safety and health of migrant workers, as discussed above.

The following action points in the policy are relevant to outbound migrants, who are the focus of this report:

- Develop and implement a comprehensive and standardised health assessment at pre-departure stage 'that endorses the dignity and protection of migrants,'
- Ensure health protection for migrant workers by entering into bilateral agreements and memoranda of understanding with migrant employing countries,

- Offer voluntary health assessments to returnees to be integrated within the national healthcare system,
- Implement a co-ordinated local response addressing physical and mental health services and social welfare support to migrant workers and families left behind.

The policy document suggests that there is a need to go beyond the issues and recommendations raised in the National Labour Migration Policy, including having a focus on non-communicable diseases as much as on communicable diseases, and public health impacts of mobility. Significantly and pertinently it raises some key issues around migrant worker health in some detail (Ministry of Health 2013). These include:

- While there has been international, regional and national policy dialogue between receiving and sending countries (for example the IOM initiated *Abu Dhabi Dialogue*[18]) there are insufficient bilateral agreements 'in which healthcare provision is stated as a responsibility of prospective employers'. There is understanding 'that Sri Lankan government initiative is needed to extend these agreements'.
- 'Inadequate insurance cover for migrant workers is a major constraint' particularly in freely accessing healthcare and medicines in destination countries. Some employers refuse to pay the healthcare costs of employees and/or deduct health expenses from migrant workers' wages. The policy document refers to evidence from background research that migrant workers are reluctant to report poor health conditions to employers or to seek medical care because they fear they may be dismissed from employment and be repatriated (Centre for Applied Research and Training 2012).
- There is a need to review and monitor compulsory health tests that are required by receiving countries which are carried out largely by private medical centres in Sri Lanka. There is also a recognition that some migrants do not undergo pre-departure health assessments and are therefore more vulnerable in destinations.
- The importance of follow up and management of non-communicable diseases such as hypertension and diabetes should be built in to pre-departure health assessments.
- There are limitations in the services provided by Sri Lankan embassies and diplomatic missions in destination countries.
- There is a need to address the fact that major causes of morbidity and mortality in workplaces are accidents, injuries, and gender-based violence particularly for domestic workers.
- Currently there is little focus on the mental and physical health needs of returning migrants. There is a need to integrate health into re-integration frameworks.

The importance of cross-departmental and multi-sectoral involvement in formulating and operationalising the NMHP is highlighted in the creation of a National Migration Health Taskforce which includes several government ministries such as Welfare, Labour, Justice, and Women's Affairs, the IOM and ILO, and academic experts.[19]

The National Migration Health Policy is more recent than the National Labour Migration Policy; therefore there has not been enough time to evaluate its implementation or impact. Stakeholder interviews for this project with officials in Government Ministries suggest that it has yet to be operationalised at grass roots level, and conditions have yet to be set for implementation.[20] While the NMHP document stresses that it covers action points not covered by or insufficiently developed

[18]International Organization for Migration (2012)
[19]Government of Sri Lanka & International Organization for Migration (n.d.).*Migration, health and development in Sri Lanka*. [Online] Available from: http://migrationhealth.lk/ [Accessed: 18th February 2015].
[20]Stakeholder interviews, 21st August 2014 & 28th August 2014.

in the NLMP, a review of the action points on health in both, as set out above, shows considerable similarity in some respects - for instance on the importance of bilateral agreements with receiving countries, and of pre-departure health assessment 'with dignity'.

Despite continuing political changes in Sri Lanka, migration has not been a political issue so far. Migration policies have not fluctuated according to political changes since the 1970s as governments depend on migrant remittances.[21] The NLMP and the NMHP have been a springboard for several policies, action plans, programmes recently including the 2015 draft National Action Plan for Return and Re-integration of Migrant Workers. This draft includes 'short/medium term' goals such as streamlining the existing insurance scheme incorporating more benefits for migrant workers, ensuring returning migrant workers have access to the national healthcare system, and encouraging operationalisation of the standard employment contract for female domestic workers going to GCC countries.[22] It remains to be seen if any of the health-related areas in the NLMP and the NHMP, as well as in other action plans and programmes will be implemented in the near future.

[21] The newly appointed Minister for Foreign Employment has publicised her concerns on, and state support for, the human and labour rights of migrant domestic workers. See ACTFORM meets Minister of Foreign Employment, Thalatha Athukorala 2015. [Online] Available from: http://womenandmedia.org/actform-meets-minister-of-foreign-employment-thalatha-athukorala/ [Accessed: 12th July 2015].

[22] We were informally allowed access to the draft Action Plan in its current form as of June 2015 while it is at evaluation stage.

CHAPTER 3

Receiving Countries in the GCC (UAE, Kuwait, Qatar & KSA), Jordan and Lebanon

The previous chapter discussed the international, regional and Sri Lankan policy developments relevant to considering the health of migrant domestic workers. This chapter provides a detailed examination of the regulatory framework for migrant health, with a focus on the health of domestic workers, in the key receiving countries covered in this study.

3.1 Migrant health regulation

The six Gulf Cooperation Council (GCC) countries are the largest recipients of temporary migrants in the world, constituting almost 43 per cent of their total population. In some countries such as Qatar and the United Arab Emirates (UAE), more than 80 per cent of the population consists of non-nationals (Gulf Research Centre 2015). In 2013, Saudi Arabia and UAE were two of the top ten destination countries in the world with nine million and eight million migrants, respectively.

Over the last two decades, the GCC has become ever more reliant on Asian migrant workers; more than three-fourths of all female Asian migrants work in the GCC as domestic workers (ibid). At the national level the sponsorship, or *kafala* system that regulates labour flow into the GCC has a direct impact on migrants' lives by linking resident permits, or *iqama*, to sponsors, or *kafeels* (Malit & Youha 2013). In this system, *kafeels* sponsor migrant workers to come from abroad for a period of, typically, two years. They use the services of recruitment agencies in sending countries to find workers. For domestic workers, sponsors must pay a fee to the recruiter and pay for the worker's airfare, employment visas, work permits, medical fitness tests upon arrival, wages and airfare home. In most countries, the worker must have the employer's consent to change contracts, to change jobs, or to leave the country. If the employer does not consent, the migrant worker becomes irregular.[23]

It is generally recognised that the sponsorship system cedes employers inordinate power over the economic, legal, and health status of a domestic worker. Abuse to female migrants has been well documented in Saudi Arabia, Kuwait, Lebanon, and the UAE (Human Rights Watch 2007, 2014). If a domestic worker falls out of favour with the sponsor, for example, by seeking justice for abuse or complaining about withholding wages or passports, she faces the immediate loss of her legal status in the destination country, leaving the choice to either remain in the country illegally or repatriate. The GCC bans workers from returning to the country for one year if they become irregular.

Neither Qatar nor Saudi Arabia has changed the sponsorship system significantly despite various officials signaling changes.[24] The UAE implemented a direct deposit wage protection system (WPS), but domestic workers are not covered by it. Qatar has recently introduced a similar scheme.[25] Jordan

[23]This varies by country as seen below.

[24]Egypt Independent (2012) *Saudi Labor Ministry began steps to abolish sponsorship system, paper says*. [Online]14/05. Available from: http://www.egyptindependent.com/news/saudi-labor-ministry-began-steps-abolish-sponsorship-system-paper-says[Accessed: 4th May 2015].

[25]The Peninsular (2015) *Emir signs law on wage protection*. [Online] February 19. Available from: http://thepeninsulaqatar.com/news/qatar/322615/emir-signs-law-on-wage-protection[Accessed: 5th May 2015].

and Lebanon introduced unified standard contracts, but did not change the sponsorship system so enforcement is not systematic. Nonetheless, the system remains for a number of reasons:

> First, some citizens benefit from sponsorship payments, so ending *kafala* could end these payments; one estimate asserts that a $1 billion recruitment industry is supported by the Middle Eastern migrant labour system. Second, the *kafala* system helps ensure control over foreigners in countries where they often outnumber natives. Third, the Asians and Africans who have largely replaced Arabs as low-skilled migrant workers in Gulf countries are less likely to protest the restrictions on their liberties imposed by the sponsorship system. Fourth, migrant-sending countries have been unable to exert sufficient pressure to end sponsorship.[26]

It must be recognised that the need for private health insurance, or a health insurance card, is a relatively new phenomenon for both the Sri Lankan migrants who have access to national health coverage in Sri Lanka, and their national employers in most destination countries. The primary stakeholders of the healthcare sector are a mix of public and private players in the GCC. Insurance penetration in the GCC remains substantially low compared to the global average, but it is increasingly expanding.

Health insurance is a rapidly growing industry in the Middle Eastern receiving context for nationals and non-nationals alike. The Ministries of Health in the GCC are the key regulatory authorities for healthcare in the region. There are mandated bodies such as Kuwait's Public Authority for General Health established in 2010 and Qatar's Primary Healthcare Institution founded in 2011. In 2010 Jordan and Bahrain proposed healthcare cooperation, mainly in health insurance, with Jordan offering capabilities to Bahrain. There have been attempts to establish regional coordination with smart health identification cards. However this has yet to materialise.

Medical insurance improves affordability of healthcare and, in turn, boosts demand. Furthermore, it enables sustainable quality development of the sector by reducing government burden. It distributes costs between public and private entities as well as provides the right set of business economics to healthcare stakeholders. Medical coverage is likely to increase significantly over the next few years, especially considering that GCC governments have mandated health insurance. Saudi Arabia led this initiative with compulsory medical insurance for expatriates from 2006. The expatriate population in GCC is expected to increase over the next five years due to high demand for skilled labour. Most GCC governments are also extending the mandate to include non-nationals, in line with Saudi Arabia's move in 2008. Other governments are either following or are expected to follow within the next few years; this would significantly drive health insurance and, in turn, the overall healthcare market (Alphen Capital 2011).

It is still relatively difficult to find homogenous data because healthcare policies, laws and regulations are highly fragmented among the various member states. For instance, the UAE enacted a system based on health insurance with a public provider, i.e. Daman and many smaller private firms. Different states appear to be hopeful of implementing that system. How that will affect Sri Lankan domestic workers remains to be seen.

A unified standard employment contract for migrants that includes comprehensive health insurance may ameliorate the situation. For example, Jordan's standard employment contract for domestic workers mandates that employers must take out life insurance for domestic workers but does not include comprehensive health insurance. Human Rights Watch has clearly documented abuses

[26]GCC: Kafala, UAE (2012) [Online] *Migration News* 19 (1) January. Available from https://migration.ucdavis.edu/mn/more.php?id=3740 [Accessed: 6th January 2015].

reported by migrants working in the GCC with exploitative recruitment and employment practices, particularly in relation to contractual violations (Plant 2008). In the past few years, leaders of the GCC agreed to consider a new unified standard contract for domestic workers including overtime pay, time off, paid annual leave and independent living, but it has not been implemented by all member states.[27]

3.2 Country profiles

United Arab Emirates

Since the discovery of large, natural gas and oil reserves in the early twentieth century, migration has been intimately connected to the Gulf's history. Emerging from the political and economic alliances of the former Trucial States, the UAE formed a formal federation in 1971, which was quickly followed by the astronomical rise in the price of oil in 1973. The UAE comprises the emirates of Abu Dhabi, Dubai, Sharjah, Ajman, Umm al-Qaiwain, and Ras al-Khaimah. Similar to the rest of the GCC, the UAE has a growing, youthful population; the population growth rate is almost double the norm for more developed countries (United Nations. Department of Economic and Social Affairs, Population Division 2009). Population growth is affected by the heavy influx of migrants, a steady, declining birth rate, and an increasing healthy life expectancy rate. Thus, the dominant socio-economic factors of the UAE are a small indigenous population, a large migrant population, and tremendous oil-generated wealth.

Mirroring the rest of the GCC, the UAE has an immigration system based on the sponsorship system. Migrants have contributed greatly to the federation's development with only 10 per cent of the national population's participation in the workforce. There are manifold abuses of the system as visa trading in the UAE has generated a multi-million dollar industry (Shah 2005). Due to the reliance on the *kafala* system, migrants have been excluded in integration policies because they rarely have the possibility of legal permanent residency (Fargues 2006). In 2007, the UAE signed a non-binding MoU with Sri Lanka establishing a bilateral contract for domestic workers, which requires recruitment agencies to provide workers with legally binding contracts. Migrant workers are totally excluded from labour laws pursuant to Art 3(c) of the Labour Law No.8 of 2007 although there are currently draft laws under review. There is a standard employment contract in the UAE.[28]

In June 2014 a unified employment contract for domestic workers was introduced in the UAE with the provision of a paid rest day per week, at least eight hours continuous rest during the day and 30 days paid leave at the end of the contract period. However, the employer has the right to unilaterally define wrong doing by the employee and the employee's rights are withdrawn if she 'suddenly leaves work without informing' the employer. Further, commentators have pointed out that this new contract does not include details of either the UAE or Sri Lankan recruitment agent and the requirement for embassy authentication of the contract is nullified, thus removing the right of sending country embassies to safeguard workers' interests and contravening foreign employment laws in most sending countries. This has led to the Philippines withdrawing the recruitment of

[27] Albawaba Business (2015) *GCC new unified labour contract turns up the heat on Qatar*. [Online] January 12th. Available from: http://www.albawaba.com/business/gcc-new-unified-labour-contract-turns-heat-qatar-643540 [Accessed: 8th February 2015].

[28] International Trade Union Confederation (2014) *Facilitating exploitation: a review of labour laws for migrant domestic workers in Gulf Cooperation Counties* [Online] Available from: http://www.ituc-csi.org/IMG/pdf/gcc_legal_and_policy_brief_domestic_workers_final_text_clean_282_29.pdf [Accessed: 4th January 2015].

nationals for domestic work in the UAE but Sri Lanka is continuing to send migrants for domestic work, under this new contract.[29]

There are an estimated 200,000 Sri Lankans employed in the UAE of whom 150,000 are in Dubai. Forty five per cent are female migrant workers of whom 90 per cent are domestic workers. Most of the complaints received by the Labour sections of the Sri Lanka Dubai Mission are related to female domestic workers, which is nearly 50 per cent of the total migrant complaints. The complaints relate mainly to irregular visas, wage disputes, and health abuses.[30]

Both nationals and migrants have applied pressure for reformation in the labour market's governance and a shift in the labour policy paradigm. Proponents of immigration and migrants' rights have called for the recognition of migrants' contribution to the region's social and economic development through more favourable migrant labor policies (Dito 2008). Many Emiratis seek to curb migration levels and to promote the education of the youth into joining the national labour market in order to maintain national identity, and to highlight security concerns in its promotion of Emiratization (Deloitte 2015).

At the beginning of the twentieth century, the UAE was generally poor by international standards as evidenced by a low healthy life expectancy rate, high infant mortality rate and high maternal mortality rate. With the discovery of oil, British and American interests were in competition to establish hospitals in the region. In 1949, the British government built Al-Makhtun Hospital in Dubai. In the 1950s and 1960s, American mission hospitals were built in Sharjah, Al-Ain, and Ra's Al-Khaymah. In 1965, Abu Dhabi had one public and three private physicians. For the next two decades, healthcare investment fluctuated with the price of oil. In the 1990s, energy companies and the military continued to have their own healthcare systems. All UAE residents regardless of nationality received free healthcare until 1982 when foreign nationals were required to assume their own medical costs beyond emergency, maternity and childcare.

Health expenditure generally increases on a yearly basis as a percentage of the federation's GDP. Public sector spending far outpaces the private sector (op. cit.) However, despite the federation's wealth and high-income levels, healthcare expenditure as a percentage of GDP lags in relation to the more developed world; it is true even in oil price boom times. With growing national and migrant populations, rising life expectancy, and diseases of affluence on the rise, both public and private expenditure on healthcare must match the increasing health needs of the UAE (NCB Capital 2009).

The Ministry of Health (MoH) has led the way to the improvement of national, or Emirati health by supporting both government-funded health services and private sector healthcare development. The Dubai Health Authority (DHA) manages healthcare in Dubai. The Health Authority of Abu Dhabi (HAAD) and the Abu Dhabi Health Services Company (SEHA) are responsible for regulating healthcare in Abu Dhabi.[31] SEHA was launched in 2007 and manages all public hospitals and clinics in

[29]Personal communication with Consultant on labour migration in Sri Lanka, 6th March 2015; and, Confusions over labour contracts for domestic workers (2014). [Online] *The Sunday Times Business Times,* July 06, 2014. Available from: http://www.sundaytimes.lk/140706/business-times/confusion-over-uae-contracts-for-domestic-workers-105616.html [Accessed 8th March 2015].

[30]Interview with Labour Counsellor, 20th October 2014.

[31]Telephone interviews were conducted by Elizabeth H. Shlala in June 2010 with senior leadership from the Health Authority of Abu Dhabi (HAAD), the national health insurance provider (Daman), and the provider of services from primary to palliative care (SEHA) on the relationship between skilled migration and healthcare for a project for the Institute for the Study of International Migration (ISIM) at Georgetown University. These highly skilled migrants act as both public policy and healthcare sector leaders.

the emirate, accounting for almost 70 per cent of Abu Dhabi's healthcare sector. It operates eight hospital brands including Al Gharbia Hospitals, Tawam Hospital and Sheikh Khalifa Medical City, as well as a large number of primary-care clinics.

All migrants fall under the Ministry of Labour and the health authorities require all migrant workers to have health insurance. Health insurance was mandated in Abu Dhabi in 2006 for all firms with more than 500 expatriate workers. The law was extended to all migrants in 2007. It was further extended to all UAE nationals in 2008. The government subsidises the compulsory basic health insurance. To apply, the sponsor must go to Daman (see below) with the domestic worker's work permit (or residency visa in the case of renewal) and copy of passport, along with his/her own passport copy, evidence the employer has personal health insurance, and a contract or letter that certifies the domestic worker's salary. Since the Government subsidises the basic plan, sponsors pay an annual flat fee. If a domestic worker is employed in Dubai or the Northern Emirates, the only option at present is to go through a private insurer for her healthcare (Manal 2014).

Mandatory national health insurance forms the foundation of Abu Dhabi's healthcare system. Daman National Health Insurance Company (Daman) is the non-life health insurance government-affiliated company in Abu Dhabi. It started operations in May 2006 with over 1000 employees. *Thiqa* insurance is provided to more than 500,000 nationals through Daman. It provides access to providers and increases consumers' usage of health services. Daman is integral to the health system with regards to quality; it holds providers accountable for services in order for them to receive payment.[32]

Despite the mandatory health insurance and health insurance card given to migrants, the sponsor remains the critical component in access to healthcare in the UAE, which reflects the situation in the rest of the region. In the UAE, most migrants contribute to the healthcare system, but high level migrants and nationals benefit most from it, receiving the highest access to, and quality of, care.

> The only way an employer can ensure that the domestic worker is sure about what kind of healthcare they can access is by way of informing them or educating them of the same. It would be the sole responsibility of the employer to assist or guide the domestic worker at all times when they require medical assistance.
>
> Cases have been reported where the employer has ignored the needs of the domestic workers in situations where they require medical help and the employers would also not bother informing them about how they can access healthcare.[33]

Kuwait

Rapid economic expansion from petrodollars in the 1970s led to the explosion of domestic service in Kuwait. Demand for domestic work entrenched migration networks from Southeast Asia, India, and more recently East Africa. 'From the mid-1970s to the late 2000s, Kuwait's migrant domestic worker population grew from 12,000 to 500,000, and the percentage of Kuwaiti households employing domestic workers increased from 13 to 90 per cent' (Shah et al. (2002) quoted by Ahmad 2010). The migrant population of Kuwait has outnumbered nationals for decades. Most migrants are Asian and the majority of domestic workers come from Sri Lanka, India and the Philippines (Shah 2007). Critically, Kuwaiti labour laws passed in 1964 did not include migrant workers who arrived en masse a decade later. Therefore, they did not have the protection of the state's labour laws. Additionally, domestic work, as a type of gendered labour, does not fall within the purview of labour laws, so

[32]Telephone interview with Michael Bitzer, CEO of Daman, June 2010.
[33]Expert interview, 13th August 2014.

domestic workers have been doubly denied state protection in Kuwait. They are totally excluded from labour laws pursuant to Article 5 of the New Private Sector Labour Law No.6 of 2010. This follows the pattern of the entire GCC in which labour laws either partially or completely exclude domestic workers (International Trade Union Confederation 2014). Kuwaiti labour recruitment agencies began to negotiate on behalf of domestic workers in difficult situations and won them a certain level of rights in subsequent decades. They ensured payment of wages, provided shelter, gave legal assistance, and started insurance programmes for migrants (Ahmad 2010). Since the late 2000s, non-governmental groups (NGOs), trade unions, and human rights organizations have worked to protect the rights of domestic workers in Kuwait. Kuwait does have a compulsory standard contract. Plans to abandon the sponsorship system and place migrants under the Public Authority for Manpower were announced in 2013.[34] To date, migrants fall under the Immigration Department of the Ministry of the Interior and are governed by Law No 4 (2009), which continues to require sponsorship (Qatar Legislations 2009). In June 2015, Kuwait passed a new law on domestic work, which requires employers to provide medical treatment but unlike the general labour law applying to the private sector, it does not have detailed provisions for paid sick leave (Human Rights Watch 2015).

Kuwait signed a MoU in 2007 with Sri Lanka on the welfare and protection of foreign workers that included a compulsory insurance scheme but the foreign employment agencies have to bear responsibility for the Sri Lankan migrant workers. According to the IOM in Kuwait, and in line with the 2011 policy of the Ministry of Health, any expatriate with legal residency is required to pay $170 (or 130 KWD) in health insurance annually in exchange for full medical coverage.[35] Despite some gains, Kuwait has a two-tier system of healthcare, segregated between nationals and non-nationals enshrined in law in 2013 (Migrant-Rights.org 2013). All domestic workers in Kuwait must be provided with health insurance before their resident permit, or *iqama*, is issued, every year or every two years in most cases. The employer usually buys the worker's health insurance. However, in some cases, the worker may have to pay for this out of the salary. With the health insurance, the worker has access to all health facilities in the public sector, including hospitalisation. Specialised tests may carry a cost but exceptions are possible. The bigger issue in accessibility arises when a sick domestic worker may not be taken to the clinic or hospital or when care is delayed.[36] News coming out of Kuwait of a two-tier healthcare system based on segregated health insurance and hospitals should be disturbing to migrant domestic workers and their supporters:

> This August, sources revealed that a health insurance company has been established to construct three migrant-only hospitals…The newly-established Kuwait Health Assurance Company … features pre-set prices for services and is expected to cover only 60% of the country's migrants. The project is part of the public-private partnerships (PPPs) plan approved in 2010 to privatize parts of the economy and decrease the country's dependence on oil. However, privatization of public health will lead to the denial of essential services to low-income migrants, who comprise a significant portion of the population. The Ministry believes the quality of its resources are inconsistent with the prices paid by migrant workers, even despite the prospective segregated and unequal services…The Ministry of Health also announced it is considering raising expat's medical fees merely to "to boost revenues and reduce overcrowding at facilities" (Migrant-Rights.org 2013).

[34]Nawara Fattahova (2013) Sponsor system on the way out – new authority in place to streamline transfers 2015. [Online] *Kuwait Times,* 19th September. Available from: http://news.kuwaittimes.net/sponsor-system-kuwait-way-new-authority-place-streamline-transfers/ [Accessed: 5th May 2015].
[35]Email response from IOM Kuwait, 2nd July 2014.
[36]Email response from Nasra Shah, Professor at Kuwait University, 22nd May 2014.

Kuwait's five-year Development Plan launched in 2010 has a clear remit to establish hospitals solely for migrants to use with a government-sponsored medical insurance programme. The contract falls under the Ministry of Justice and the Ministry of Commerce and Industry.[37]

Qatar

Qatar is the smallest country in the GCC with two million residents, but it is rich in hydrocarbons and has the second highest per capita GDP in the world. Migrants have flowed into the country since the 1970s. Non-nationals make up 85.7 per cent of all residents and 94.1 per cent of the workforce. Fifty nine percent (58.6 per cent) of non-national females are in the domestic sector. Three quarters of the foreign workforce is Asian; India is the biggest sending country (De Bel-Air 2014).

Domestic workers in Qatar are excluded from the labour law, so, no legal limits to their working hours or fixed days off are enshrined in the country's employment law. They may not complain to the Ministry of Labour and Social Affairs about their work conditions. Domestic workers in Qatar have suffered documented forms of abuse including: discrimination; restrictions on their freedom due to the sponsorship system; isolation; physical and sexual violence; and difficult working conditions. It is a challenge for domestic migrant workers to seek and receive justice in Qatar. A migrant must obtain an 'exit visa' that is approved by her sponsor in order to leave the country. A migrant must also have the permission of the sponsor to change jobs (Amnesty International 2014).

A 2011 survey found that 47 per cent of Qatari nationals wanted the sponsorship system tightened. The same study showed that 75 per cent of respondents believed that migrants put a strain on the country's health services.[38] Qatar boasts of state of the art healthcare for women and children. Healthcare has been free to all residents with a health card issued to them regardless of nationality for approximately $22 and renewed online.[39] By the end of 2015, this will change as Qatar follows the rest of the GCC trend to force migrants into purchasing private healthcare insurance instead of relying on state care.[40] Qatari nationals will not have to buy private healthcare insurance to cover healthcare costs and services.

Kingdom of Saudi Arabia

Saudi Arabia has the biggest economy in the Arab world and it has the world's second largest oil reserves. It became a migration destination country in the 1930s. As of mid-2013, non-Saudis made up 32.4 per cent of the total resident population of 29,994,272. South Asians accounted for 56.6 per cent of the labour force, and 89 per cent of the private sector workforce (De Bel-Air 2014). The Nitaqat campaign for the 'Saudisation' of the workforce began in 2011. Five hundred thousand Sri Lankan migrant workers reside in Saudi Arabia, approximately three-fifths of whom are women.[41] In

[37]Kuwait Times (2013) *Health insurance company plans being finalised – hospitals for expats.* [Online] August 18. Available from: http://news.kuwaittimes.net/health-insurance-company-plans-being-finalized-hospitals-for-expats/ [Accessed: 30th August 2015].

[38]Gulf News (2011) *Qatari citizens wants sponsorship rules tightened further-survey*. [Online] January 8. Available from: http://gulfnews.com/news/gulf/qatar/qatari-citizens-want-sponsorship-rules-tightened-further-survey-1.742530 [Accessed: 30th August 2015].

[39]Peter Pallot (2014) Qatar provides free health care-but red tape can cause stress. [Online] *The Telegraph* 15 July. Available from: http://www.telegraph.co.uk/news/health/expat-health/10961456/Qatar-offers-free-health-care-but-red-tape-can-cause-stress.html [Accessed: 20th March 2015}.

[40]Peter Pallot (2014)

[41]Palash Gosh (2014) Sri Lanka and Saudi Arabia ink migrant labour rights deal, more than one year after the execution of female domestic worker. [Online] *International Business Times* March 07. Available from: http://www.ibtimes.com/sri-lanka-saudi-arabia-ink-migrant-labor-rights-deal-more-one-year-after-execution-female-domestic?rel=rel2 [Accessed: 09th August 2015].

Saudi Arabia, migrant workers are totally excluded from labour law pursuant to Art 7(2) of the Labour Law 2006 (Royal Decree No. M/51). In the historic Resolution No. 310 of 2013, or the Household Regulation on Service Workers and Similar Categories, the employer is barred from imposing work on the domestic worker unless the work has been agreed upon, and provided the work does not substantially differ from the original work. The employer is also barred from imposing any dangerous work that threatens the health, safety and human dignity of the domestic worker. Furthermore, the employer is mandated to provide appropriate accommodation to the domestic worker; provide the domestic worker the opportunity to enjoy a daily rest of at least nine hours a day; personally, or send a representative to, answer complaints, if any, made by the domestic worker; and not to 'rent out' the domestic worker. Other benefits for domestic workers under the regulations are a weekly rest day; one month leave after two years of service if renewing the contract; paid sick leave of not more than 30 days; health care according to the rules and regulations of Saudi Arabia; and end-of-service benefits equivalent to one-month salary after four years.[42] Employers who violate the regulations shall be fined 2,000 Saudi riyals and prevented from recruiting domestic workers, while domestic workers shall be fined 2,000 Saudi riyals and prevented from working in the Kingdom.[43]

In 2014, Saudi Arabia signed a MoU with Sri Lanka to safeguard domestic workers. Health and personal safety are mentioned in the document. Under the agreement, the employer may not keep the domestic worker's passport and wages must be remitted to a bank account. It includes the responsibility of the employer for the medical expenses of the employee, and in addition stipulates at least one rest day a week, and the right of the employee to keep her own passport and work permit and to freely communicate with the Sri Lankan embassy in the country and her family in Sri Lanka. Vadivel Krishnamoorhy, Sri Lankan Ambassador in Riyadh expressed his satisfaction with the agreement and hoped for a standard contract to follow.[44] He told Arab News that Sri Lankans working in the Middle East send home about $2.5 billion annually in remittances. However, this contract is not at present in operation because of the lack of 'diplomatic procedural clearance'.[45] In early February 2014, the Sri Lankan Embassy in Riyadh established a 24-hour toll-free phone line for workers to discuss their problems and grievances.

Despite the efforts of the ambassador, there is still fear for the health and welfare of Sri Lankan domestic workers after the 2013 beheading of a Sri Lankan woman for the alleged murder of a Saudi baby under her care whilst she was a minor. The key to the implementation of these rights and responsibilities will be enforcement mechanisms focused on private homes-cum-workplaces. Abuses against domestic migrant workers are well documented (Human Rights Watch 2008). Nevertheless, the remittance contribution of female migrant workers is critical to Sri Lanka's economy. It is estimated that migrant workers' remittances will reach $10 billion by 2020 (Sri Lankan's GDP is currently $60 million).[46]

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[42]Republic of the Philippines. Department of Labor and Employment (2013) *A first between Saudi Arabia and a country of origin.* [Online] Available from: http://www.dole.gov.ph/ro_polo_updates/view/631[Accessed: 2nd February 2015].

[43]GMA News *(2013) New Saudi rules ensure rights, safety of foreign household workers.* [Online] *October 31. Available from: http ://www.gmanetwork.com/news/story/333439/pinoyabroad/news/new-saudirules-ensure-rights-safety-of-foreign-household-workers [Accessed: 2nd February 2015].*

[44]Government of Sri Lanka (2014) Sri Lanka, Saud Arabia sign landmark deal on migrant workers. [Online] *News Line* Available from: http://www.priu.gov.lk/news_update/Current_Affairs/ca201401/20140116sl_saudi_arabia_sign_landmark_deal_migrant_workers.htm [Accessed: 2nd February 2015].

[45]Personal communication with Consultant on labour migration in Sri Lanka, 9th March 2015.

[46]Palash Ghosh (2014).

The healthcare infrastructure sector is booming in Saudi Arabia. There are currently 132 healthcare centres and hospitals being built and plans for 22 more as well as two medical complexes. Like the rest of its neighbours in the Middle East, Saudi Arabia relies heavily on migrants in running the healthcare sector.[47]

> The six countries that make up the GCC have 10 times as many doctors and nurses per 1,000 people as some of the world's most impoverished nations, like Afghanistan, Sudan or Yemen. But 75 per cent of these physicians and 79 per cent of nurses are not nationals from the countries in which they work, according to a policy brief on health worker migration in the GCC published by the Aspen Institute. These statistics are in spite of nationalization programs aimed at injecting local, not expatriate, labor into the workforce. In 2001, after 20 years of "Saudization," only 21.7 per cent of physicians in Saudi Arabia were Saudi nationals (Whitman 2015).

Since 1999, The Cooperative Health Insurance Law (No. 71) has ensured the provision and regulation of healthcare to all non-Saudis resident in the Kingdom. The sponsor is responsible for acquiring Cooperative Health Insurance on the worker's behalf. A residence permit may not be issued or renewed until the Cooperative Health Insurance document has been shown to cover the entire period of employment. The law includes penalties for sponsors and insurance companies who fail in their obligation to the migrant worker.[48]

> The GCC healthcare market is forecast to jump to $69.4 billion by 2018 from about $39.4 billion in 2013, according to Alpen Capital, an investment bank. While Saudi Arabia is expected to remain the largest market in the GCC, Qatar and UAE are forecast to be the fastest growing healthcare markets.[49]

As in the UAE, all migrants contribute to the healthcare system in Saudi Arabia, but high level migrants and nationals benefit most from it, receiving the highest access to, and quality of, care.

Jordan

In the 1980s, Jordan became a destination country for domestic migrant workers. It now has 6.5 million people of whom at least 70,000 are domestic migrant workers (Frantz 2014). More than 30,000 migrant domestic workers come from Sri Lanka (Human Rights Watch 2011). In 2003 Jordan became the first Arab country to begin using a standard unified contract for domestic workers. Jordan signed a MoU in 2007 with Sri Lanka on the welfare and protection of foreign workers that included a compulsory insurance scheme, but the foreign employment agencies had to bear responsibility for the Sri Lankan migrant workers. In 2008, Jordan became the first country in the region to include domestic workers under the labour law. It is unclear what difference that has actually made in domestic workers' lives, but it sets a very important precedent. In 2009 the Labour Ministry included a provision in the standard contract prohibiting the worker from leaving the home without the employer's consent, even after working hours. On 13 September 2013, the provision for the worker to ask for approval to leave the house was modified by a provision requiring the worker

[47]Deloitte (2015) *Global healthcare outlook.*

[48]Saudi Arabia. Ministry of Labour (2009) *The Cooperative Health Insurance Law (No. 71)* [Online] Available from: http://gulfmigration.eu/saudi-arabia-the-cooperative-health-insurance-law-no-71/ [Accessed: 4th February 2015].

[49]Saudi Gazette (2015) *Expats risk losing iqamas with 14 days left for mandatory health cover for dependents*. [Online] January 06. Available from: http://www.saudigazette.com.sa/index.cfm?method=home.regcon&contentid=20150107229767 [Accessed: 4th February 2015].

to notify the employer before leaving the house (Tamkeen Centre for Legal Aid and Human Rights 2012). The change was important because domestic workers forcibly confined to the homes in which they work often suffer psychological harm as they are unable to interact freely with the world beyond the walls of their employment. Domestic workers in Jordan and Lebanon have experienced isolation, restricted communication, and barriers to help due to exploitative recruitment agencies and employers (Frantz 2014).

Regulation No. 90/2009 of Domestic Workers, Cooks, Gardeners and Similar Categories' states that the employer is responsible for providing healthcare to the worker.[50] There is a Domestic Workers Directorate established by the government to aid domestic workers who make formal complaints to their embassies. Nonetheless, abuses continue and denial of medical care is included among them (Human Rights Watch 2011). The abuses of migrant workers in Jordan also include high interest rate loans made by recruitment agencies, contractual discrepancies misrepresented to migrant workers, and lack of enforcement of the existing legislation (Mendoza 2011).

Jordan's healthcare spending as a proportion of GDP was 9.8 per cent in 2012, a high figure by regional standards. Just over 40 per cent of the population has health coverage from the Civil Health Insurance Programme and private health coverage stands at nine per cent.[51] Thirty per cent of nationals do not have health insurance and they are mainly in the private sector. Despite the building of new hospitals and clinics in recent years, Jordan's healthcare system suffers from over crowded government hospitals and high costs in private hospitals. Mental healthcare is severely lacking in Jordan (GNRD News 2014).

Although the '2009 Regulation of Domestic Workers, Cooks, Gardeners and Similar Categories' limits the number of hours a worker can work to ten 'flexible' hours per day, and establishes that the worker receives one day off during the week, an annual vacation, and sick leave, domestic workers are often deprived of these rights in practice. 'Sick workers are sent back to their agencies in 90 per cent of cases. The health insurance that they are entitled to in Jordan is only for emergencies, not for standard healthcare as for the citizens.'[52] The difference in health insurance coverage is clearly related to their low socio-economic status. Domestic workers are deprived of medical care in Jordan despite the laws that are supposed to protect them (Tamkeen Center for Legal Aid and Human Rights 2010). Abuses against migrant domestic workers in Jordan became so severe that Sri Lanka suspended deployment of workers in August 2009 but resumed cooperation by late 2010 (Human Rights Watch 2011).

Many domestic workers continue to work in environments that are unsafe, and some fall from high balconies, often suffering broken bones or resulting in death. It may cause them permanent disabilities that affect them for the rest of their lives. In 2011, the total number of cases of death for Sri Lankan workers was 19, six of which were suicide (Tamkeen Center for Legal Aid and Human Rights 2010). Many domestic workers suffer from work pressure, whether it is long working hours or the amount of work that needs to be performed. Jordan needs to use the appointed inspectors to make home visits in cases of suspected exploitation (Wilcke 2011). It also must help domestic workers to escape from abusive situations by facilitating a change in employers; access to mental and physical healthcare; and/or returning home instead of punishing them for becoming irregular

[50]Jordan. Ministry of Labour (2009) *Regulation No 90/2009 of Domestic Workers, Cooks, Gardeners and Similar Categories.* Promulgated by Virtue of Section 3/B of Labour Code No 8/1996 and amendments there of. [Online] Official Gazette No 4989 dated October 1, 2009, p. 5348 [Online] Available from: http://www.ilo.org/dyn/travail/docs/642/Regulation%2090.2009.pd [Accessed: 14th January 2015].
[51]Health (From the report: Jordan 2014) [Online] Available from: http://www.oxfordbusinessgroup.com/country/jordan/health [Accessed: 14th January 2015].
[52]Interview, 17th July 2014. Anonymity was requested.

and with concomitant fines. As a regional expert stated, the situation is unlikely to change because oftentimes, 'The employer thinks that he buys a machine.'[53] Machines do not have rights and do not require access to healthcare.

Lebanon

Lebanon may be better known for its history of emigration than immigration. It continues to send highly educated migrants to the GCC, Europe, North America and Australia. At the same time, it is a destination country for 200,000 domestic migrant workers from Sri Lanka, Ethiopia, the Philippines, and Nepal. They represent 5.6 per cent of its population.[54] Sri Lankan domestic workers began arriving in 1978. Migration increased significantly after the end of the Lebanese civil war in 1990. There were 12,527 migrant domestic work permits issued to Sri Lankan women in 2010 alone (Hamill 2011). In 2010 Sri Lankan domestic migrant workers in Lebanon sent home a total of $17.8 million in remittances (Human Rrights Watch 2010b). Lebanon also hosts large Palestinian and Iraqi refugee communities. The war in Syria has meant the arrival of forced migrants fleeing the conflict.

Lebanon has not yet ratified the ILO Domestic Workers Convention or the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Migrants to Lebanon legally enter the country through the sponsorship system. They fall under the authority of the Ministry of Labour and the General Directorate of General Security. The Lebanese Labour Code, enacted in 1946, excludes domestic workers, both nationals and non-nationals, from its provisions.[55] In the absence of labour laws, the Ministry of Labour enacted a standard employment contract in 2009 to set the terms of employment rights and responsibilities in Lebanon (UNHCRH 2009). Under the contract, workers are not allowed to change jobs without a release waiver (*tanazul)* signed before a notary public and approved by the Lebanese authorities (Human Rights Watch 2010b). A 2010 study found that due to the high cost of sponsorship[56] the vast majority of employers believe that they have the right to keep a migrant domestic worker's passport in order to prevent her from fleeing. The same reason was given for not allowing her to leave the house on her day off (Abdulrahim 2010).The combination of the sponsorship system and lack of labour laws make domestic migrant workers highly dependent on their employers legally, physically, and psychologically (Human Rights Watch 2010b).

Lebanon does not have universal health coverage. Nationals die due to lack of health insurance and access to emergency care. It is accused of having a 'clientalist' healthcare system in which more than half of Lebanese nationals have no healthcare coverage. The Ministry of Health has argued that the stress of refugees has crippled the hospital infrastructure in Lebanon. The Public Health Committee in parliament has complained that despite the Ministry of Health's inspectorate, the health system has virtually no oversight. Nationals lose National Social Security Fund (NSSF) benefits due to retirement or loss of employment (Hamyeh 2014). Most believe that the healthcare system is unaffordable and inaccessible for the majority of residents. 'Health is easy to access for everyone

[53]Expert interview, 17th July 2014. Anonymity was requested.

[54]Mazin Sidahmad (2014) Lebanon's migrant workers under pressure. [Online] *Aljazeera* 10 October. Available from: http://www.aljazeera.com/news/middleeast/2014/09/lebanon-migrant-workers-pressure-201495111252217645.html [Accessed: 5th March 2015].

[55]Lebanon, Code of Labour. A comprehensive English translation of the Lebanese Code of Labour. [Online] Beirut, Bureau de Documentation Libanaisedt Arabe*L'Argus de la Legislation Libanaise* l 56 (1) First Quarter. Available from: http://www.ilo.org/dyn/travail/docs/710/Labour%20Code%20of%2023%20September%201946%20as%20amended.Publication%202010.pdf [Accessed: 5th February 2015].

[56]$2000-$6000 in addition to the return airfare ticket home according to Roland Tawk, Lawyer for Human Rights and Domestic Workers in Lebanon.

once you have the money to pay the fees, but if you do not have the money to pay the fees, no one can access it- Lebanese or foreign. Priority is given to local people (nationals).' [57]

Domestic workers' insurance does not cover medicine, dental care, mental health or residential hospital care. A worker costs an employer $70-$100 per year. Employers may deduct the costs of tests such as pregnancy from the employee's salary illegally. Since these women are generally sequestered in private homes with no supervision from the Ministry of Labour, employers have inordinate control over the health status of their migrant domestic workers.[58] The employer is responsible for taking the migrant to the doctor, clinic, and hospital. They generally take sick domestic workers to less expensive government hospitals. There is a general need for better, more expansive healthcare insurance. Undocumented workers are in the worst situation in terms of healthcare. Healthcare may be withheld if the domestic worker does not have the proper documentation. The Ministry of Health created a four-digit hotline (1214) to report violations or refusal of care, but the problem for migrants is that Arabic is the only language of communication, which they are not conversant with. The legal system is dealing with domestic workers' abuses; and convictions are being made (Wansa 2014). The decisions rendered, which set legal precedents, will pave the way to the better protection of migrant domestic workers' rights.

The goal of this chapter has been to provide an overview of the complex and varied healthcare infrastructure and insurance framework within destination countries. Throughout the GCC, Jordan and Lebanon, there is discrepancy between the laws and policies pertaining to the healthcare of migrant domestic workers at the national level and international and regional agreements. The ability of migrant domestic workers to access and use healthcare services is hindered, and sometimes completely blocked, by a lack of comprehensive healthcare insurance and in many cases an inability to access healthcare services available to nationals. The employer, as the sponsor is the lynchpin to access the system.

There are a number of reasons for the current poor state of affairs. First, with the exception of Jordan, in principle, the employment of migrant domestic workers is not regulated through national labour laws. Second, due to the sponsorship system, the private employer determines the worker's access to, and usage of, the healthcare system. This is exacerbated by standard employment contracts, increasingly being adopted in the region, which provide weaker protection for healthcare rights than current national labour laws. Third, the healthcare systems and levels of private insurance provision in destination countries vary greatly. Nationals themselves often do not have access to the best healthcare services, and do not have much experience with private insurance and healthcare cards. UAE is the exception, not the rule. Likewise, Sri Lankan migrant domestic workers hail from a national health system in which treatment is free, and they do not have experience of private comprehensive health insurance or health insurance cards. The situation is worsened when the employer is the primary educator and/or point of access to this new, unfamiliar system in a foreign language and environment. Much more work is required to make the transition among various healthcare systems cohesive in order to protect domestic workers' health, which is a human right. The women interviewed in this project provide their own views of navigating the complicated, foreign, and *critical* healthcare arena in destination countries.

[57] Expert interview with Caritas Lebanon Migrant Center, 17th August 2014.
[58] Interview with Roland Tawk, 9th July 2014.

Chapter 4

Sample Characteristics and Migration Motivations

This chapter will describe the main characteristics of the sample. It will also set the scene for the following two chapters by discussing the factors behind the interviewees' decision to migrate, and the reasons they give for their migration. The methods employed in the primary research are described in Annexe 1.

4.1 Individual and household characteristics

Table 1 sets out some key socio-demographic characteristics of pre-departure migrants and returnees interviewed.

In terms of age, the returned migrants are a far older group, with 24/40 (60 per cent) over the age of 40 compared to three women out of the 20 first time pre-departure migrants (15 per cent). This is not surprising given that 31 of the returnees had migrated previously, 15 to multiple countries, whereas we interviewed first-time migrants in the pre-departure category. Nevertheless, over two-thirds of pre-departure migrants - 14/20 (70 per cent) - were 30 years of age or over. The majority of both pre-departure migrants and returnees were married: 70 per cent in each case. This high proportion of married women among migrants dispels a myth around migrant domestic workers that they are more likely to be divorced as told to us by a recruitment agent we interviewed.[59] More than half among both pre-departure and returned migrants also had relatively small families, at least where children were concerned: 60 per cent of pre-departure migrants and 57.5 per cent of returnees had one or two children. The majority of the sample in the two areas we conducted field research, Kalutara and Kurunegala, were Sinhala Buddhists.[60]

[59] Stakeholder interview, 4th April 2014.

[60] Budgetary constraints in this small explorative research project meant that we were not able to include a geographically more diverse sample which would also have meant a greater ethnic-religious diversity. However, the sample broadly reflects the population patterns in the two districts. According to the Census of Population and Housing 2011, 91.4 per cent of the population in Kurunegala district were Sinhala and 88.5 per cent were Buddhists. In Kalutara district, 86.7 per cent were Sinhala, and 83.5 per cent were Buddhists. *(Source: Department of Census and Statistics. Information collated by CENWOR).*

Table 1
Key individual characteristics of the interviewees

Characteristics	Pre-departure migrants (N=20)	Returned migrants (N=40)
Age group		
24 - 29	06	02
30 - 34	05	10
35 - 39	06	04
40 - 49	03	17
50 - 59	00	07
Marital status		
Never married	04	03
Married	14	28
Separated	02	02
Widowed	00	06
Divorced	00	01
Number of children		
None	05	03
1 - 2	12	23
3 - 4	03	14
Ethnicity		
Sinhala	15	31
Tamil	03	05
Moor or Muslim	02	04
Religion		
Buddhist	15	29
Hindu	01	03
Islam	02	05
Roman Catholic	01	01
Other	01	02
Highest level of education		
Did not attend school	00	01
Grade 1 - 5	02	07
Grade 6 - 10	14	27
Passed OL	03	04
Passed AL	01	01
Post-education training		
Yes	11	11
No	09	29

As seen in Table 1, the majority of both pre-departure and returned migrants had at least a secondary school education - 90 per cent of pre-departure migrants and 80 per cent of returnees - but only a handful in both samples had actually completed any key examinations. This evidence is in line with macro-level evidence and findings in other studies of the low educational levels of domestic workers, whether migrant or locally employed (see Chapter 1; Jayaweera, Dias & Wanasundera 2002). It is interesting that pre-departure migrants are slightly less likely than returnees to only have a primary school education and is probably an indication of their overall younger age range, given that educational opportunities have been expanding in Sri Lanka (Department of Census and Statistics 2012). Commensurate with this difference is that over half of pre-departure migrants said

they had undertaken some training after leaving school compared to less than a third of returnees. The interviews revealed that most of the kinds of training done by the women were, however, at a basic, but practical skill level: for instance, sewing/dressmaking, and training in using machines or in quality control in garment factories. The only returned migrant who had passed the General Certificate of Education Advanced Level (GCE A/L) examination had trained as a nurse for six months and obtained a certificate. Many women in both categories, who had some employment before going abroad, had worked in garment factories - nine out of 13 among pre-departure migrants and 10 out of 22 among returned migrants. The rest had largely been involved in small scale self-employment such as sewing or food preparation and selling, or agricultural labour. Such evidence supports the macro-level pattern of participation in the informal sector among the female population from which those who migrate for domestic work abroad are drawn (see Chapter 1). Only one woman in each category in the sample had worked as a domestic worker within Sri Lanka before going abroad.

Among returnees, 33 (82.5 per cent) were not undertaking paid work at the time of interview. This could partly be because there had not been enough time to seek employment; just over half the returnees had been back less than six months prior to interview. However, more significantly 16 out of the 33 (48.5 per cent) said they were not working because they intended to migrate again soon. Five women gave health reasons for not working.

Table 2 sets out some household characteristics that are important for understanding the interviewees' socio-economic circumstances. There is a fairly even split in both categories between residing in urban or rural areas in the two local districts selected. The majority in each category lived in nuclear households, whether married, or not married/separated/divorced and with parents or children: 75 per cent among pre-departure migrants and 60 per cent among returnees. The difference here may possibly be accounted for by the fact that returnees have had to rely on non-nuclear household arrangements for the care of children while they were abroad.

Table 2

Key household characteristics of the interviewees

Characteristics	Pre-departure migrants (N=20)	Returned migrants (N=40)
Area		
Urban	10	21
Rural	10	19
Type of household		
Nuclear	15	24
Extended	05	16
Electricity		
Yes	17	37
No	03	03
Pipe borne water		
Yes	13	24
No	07	16
Own transport		
None	11	20
Motor cycle	00	06
Bicycle	06	09
Three wheeler	02	02
Not specified	01	03
Appliances*		
None	02	04
1 - 2	05	08
3 or more	13	28
Mobile phone		
Yes	14	27
No	01	05
No answer	05	08
Monthly family income (Rupees)		
5,000 - 9,999	06	09
10,000 - 14,999	07	13
15,000 - 19,999	03	08
20,000 - 29,999	02	06
30,000 - 60,000	02	03
Not specified	00	01

** Appliances asked about: Fridge, Iron, TV, Fan, Computer*

As is the prevalent pattern in Sri Lanka among families in different socio-economic circumstances,[61] home ownership was common: 90 per cent of pre-departure migrants and 82.5 per cent of returned migrants lived in family owned accommodation (not shown in table). Over four fifths in both categories had electricity in their households but pipe-borne water was less common. Most who did not have the latter relied on getting water from a well. Women living in rural areas were less likely to have piped water in their homes. Around half or more of the interviewees' families did not own a

[61] According to the Census of Population and Housing, 2011 (Department of Census and Statistics) 83 per cent of households in the country had ownership of the houses they live in.

means of transport, but when they did it was most likely to be a bicycle. It is interesting that 65 per cent of pre-departure migrants and 70 per cent of returned migrants had three or more appliances including a TV, fan, fridge or iron. We would have expected a greater difference between the two groups given the remittances of the returnees, but it is possible that pre-departure migrants belonged to families in which one or more members had migrated abroad as domestic workers or for other low skilled work, and had helped families acquire household goods. The majority in both categories also had a mobile phone. In terms of family income, the impact of remittances on the household incomes of returning migrants is clear. Among the returnees, 42.5 per cent had a monthly household income of Rs. 15,000 or more compared with 35 per cent of pre-departure migrants. However, given that the national poverty line at present is Rs. 15,696 based on an average household of four people,[62] the proportion in both categories that could be defined as living in poor households is relatively high.

4.2 Subjective financial well-being and reasons for migration of pre-departure migrants

The above patterns unsurprisingly highlight the challenging socio-economic circumstances of both pre-departure migrants and returnees. Firstly, an analysis of the pre-departure migrants' perceptions of their economic situations and their reasons for migrating, provide some rich and illuminating detail around the patterns set out in the tables. Among the pre-departure migrants 17/20 (85 per cent) said that the financial circumstances of their families were 'not good', as the following accounts show.

> Yes, if we have lunch it is very difficult to think about dinner. It is a very difficult time. Very difficult to meet the daily needs. Husband does not have a steady job. He is a labourer. The child also suffers a lot. I always think about this. The house also has no facilities. It is with difficulty we live in the thatched house. We have to wait for husband to do some labour work and come back to cook something for dinner. It is a very poor economic life we are leading now. I cannot find a job even to do in this area (PDKUR07).

> My husband does not have a permanent job. We eat with the money he earns for the day. It is with difficulty that we are educating the children. We are suffering (PDKUR09).

It is within this economically strained framework of under-employment/unemployment and the inability to meet basic needs that the hopes and expectations of migration are set. Nineteen out of the twenty pre-departure women had a financial motivation for migrating.

> My husband's job is picture framing. We do not have the means to expand that. At present we do it on a very small scale at home and hand them over to shops for selling. I want to expand it to do it on a larger scale. I have borrowed money, as I have economic problems, I pawned my jewellery and could not redeem them. All my children are still schooling. The eldest one is in A/L class. He needs a lot of money for tuition. We have built only two rooms; I like to complete it and have a nice house. Because of these I thought of going abroad for work … My main aim is the economic benefit. We undergo a lot of difficulties here due to lack of money. Some days I worry a lot for not being able to pay children's class fees. Sometimes my husband is unable to do his work; then living becomes very difficult. During the rainy season it is not possible to work with the raw material (barks) used for picture framing (PDKAL02).

> Because of the Tsunami in December 2004, we lost all our property. We just managed to save our lives and come here. We now live in a Tsunami aid house. These were originally

[62]Calculated as the minimum household expenditure per person per month to fulfil basic needs. *Household Income and Expenditure Survey*, 2012/13. Department of Census and Statistics, 2014. Available from: http://www.statistics.gov.lk/page.asp?page=Income%20and%20Expenditure.

> jungle land. We cleared them. It is a long way to the main road. We cannot get a job according to the level of our education … My father does not get much of an income now. Even if I get marriage proposals we do not have money for those. I worked earlier at the Garment in Wadduwa. I get home very late after work. So I stopped working. The house has only what was done by Tsunami aid. I like to complete it. I like to save some money for us to live … What my father earns is not enough for our meals even. The type of money you get in that country is not given in any job here. That is why I thought of going to another country to work (PDKAL06).

At times desperate financial situations lead to or exacerbate family problems, which in turn provide a motivation to escape for a short while at least and to try to find a solution that could lead to more harmonious family relationships, as one interviewee described at length (Box 1).

Box 1

My husband does not have a permanent job. He works in a sand pit. He doesn't get a proper income. We can only live for the day and cannot do anything besides that. If the children fall sick we don't have money to buy medicine. I have to ask my mother or father. It is very difficult to buy anything that they like to have. We do not even have a proper chair in the house.

When there were economic difficulties disputes started on and off. When the children ask me for various things I do not have money for those. Then when I tell my husband and he does not have money to get them he gets angry. Fights. The children are also getting bigger. They need more food. They like to dress well. Then when they ask for clothes there is no way of getting them. Then my husband scolds the children. Then the household is full of problems. He wants to work only in the sand pit near home. He does not want to work anywhere else. The problems were getting aggravated. So I decided to migrate.

Because my parents did not have money I could not proceed with my education. I do not like my children to be like me. My hope is to somehow educate the children as much as possible. I have to do something to get them the supplementary study material, clothes, shoes, bus fare to send them for extra classes. It is not possible for them to study further with the poor economic conditions that we have at present. Therefore I am thinking of my children's education when I am migrating.

We got into debt when we built the foundation for the house. I paid the interest on the loan for a long period. But the interest is not paid still. The youngest child got sick. At that time also we got into debt. I have pawned my jewellery. The debt burden increases daily; it is not reducing. We are told to pay even a small amount of the loan. But there is no way to do that. So that is another reason as to why I am going abroad.

When I tell my husband about the children's needs he gets angry. The fighting is not constant but it does happen. Because my parents live close by there is not much fighting because he is a bit scared of them. He is a person who does not take his responsibilities seriously. He does not bother about the economic problems we have or the needs of children. He spends the little money he earns by selling sand. If I talk about it he gets angry. He scolds. He does not hit. He does not fight in front of the children. When he scolds like that I feel disheartened. I thought, it is good if I can go abroad to get away from the scolding. Since he wastes money I will not send all the money to him. I think that then, he will reform himself (PDKAL07).

It is also, however, important not to under-estimate the male alcoholism, financial irresponsibility of spouses (as in the above case study), and in a few cases, outright domestic abuse inflicted on the women, that emerge as drivers of <u>both</u> household economic instability <u>and</u> the migration of the women.

> I faced lot of problems from my husband. He used to beat me and shout at me. He dashed on the ground and shattered all household goods that I was very fond of. The two children look on scared and amazed. He looks for me to kill me. I hide for hours away from him. He

> harassed me sexually. When I could not bear this pestering any more, I decided to come to my mother's place. She has a lot of economic problems. Although she had worked abroad for many years, she has not even built a house. When I see the tiny house we live in now and the financial problems she is faced with, I thought I must at least build a house. So, to build a house in the plot of land given to me by my grandmother and to escape from the violence of my husband, I decided to go abroad as a domestic helper (PDKUR02).

The reasons interviewees give for migrating specifically as domestic workers further highlight the economic issues that are at play. Firstly, given relatively low educational levels there is the lack of suitable employment opportunities that bring economic rewards to maintain even a basic standard of living. Secondly, domestic work abroad comes with in-built benefits at least as promised and/or expected, such as free accommodation, meals, free medical treatment, not to mention the fact that the actual costs of migration are borne by the agency who also gives an additional sum of money to the migrant's family on her departure. All these appear as substantial 'pull' factors in the interviewees' accounts.

> We do not have an education or training to earn money or do a job. If I work abroad, I can have free food and lodging, and save some money too (PDKAL05).

> While in this country I did many jobs. I worked in a garment factory, worked as a labourer in paddy fields, clearing gardens; but none of those helped me to save anything. More than anything I want to save some money and build even a very small house. When we go abroad as a housemaid, accommodation, food and medicine are all free; then I will be able to save my full salary. Some households could give us gifts too. I thought that the only way to come out of our problems is to go abroad and work as a housemaid. So I choose this job (PDKUR03).

> Before leaving, this agency gives us a sum of money and bears all other costs. And for poor people like us it is very useful. In the end they give some money to the family as well. After getting the visa and leaving the country they continue to make inquiries. I thought of all this and decided to go to solve my family problems (PDKUR08).

4.3 Returnees' migration motivations and post-migration financial situation

All 40 returnees in the sample had a financial motivation for migrating. The returnees exhibited very similar family characteristics to the pre-departure migrants, which gave rise to identical reasons to migrate - that is, under-employment and struggle to meet basic living needs and educational requirements of children, domestic tensions or abuse. But the actual financial outcome of migration for returnees does not in many cases appear to have sufficiently met the expectations of migration. To the question of whether they felt they were financially better off or not after migration, 25 out of the 40 interviewees (62.5 per cent) replied negatively. But the qualitative responses suggest a more complex reality which balances positive and negative outcomes. While each returnee's experiences of the impact of her migration on her financial circumstances and that of her family need to be understood within the framework of her own 'migration story' as a whole, some common themes emerge. Most of the women in one way or another had seen an increase in economic capital for their families if not for themselves personally. This generally took the form of house-building or renovation, paying off loans and other debts, and increasing the human capital of children through investment in their education, as the following examples show:

> We did not have a house of our own to live in. Now I have constructed a complete house. Bought a motorcycle for our travelling. Standard of living has improved a lot from what it was. I provide everything necessary for my daughter's education so that her education will not be disrupted (RKUR19).

> Built the house, got electricity to the house, sent money to spend for children's education and for home expenses. My husband cannot go for work now leaving the little child … was able to pay my debts. We were in a house that belonged to someone else. Now we have our own house and land (RKUR10).

There are, nevertheless, several caveats to be noted in such seemingly rosy accounts. Firstly, many of the interviewees have only been able to reach this level of economic security through multiple episodes of migration for domestic work over many years. Their economic edifice has had to be built up slowly, sometimes with many setbacks and uncertainties.

> I am a person who had gone abroad many times to work. When I was working in Kuwait my husband died. Other than having to facing that incident every time I went abroad, I achieved my objectives; such as providing education to my children, feeding them, getting them married. I have built a house for myself. I have no fear of the future. I am hoping to go to Oman, work there, earn, save some more money and stop going abroad for work (RKUR17).

Secondly, many of the returnees speak of being able to provide for the economic security of their families but at the cost of ultimately having no money left.

> Money spent to settle the loans and build the house a little bit. Now all the money I have earned is finished (RKAL15).

> I would send about Rs. 20,000-30,000 almost every month. My husband or daughter had not wasted the money I would thus send. They had put it to renovating the house; bought a three-wheeler. My daughter was expecting a baby and some of the money was used for that. During this time my father passed away and some of the money was used for the funeral service. Bought a cycle for my daughter … Even though the money I earned there is now spent, I am happy that it was an extra means of income for the family. The three-wheeler is a help for my husband's job. Even though I don't have money I feel happy (RKUR20).

> I am sad that all my money is over; but as all that was spent on family requirements I do not think much about that. I will go abroad again and earn some money (RKUR03).

This last comment "I will go abroad again and earn some money" highlights a third point: that many of the women are enmeshed in a seemingly unending circle of migration. As long as they are able to keep securing employment as domestic workers, they will keep going abroad whatever the costs are to their health, as discussed in more detail later, or to the well-being of their families, particularly children and parents. As stated above nearly half of the returnees who were not working or did not seek work since coming back said the reason for not seeking local employment was that they intended to migrate again quickly.

The reasons that some women's economic circumstances did not improve after migration were mainly to do with either not being able to remit as much money as they sought to do because of employers defaulting on paying agreed wages, or more commonly, family members' mishandling of money sent back.

> I expected to work for about two years, save something and then return to Sri Lanka. But I had to return before the contract period. I did not get the salary for one month that I worked at the house and for the month that I spent at the Embassy. I had to get Rs.30,000/ from Sri Lanka to return home. So I had to get into further debt (RKAL05).

> My brother took Rs. 20,000 to buy a three wheeler. He cheated me. He took the money saying that he will buy me a three wheeler but I found out that he has bought the vehicle in his name. I checked with the finance company and stopped paying the instalments (RKAL03).

> I wanted to earn money to build the house, to educate my daughter and save some money for myself.
>
> But none of these had happened. It is my mother who had fed my daughter and looked after her. My husband had started this affair with this other woman and it is to prevent me from coming to know it that he persuaded me to go abroad. He had used all the money I sent to drink and meet the needs of this other woman. He has built her a house. I cannot ask about it. He scolds me and beats me. I cannot be here watching all this. I am leaving my daughter in my mother's care and going. I told my husband that I will send the money in his name and he was happy to sign the letter to say that he agrees to my going abroad. This time I will not do the foolish things I did last time. I will send part of the money to my mother and keep the rest with me (RKUR11).

Amidst all the difficulties and loss of hard-earned money this last interviewee has experienced, her determination to somehow finally achieve her objectives in migrating through a carefully thought out strategy is clearly revealed. Despite the awareness that "the home people do not know the difficulties we undergo and they spend the money, they forget their duties" (RKAL19), the women who feel they have gone some way towards achieving their migration objectives manifest a sense of mental wellbeing associated with economic independence and the ability to make financial decisions: "I have the economic strength. I feel that I can do something. I have money" (RKAL04).

This chapter has considered the migrants' socio-economic and family circumstances in Sri Lanka that frame their motivations to migrate, and enmesh them in a pattern of migration that may have serious consequences for their health. We will turn to the complex relationship between the returnees' health experiences during migration and on return, and their orientations towards their families, in Chapter 6. Before this, in the next chapter, we examine the Sri Lankan infrastructure around migration and health and the way this affects the migration experiences of the women we interviewed.

CHAPTER 5

Perspectives on Governance and Institutional Framework Relevant to Migrant Health

In the past few years there have been many changes in the infrastructure surrounding migration that specifically relate, or are relevant, to women migrating as domestic workers to the GCC States and surrounding countries. In this section we focus on aspects of this infrastructure that apply to the health of the migrants during the pre-departure stage, in receiving countries and on return, with particular emphasis on the sending country framework and perspectives of pre-departure and returned migrants and relevant stakeholders in Sri Lanka that we interviewed.

Our interviews show that most of the migrants follow systematic 'steps' in the migration process. And, particularly at the pre-departure stage, they receive and process a considerable amount of information relating to protecting their health alongside their other rights as employees while working in destination country households. However, the interviews also reveal serious gaps and inconsistencies in the infrastructure at best, and outright discriminatory and abusive processes and practices at worst, which negatively impact the actual health experiences of the women at all stages of migration.

5.1 Local level processes

The international recruitment process begins with an employment agency in the destination country submitting 'a job order' (generally attested by the Sri Lankan embassy or mission in the country) including money from a sponsor (employer) to recruit domestic workers. But it is at the sending country level that much of the governance and institutional framework in recruitment is located. Since mid-2013, SLBFE processes for outgoing and returning migrant workers have been devolved to district, divisional and village level, and a system of checks and signatures has been instituted locally before the prospective migrant worker gets to the stage of registration with the SLBFE prior to departure.[63] This appears partly to be in response to recruitment (sub) agent and also potential migrant worker malpractices such as falsification of documents showing age (Centre for Applied Research and Training 2012) and ostensibly to protect the rights and welfare of the workers.

However, these institutional practices also derive from gender norms that define whether and when women domestic workers, and particularly but not exclusively those with children, can migrate. The minimum age for domestic workers going to the receiving countries considered in this research has been raised to 23 from 21, except for Saudi Arabia where the lower limit is age 25.[64] A family background report at local level is now necessary for all women 'who aspire to migrate' as domestic workers and for any other 'non-professional employment'. The most recent iteration of this requirement is in Circular MFE/RAD/10/13 from the Ministry of Foreign Employment to Divisional Secretaries,[65] which stipulates a mandatory requirement of providing a certified report of family background of Sri Lankan female domestic workers leaving for foreign employment 'to prevent various difficulties and social problems that may be caused … when women migrate for employment without confirming the protection of their children'. It is made clear in this circular that:

[63]Personal communication with Consultant on labour migration in Sri Lanka, 4th March 2015.
[64]Rasika Somaratha (2013) Increasing minimum age limit of female workers to the ME: decision to be implemented immediately. [Online] *Daily News* 10 May. Available from: http://archives.dailynews.lk/2013/05/10/news22.asp [Accessed: 6th March 2015].
[65]Divisional Secretaries head administrative sub-units (Divisional Secretariats) of districts in Sri Lanka.

> Recommendation shall not be given for migration for employment to the mothers who have children below the age of five years and recommendation may be given to the mothers who have children above the age of five years only if it can be satisfied to the effect that protection is provided to them.[66]

An earlier circular - 13/2013 - refers to 'assurances' required for clearance relating to 'illnesses, which cannot be detected through medical investigation'.[67] Among our interviewees, 11 out of the 37 returnees (30 per cent) who had children had a child under five when they last migrated while none of the pre-departure migrants did, possibly reflecting the recent more stringent implementation of the directive. The report of the UN Special Rapporteur on Human Rights of Migrants after his country visit in May 2014 raises some of the gender inequality and human rights issues arising from the above directive:

> I regret this discrimination against Sri Lankan women in relation to the right to migrate. The fact that they have small children, or that many domestic workers suffer abuse, exploitation and other human rights violations - including the tragic execution of Rizana Nafeek, cannot be used as a reason to deny them the right to leave their country, provided for in the International Covenant on Civil and Political Rights, ratified by Sri Lanka. Women's rights organizations in Sri Lanka are protesting against the Circular of January 2014, which they claim leads to irregular migration. I have also been informed that, due to forged documents and corrupt officials, the age limits and Circular are not properly implemented anyway. While the Sri Lankan Government's intentions behind these restrictions seem to be good, aiming to protect these women and their children, restrictions on women's right to leave their country is not the right way to achieve such objectives. In fact, I was told that many women migrate in order to escape from family issues, including domestic violence. I urge the Government to focus on other means, such as creating more income-generating opportunities for women in Sri Lanka, including in rural areas, diversifying child-care support measures, and enhancing gender equality and men's participation in their children's upbringing.[68]

Typically a first-time migrant who follows a formal migration procedure and living in an area where there is a high volume of outward migration for domestic work in Gulf countries, would initially approach or be approached by a sub-agent (broker) operating locally, often a friend or relative or a friend of a friend. In our sample 24 out of the 60 women (40 per cent) specifically mentioned recruitment through a sub-agent, but several others mentioned being helped by a friend or relative in contacting the agency, which does not preclude the friend or relative from being paid for their services. The bureaucratic process thus initiated stretches from a very local (*Grama Niladhari* - village officer) level to a district level and is illustrated in the following example among our pre-departure interviewees.

[66] Circular MFE/RAD/10/13.
[67] SLBFE Circular 13/2013 dated 07/06/2013.
[68] UN Special Rapporteur on Human Rights of Migrants concludes country visit to Sri Lanka. [Online] Available from: http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=14645&LangID=E [Accessed: 6th March 2015].

Box 2

I thought of migration after a friend of my husband asked me whether I like to migrate. He is working as a sub agent. I discussed with my husband and decided that the only way to overcome our problems was to migrate as a housemaid. The sub agent took me to an agency in Maradana, Colombo. I was told to get a passport. That day itself we went to the passport office and got the passport done under the one day service. The agency took down all my details and gave me a form to fill. I got it filled by the *Grama Niladhari* and got it countersigned by the A.G.A*'s office and took it to the police station. I was told that the police report cannot be given that day itself. They said they will come to the house and it will be given after inspection only. I gave the *Grama Niladhari's* certificate and a letter to the police station. The police officers came to the house and after inspection I was given the police report after a week. Before I gave the documents to the Kalutara District Secretariat, I obtained the family background report. A gentleman came to our house. He asked about the family and the child. My husband's agreement was obtained in writing and he gave the report. I gave all the documents to the agency, SLBFE and District Secretariat. After that I was sent for training by the agency (PDKAL05).

* AGA (Assistant Government Agent) now called Divisional Secretary, see footnote 65.

At this early pre-departure stage, amidst all the flurry of inspections and documentation, the health of the prospective migrant worker seems to be less of a concern generally, including to herself. In the interviews with both sub-agents and migrants it seemed clear that 'health' was a separate category of pre-departure preparation that was addressed through the training programme and the medical testing procedure as shown below. Some interviewees talked of the Family Health Worker and/or Development Officer/Women's Development Officer;[69] in both cases their primary remit seemed to be to ascertain if proper care arrangements about any children of the migrant have been made and set out in the family background report.[70] However, a few interviewees said that Development Officers gave useful information on staying healthy while working abroad including on sexually transmitted diseases (STDs) and mental health.

> Good mental health is also necessary to safeguard your physical health. The Development Officer also explained that women who migrate are subject to a lot of mental stress. Homesickness, living and working in an unfamiliar environment, engaging in unfamiliar work and lack of adequate rest, loneliness can contribute to mental distress. However, we should keep in mind the reason as to why we migrated. Then it will be possible to face the pressures that we have. We were told, as far as possible, not to think of home, children and be sad. Then we cannot work, our self-confidence will erode and we can fall sick. When we cannot do our daily work we will get scolded. We will forget what we have to do. You need to be aware when you are working with electrical equipment. If you are not, then you can face problems (PDKAL07).

This example of an instrumental approach to health - maintaining good health for the sake of money, family, prevention of abuse by employer etc. - is illustrative of the nature and slant of information and advice given to the women throughout the pre-departure stage as shown below.

[69] The WDO is appointed at district level by the Women's Bureau of Sri Lanka, the policy implementing body of the Ministry of Child Development and Women's Affairs (ILO 2013). WDOs, and Development Officers working for the Ministry of Foreign Employment Promotion and Welfare, implement the '*Rataviruwo'* Programme promoting re-integration and employment/self-employment of returning migrant workers at the local (divisional) level.

[70] Interview with Development Officer, Kalutara District Secretariat Division, 3rd September 2014.

5.2 Health information in training

All 20 pre-departure migrants had undergone the SLBFE training programme in one of the regional training centres; this is not surprising given that we sought interviewees who could give their views on the existing regulatory framework relevant to health. Among returnees 36 out of 40 had undertaken the training before the last migration episode or before previous episodes. The four women who had not taken up training migrated through personal contact. The duration of the training programme varied according to how much experience of migrating for domestic work the women already had: typically 21 days for new migrants, 7 - 14 days for those re-migrating, and longer training periods for those needing literacy education. For all the women recruited through an agency, the training, including materials needed and accommodation, but not necessarily travel to attend the training, was paid for by the agency from money transferred by the receiving country sponsor via the agency abroad.

Providing information on health plays a significant, if not a very lengthy part in the training schedule. One woman said "the lectures on health during training is not enough, health information is explained only lightly, the time spent on it is not enough" (PDKUR07). Another woman felt she spent more time making tea than listening to lectures. A review of the syllabus on 'common competencies' in the workplace shows that there is coverage of 'maintaining a healthy and safe environment' including household hazards and risks and occupational health and safety procedures, predominantly relating to first aid and fire, and evacuation. There are instructions to inform 'the lady of the house' of any work-related injury 'and they will call the family physician in case of serious injuries' (Sri Lanka Bureau of Foreign Employment, 2011, p.32). There is a section on 'rights and responsibilities' of the migrant worker in which there is reference to the 1990 migrant workers convention and the 2011 domestic workers convention (only the first of which has been ratified by Sri Lanka). This section covers:

- Basic human rights - e.g. right to freedom from torture, slavery etc.; food, salary, 'right to ask for medicine', privacy, work permit (*Iqama*), equal treatment with nationals regarding overtime, holidays; emergency medical care, rest and at least six hours sleep, legal assistance, consular assistance and protection, equality with nationals before courts and tribunals, return ticket once the contract is over.
- The migrant should have the right to 'ask for things mentioned in the contract they signed'.

Since 2012 migrants leaving as domestic workers and care givers of children and elders (since many domestic workers are also obliged to provide care) are required to demonstrate their knowledge gained in the 38 modules of training and to achieve a NVQ Level 3 certificate as 'professional housekeeping assistants'.[71] This attempt at up skilling - in name, if not in relation to knowledge and skills acquired, remuneration or rights - is part of the government's approach to reducing 'unskilled' outward migration:

> We do not approve females going for overseas work as domestic aides. However, we cannot put a full stop to it immediately. Therefore, we have launched a number of programmes to upgrade their skills and find more gainful employment in specialised vocations (SLBFE spokesperson, reported in *Daily News*, 10/05/2013).[72]

[71]Personal communication, ILO staff, 4th March 2015.

[72]Rasika Somarathna (2013) Increasing minimum age limit of female workers to ME: decision to be implemented immediately. [Online] *Daily News* 10 May. Available from: http://archives.dailynews.lk/2013/05/10/news22.asp [Accessed: 06th March 2015].

Information on the body, maintenance of good health while working abroad, illnesses, medical testing, and access to healthcare is covered in a lecture and through several videos on STDs. Most of the women we interviewed provided a uniform account of the health information they were given in training, as shown in the example in Box 3.

Box 3

> Awareness on health was created through lectures and videos. It was explained how to work while safeguarding your physical and mental health. Whenever you feel sick or uncomfortable in the body how it can be overcome was explained. We were told to take two Panadol tablets immediately when suffering from a headache, body ache or having a slight fever. Also we were told that we have a right to get treatment in case of an illness. If the illness aggravated we were told to inform the employer (madam). We were advised to be mentally happy and not worry all the time about the family and home. This causes sickness, creates problems, and the employer will get disgusted. This will make the employer scold you. You must keep in mind always that you have come to work and work in a happy mood. We were told that if your mind is happy then your body would be healthy too. We were advised to give rest to the mind and body. Once you finish your work to go to your room and rest. Be happy. You must somehow eat the food you get. Do not avoid eating. When we do the cleaning we are entitled to get a face mask and gloves. We were told to adhere to these practices. How to prevent contracting venereal diseases, AIDS was explained.
>
> How your behaviour can prevent sexual harassment was explained. We were advised not to show ourselves to the man of the house and not to smile with him or talk to him. If he wanted something, we were told to give it to madam always. We were advised to stay in our room safely (RKUR01).

In this account, as in most accounts of the interviewees, taking primary responsibility for their own health and well-being - i.e. self-help - is strongly stressed in training: for instance through bringing from home a stock of basic medicines such as pain-killers for colds and flu and traditional oil or balm for muscle ache, eating as well as possible and avoiding unhealthy food, trying to protect oneself from accidental injury and potential sexual abuse, attempting to achieve a good mind-body balance that would also impact on the relationship with the employer.

> The most important thing is to keep your mind at peace. However much you feed the body, if the mind is sick you will lose all your happiness. They might scold you in filth and hit you too. To avoid all this it is necessary to work with a clear mind with keenness and mindfully. Sometimes it is possible that you have to face physical, mental or sexual abuse. Mechanisms to use mindfulness, when things like that happened were shown in a video. We were told to avoid sexual abuse and not to show ourselves to the master (PDKUR07).

But the responsibility of the employer to provide access to healthcare and medical treatment is also emphasised.

> At the discussion of health matters during the training I got the impression that we will have to look after our own health. We were asked to request the employers for treatment in the event of illness (PDKUR04).

A concern with pre-departure training programmes in sending countries that has been raised more generally is the extent to which migrant workers have the resources, power and institutional support in destination countries to apply the information on rights in a way that is beneficial for them (Jones 2015). In Chapter 6 we will examine the relation between the health information absorbed in training by the interviewees and the reality of their health experiences in employment.

For the interviewees, most health information at the pre-departure stage was given during training: "It was mostly during the training programme that we could discuss health matters. In other places discussion was mostly about the safety of the children" (PDKUR04). The evidence in some other studies of civil society organisations such as the Migrant Services Centre that was a useful source of information, advice and support for avoiding or tackling problems in migration was not borne out to the same extent in our research, at least as regards health issues (ILO Country Office for Sri Lanka and the Maldives 2013).

From the perspective of the migrants, the health information given in training was most useful. However, there was concern among some of the women about the unhygienic and unhealthy conditions under which the training itself took place:

> When we went for the training on some days we did not have water to bathe. On some days the food was not good. The way some trainers spoke was not good. I cannot say that they discharged their responsibility properly (PDKAL10).

> The residential quarters where we were for the training programme were very unclean. The beds were full of bed bugs. I had to clean the beds and kill bugs for several days (PDKUR10).

5.3 Medical tests

For women migrating as domestic workers to Gulf countries a medical test for 'fitness' to work is compulsory both before they leave Sri Lanka and soon after they enter the destination country. This requirement is clearly tied up with the fact that the employer pays the recruitment costs and if the employee is perceived to have a health problem that is seen to affect her ability to work, the employer then needs to find a replacement. In general if the domestic worker recruited needs to leave before completion of the first three months of employment for instance for a health reason, the foreign agent demands a return of the recruitment fee paid to the local agent or a new recruit in place of the existing worker.[73] In Sri Lanka, as in other Asian sending countries, the tests are conducted at regional centres accredited with the GCC Approved Medical Centres Association (GAMCA) according to a standardised format. From the accounts of our interviewees, all medical examinations and tests are done by women doctors, nurses and healthcare assistants. All 20 pre-departure migrants and 38 out of the 40 returned migrants underwent pre-departure medical testing. The two women who were not tested said they initially migrated on a visitor's visa (which their employer subsequently changed to a work visa), and therefore did not need to undergo testing before departure. One of these women had been examined once she reached Dubai. Most women recruited by an agency were taken for the test by a representative of the agency or by a sub-agent. Overall only essential information required for the tests themselves was given beforehand although this varied a little according to the woman's relationship with the agent or sub-agent.

> I was told about the date and time of the medical examination. I was asked to come on an empty stomach for blood and urine tests (PDKUR04).

Box 4 sets out in detail a typical interviewee account of the components of a pre-departure medical test. A civil society stakeholder was however critical of the fact that there were some key omissions, such as specific tests for epilepsy, arthritis and asthma.[74]

[73] Interview with Director of a medical testing centre, Colombo, 7th April 2014.

[74] Local level stakeholder interview, Colombo, 27th June 2015.

Box 4

Eyes Test-A Medical Assistant presented a board for me to read, marked the ones I read correctly and gave the report to the Medical Officer.
Height-The Medical Assistant measured the height, marked it and gave it to the Medial Officer .
Weight: The same Medical Assistant observed and marked the weight and gave it to the Medical Officer.
Teeth- were examined by the Medical Officer, but was not referred the dental clinic.
Tongue- was examined. Chest-examined with the stethoscope.
Chest X-ray was taken and the report was given to the Medical Officer immediately.
Blood pressure was checked by the Medical Officer herself.
Tuberculosis- Asked me whether I suffer from a continuous cough; I thought it must be for Tuberculosis.
I was not told the blood was tested for Diabetes, Cholesterol and Dengue.
Sexually Transmitted Diseases- Full body was checked up for STDs; especially the womb; blood samples were also obtained for testing.
HIV/AIDS – a blood sample was taken for testing. Breasts – breasts and neck were checked for cancer.
The Medical Officer provided me advice on birth control.
(RKUR18)

A key issue that emerges in the accounts of most of the interviewees is not only that they were not given sufficient explanation of the tests themselves but also that most often their consent was not taken either verbally or through a signature on a document. Of the 38 returnees who had undergone pre-departure testing, 30 (79 per cent) were not asked for consent to undertake the tests; and 16 out of the 20 pre - departure migrants had not been asked for consent. If the women's accounts are unpacked further, several other issues that infringe their rights over their own bodies are highlighted. Firstly, consent is not only lacking in relation to testing being conducted and samples of bodily fluids collected, it is also not taken for the test results to be given to the agency. In some cases, the interviewees said verbal consent was taken for the results to be given to the agency but not for conducting the tests. However, in the majority of cases consent was not obtained for either. Instead, the women were told that their reports will be sent to the agency. Copies of the reports were given only if they were migrating as individuals and not through an agency. "I was verbally told that reports will be sent to the agency" was the response of several interviewees when asked about consent. It is interesting however, that most of the interviewees expressed little concern about the fact that their consent was not asked for, and, for some, it was as if a question regarding this issue was redundant, as the following examples show:

> Whether you give your consent or not the medical test is done. I was told that it is essential to go for a medical test. I was not concerned about going for the test. I was not frightened (RKUR06).

> Because it had to be done they would have done it whether I liked or not (PDKUR01).

But there was also a sense that the interviewees did not mind a set of comprehensive tests being done without cost to them, to assess their state of health, as clearly these low income women belong to a category of the population that somehow does not get the benefit of routine health checks within the national free healthcare services provided in Sri Lanka.

> Although my consent was not obtained I did not mind it because it helped me to find out whether I was in good health. What I wanted was to get the tests done (RKUR16).

> They did not explain anything much. But they were kind. The uterus was examined. A lady doctor was there … Agency said testing was mandatory … I was happy to get it done without my having to spend money. Easy too (PDKUR07).

According to the interviewees and the sub-agents we interviewed, the normal practice is for the reports to be sent directly to the agent and results are often not discussed with the women unless there was a problem. Many women however were clearly unhappy that they too did not get a copy of the results but were uneasy about asking for them given the authoritarian manner in which the tests were conducted.

> I did not get the medical report. They had sent it to the agency. When I inquired from the agency they said that all the reports were good. It is good if they give us a copy, we also like to know that we are healthy (PDKAL10).

> I would have liked if the reports were given to me as well. Then we will be happy that we are healthy. Also we could show them to other doctors when we fall sick. If we are given copies of the medical reports it is good (RKUR13).

A second important issue emerging in our interviews affecting the women's rights over their own bodies is medical interventions that were performed, again without their consent, and sometimes without clear information being given. In general for female domestic workers the possibility of undisclosed pregnancy before migration is one of the biggest fears of employers and agents. Examples of many unethical, and at times inhumane preventive measures in sending countries such as incarceration in the pre-departure period and forced contraception have been highlighted in reports of human rights organisations (Caram Asia 2007). The Director of a medical testing centre that we interviewed[75] said that testing centres are forbidden by the Sri Lankan health ministry to provide contraception to women and that giving Depo-Provera injections was stopped over three years ago. Yet, 12 out of the 40 returnees (but none of the pre-departure migrants) said that a procedure was performed at the testing centre; most often this was a contraceptive injection.

> Yes. I was asked about the age of my youngest child. Injection for contraception was given. This was to prevent contraception for three months until I went abroad. I was asked about methods of contraception I used before the injection was given (RKAL07).

> The injection was given. It was not explained. From my former experience I thought it was to prevent pregnancies (RKUR02).

This anomaly cannot entirely be explained by when these returned migrants left the country, that is, if it was before rules banning contraceptive injections came into effect. Some of the women who were given these injections were very recently returned migrants who left Sri Lanka for their last migration episode two years prior to interviews.

It is also interesting that fear of pregnancy and intervention around this, figures even in the compulsory destination country medical test. Nine of the returnees said they had undergone 'a procedure', usually an injection which they said was either to prevent pregnancy or "to prevent catching diseases - I was told" (RKUR10). Lack of consent in the destination medical test was again an issue; 17 of the returnees were not asked for consent to the tests and five of those who had to undergo a procedure were not asked for their consent.

Stakeholder interviews we conducted and other studies reveal a sceptical perception of stakeholders that some migrant domestic workers attempt to find ways and means to hide or overcome health conditions that prevent them from leaving the country for work, in their determination to somehow 'pass' the medical test and migrate. One stakeholder involved in the medical testing procedure said that in her experience some women who test positive in the pre-departure pregnancy test, have an

[75]Stakeholder interview, Colombo, 7th April 2014.

abortion and return for the test claiming that they have had a miscarriage.[76] Suppression by the prospective migrant of longer term chronic illness, and at times, the failure of medical tests to detect these conditions, as well as the lack of assessment of mental health in the testing procedure has been highlighted in other accounts (Centre for Applied Research and Training 2012; Transparency International Sri Lanka 2010).

A third important finding in our interviews was that where a medical issue affecting a woman's health - whether seen to affect her capacity to migrate or not - was detected in the medical test, there was no evidence of a direct referral to a specialist or family doctor by the doctor conducting the test. In the interviews we came across instances of breathing difficulties, thyroid problems and diabetes. Generally the woman is merely advised to go for further testing or seek treatment. Given the evidence above that women migrating as domestic workers do not appear to have routine contact with the health services and seem to welcome this opportunity for a health check, it is of concern that a referral process is not in - built in the testing procedure. The overall aim of the medical test appears to be to make sure that the women are 'fit to work' as domestic workers in destination households. There is less concern that the women themselves are of good health and for the need for measures to prevent or address illness for their own sake - that is, to ensure a human right to good health. In this regard, one pre-departure migrant summed up her feelings about the medical test:

> The medical test was done in parts. It would have been better if a full body check up was done. I feel the check up was done to see whether we suffered any illnesses that would affect our living there. More attention was paid to check for HIV/AIDS and STDs. We were given a general awareness of what tests we were subjected to; but I would have preferred a deeper and a better understanding of the tests done and why those particular tests were done. As I am not going through an agency I was given the reports, but others did not have at least that benefit (PDKUR06).

5.4 Employment contract

Among our interviewees, 38 out of 40 returnees said that they had signed an employment contract at the SLBFE in the presence of an SLBFE official prior to their last migration, and 18 out of 20 pre-departure migrants had already done so. Among these were women who had found a job through personal contact rather than through an agent. This 'standard' private recruitment employment contract template for domestic workers is in operation between domestic workers and employers in the region, with the exception of Hong Kong and more recently, UAE (see Chapter 3).[77] It is required to be signed by the employer at the initial stage of submission to the Sri Lankan embassy or diplomatic mission in the receiving country for authentication in accordance with the Foreign Employment Act before it is passed on to be signed by the migrant worker at the SLBFE. However, Sri Lanka cannot use it as a legal document where disputes arise unless agreed upon bilaterally with a receiving country. Alongside stipulation of the contract period, salary and methods of payment, and duties of the employee, the contract has several specific conditions relating to the obligations of the employer to safeguard the health of the domestic worker. Most importantly it states:

> The employer shall provide all medical services including hospitalisation expenses, medicine etc. free and also winter clothing whenever outside temperature is below 20^0C.

In addition it states that the working hours of the employee 'shall not exceed 12 staggered hours per day' and that the employer would provide 'suitable and sanitary living quarters as well as adequate

[76]Stakeholder interview, Colombo, 7th April 2014.
[77]Personal communication with Consultant on labour migration in Sri Lanka, 13th July 2015.

food'. The employer 'shall treat the employee in a just and humane manner' with no use of physical violence. Additionally, the contract can be terminated by either the employer or employee 'on the grounds of serious illness, disease or injury of the employee' and where her continued employment 'is prejudicial to her health' repatriation expenses would be borne by the employer. The employee may terminate the contract without notice if she receives maltreatment, non-payment of salary or physical molestation and assault. However, the employer also may terminate the contract with no notice on grounds of 'serious misconduct or wilful disobedience' by the employee. Disputes between the employer and employee must be referred to the recruitment agent or the Sri Lankan embassy, and if remained unresolved the Sri Lankan embassy would refer them 'to the appropriate authority of the host country for adjudication'.[78]

The women interviewed in this study showed awareness of the terms of the contract they signed at the SLBFE but this information was given as part of their training, rather than thoroughly explained by SLBFE officials before signing. In their accounts, there was a stress on the responsibilities of both employer and themselves as employees to adhere to the terms of the contract:

> There was detailed discussion on our rights. We were told that asking for treatment is our right and that the employer is bound by the terms of the contract to provide medical attention. The responsibility of staying till the end of the contract was with both parties. They had to provide a separate safe place for sleeping, provide food, water, and time for sleeping (RKUR11).

> We were told about the importance of being aware of the clauses in the employment contract. We were asked to be thorough with the employment contract before leaving Sri Lanka and that the salary, nature of work, service period are all included in it. We were told that both the employer and the employee should work sincerely to adhere to the contract. Meals, leave, sleep and rest, and safe areas assigned for our use were explained (RKUR15).

However, there is strong evidence in this study that for many of the women the conditions of the contract they signed were violated by the employer. The evidence relating directly to their health situation in the receiving context is examined in detail in the next chapter. Here we focus on aspects of the contract discussed by the interviewees that impinge on their rights and their health.

One of the malpractices around the employment contract highlighted by other studies is the existence of two contracts, one signed in Sri Lanka before departure and one in the receiving country which contains less favourable conditions (Transparency International Sri Lanka 2010). Six of the returned migrants we interviewed said they had had to sign two contracts. This is clearly illustrated in the following case study of an interviewee who found, once in her employer's household, that in addition to her work as a domestic worker she was required to work in a bakery run by her employer:

> In addition to the work in the house I had to do bakery work. I was taught to make bread, rolls, cutlets, cakes and other sweets. I learnt how to put them in the oven/ furnace and to take them off the oven. My hands got burnt, but I had to do that work (RKAL11).

This directly contravenes the contract she signed in Sri Lanka which clearly states: 'the employer shall in no case require the employee to … be assigned in any commercial, industrial or agricultural enterprise'. Not only did she suffer severe burns to her hands, which were ignored by her employer but also money was deducted from her salary to cover any mistakes she made: "If I make a mistake

[78]Contract of Employment for Domestic Helpers from Sri Lanka in the Middle East Countries - Private Recruitment

or some damage happens to the machinery, the cost involved was deducted from my salary". The following quote aptly sums up her experience, those of her co-workers, and her feelings.

> No, I never thought that I would have to do bakery work after going to do domestic work. But, I had the brains to learn all that. The maid who did not learn was beaten and tortured. There was no end to the work we had to perform. At the slightest mistake we were scolded saying that they are paying us to do all this work and not to idle. I thought medical treatment would be provided in case of sickness. They did not care about illnesses. Even the burns were ignored. No clothes were provided to wear during extreme cold. I thought warm clothes would be provided. Things were different to what I expected (RKAL11).

She also received no support from the employment agency in Saudi Arabia once she entered the country:

> Once I went there a representative of the Agent entrusted me to the relevant Madam at the airport. He said he will come to the house to see me; but he never came as long as I was there (RKAL11).

Some interviewees said that when they went to sign the contract at the SLBFE it was crowded, and officials did not show much interest in explaining the contract or answering any questions they had. The majority of responses of the returnees relating to contravention of the employment contract was about under-payment or non-payment of agreed wages, at times without their knowledge.

> I cannot bear up the injustice meted out to me in that country. I feel like shouting aloud for the whole world to hear when I think of that. I was not given the agreed salary. I worked like a bull for a low salary. I was paid around Rs.20,000 to 22,000 a month. Those who joined later were paid higher salaries. I cannot sleep when I think of that injustice. I even lose my appetite when I think of that. I get angry and feel sorry for myself (RKUR15).

> I decided to go because of the economic benefits. I expected to be paid the due salary on the due date, but it did not happen that way. I didn't receive the correct salary. They had sent home a lesser amount (RKAL16).

There were also instances of lack of food and inhumane living conditions:

> The training given by SLBFE was useful to some extent. The family was also told. Sometimes it was difficult to apply what was taught during training when working abroad. I never got breakfast: only tea; sometimes no lunch too. Only in the night food was given. I somehow stuck it out. Advice given is limited to advice only. We cannot apply them in those countries (RKAL20).

> I could not take care of my body. I could not bathe daily. The food given was unpalatable. There was nothing called sick leave. There was no separate place for me to rest (RKAL02).

However, not all employers violated the contract and there were examples of just and kind treatment too.

> All the members of the household were kind to me. I also was kind to them and worked diligently. I could retire to bed at 10.00 p.m. and wake up at 5.00 a.m. the following morning. They treated me as one of them. They provided me protection. I had a comfortable room for me to rest (RKAL08).

It is a positive factor that an employment contract for domestic workers, stipulating certain conditions and rights does exist, given that domestic work is not covered by labour law in the Gulf countries (see Chapter 3) as well as in many other countries in the world (ILO 2013). While

employment contracts in themselves are generally legally binding on both parties anywhere in the world, the problem with regard to domestic workers is that there is little monitoring or enforcement of the terms of the contract. And where employers deviate from the terms of the contract there is little opportunity for women to seek legal redress (Transparency International Sri Lanka 2010). Most attempts to deal with issues surrounding decent work for domestic workers at present are in the form of bilateral agreements and MoUs. One stakeholder said that most of the bilateral agreements and MoUs signed between sending countries in the region and receiving countries "do not bear any practical value in implementing terms and conditions, thus becoming mere political statements".[79] There is, therefore an imperative need to secure legal enforcement of contracts in receiving countries and improve access to justice mechanisms for domestic workers, as part of future dialogue between the Sri Lankan government and the receiving countries.

5.5 Welfare insurance

The Foreign Employment Insurance Welfare Scheme in Sri Lanka is a state run and managed scheme. It applies to all Sri Lankans who are registered with the SLBFE. The registration fee paid by migrant workers covers the cost of the insurance premium, which is between Rs. 7,700 and Rs. 10, 200 (excluding VAT) depending on the salary earned abroad. It covers workers for the maximum two years they are entitled to work abroad. In the case of domestic workers payment is made by the local agency using money paid by the sponsor abroad. The insurance scheme covers the following areas:[80]

1) Repatriation due to harassment, illness, accident or injury and repatriation due to pregnancy as a result of sexual harassment by a sponsor or his family members. Those with 'venereal diseases' are excluded. The return ticket is reimbursed but policy holders are only entitled to medical expenses incurred after return to Sri Lanka, medical expenses abroad are not covered. Significantly 'runaways from sponsor' are also not covered, apparently without any exception and irrespective of the reason.
2) Death due to any cause (except suicide) while abroad or within three months of return due to a critical illness or accident occurring abroad during the contract period. The cost of the repatriation of the body or any medical expenses after return can be claimed in the compensation to heirs.
3) Permanent disability or partial disability while working abroad during the contract period. Compensation, medical expenses in Sri Lanka and return ticket can be claimed.

In all cases 'certificate, information and evidence required' should be submitted within six months of event occurrence. An important point about the current insurance scheme is that it only applies to the two years covered by the employment contract. If the workers extend their contract beyond the two years and they do not re-register with the SLBFE, their entitlement to insurance is lost (Del Rosario 2008).

Among the 40 returnees in our sample, 38 had obtained the insurance (that is, all who migrated through the SLBFE channel - see above) and all 20 pre-departure migrants had done so. Examining the accounts of the pre-departure migrants, the information on the insurance scheme given to them - mainly as part of training - appears somewhat misleading as many of the women believed that they receive adequate protection despite the clear gaps and anomalies evident in the scheme in terms of protecting the health of migrant domestic workers throughout the entire migration process.

[79]Personal communication with Labour Consultant, 27th February 2015.

[80]Sri Lanka Bureau of Foreign Employment (2015) Benefits of insurance coverage. [Online] Available from: http://www.slbfe.lk/page.php?LID=1&PID=110? [Accessed: 15th March 2015].

> In case we have to come back to Sri Lanka due to health problems before completing the contract period, we could claim compensation (PDKUR06).
>
> We were told that we can get compensation. If we fall sick, get treatment and do not get well we should submit the hospital records to the Bureau within three months of returning to Sri Lanka (PDKAL07).

In fact, it was apparent that the women were not properly informed about what this insurance covers (e.g. repatriation if pregnant because of rape) and what it does not (e.g. medical costs incurred in the receiving country). Most women recruited by an agency were not aware of the cost of the premium, as the agency made the payment directly. They were not routinely given a copy of the policy, instead they were simply given a receipt, which they were instructed to keep in a file 'at home'. Many women were also not aware of how to submit claims.

> I got a receipt. Though there is no health insurance, the SLBFE gives insurance. The agency pays for it. The contents were not well explained at the time. Only what we learnt in the training programme. The signing was done in the office in a hurry (PDKUR07).
>
> Though the insurance was taken the information in it was not explained … Money was taken. A receipt was given. I was told that I will get a copy later (PDKAL04).

It is significant that despite obtaining insurance that was supposed to cover them for repatriation in the event of 'harassment, illness, accident or injury' and despite many of the returnees experiencing such situations while in employment, as will be shown in more detail in the next chapter, there was no real awareness of their entitlement to repatriation, and to claims. The main reason would seem to lie in the confusion around the current insurance framework. Little connection is made between their actual experiences and the protection that is formally afforded not only through the welfare insurance scheme but also as stated in the employment contract. Relatively few of the returnees who had experienced harassment by the employer or illness because of their employment conditions actually returned before the contract ended. Among the returnees 13 out of 40 came back to Sri Lanka before the expiry of the contract. The main reasons for early return were divided between 'family' and 'health'. Those returning for a health reason either had not attempted to make claims from the insurance or had tried to do so unsuccessfully.

> Although my health condition deteriorated day by day they never thought of sending me home to Sri Lanka. They wanted to get me to work. I was virtually imprisoned. They threatened to cut my neck if I informed anyone. I remained silent for fear of death. It was because of the pressure applied by my home people that I was sent home as a mentally disabled person without even paying the salary. (I learnt about that only later). I informed the Foreign Employment Bureau in writing of my pathetic plight. So far I have not received a reply or been informed of a decision taken on this issue (RKAL10).

This particular woman had returned nearly two months before being interviewed and had in fact been seen by the doctor at the airport on arrival, as she had been mentally disoriented. She had been referred to *Sahana Piyasa*, the SLBFE welfare centre for returning migrants near the airport, before being discharged to the care of her family with a letter of referral to her local hospital. Even though in this project we did not come across many women or their families who had made formal complaints to the SLBFE and applications for compensation from the insurance scheme, there has been criticism in other studies regarding the current grievance handling policies and mechanisms. The points made include: confusion in the co-ordination of the system between different state institutions in Sri Lanka, between central and local centres and between all these institutions and Sri Lankan embassies in the receiving countries, lack of adequate numbers of officers with relevant skills to handle grievances in both sending and receiving contexts, and deficiencies in dialogue with

receiving country institutions to address issues that lead to grievances of migrant workers (ILO 2013).

5.6 Sri Lankan embassies/consulates/missions in receiving countries

Despite asking a specific question, there was very little information from our returned interviewees regarding any role played by Labour Welfare Divisions and Officers in Sri Lankan embassies/consulates/missions in receiving countries in relation to their employment situation and impact on their health, and other issues around their treatment by employers, agencies, and other organisations or groups, and their right to good health and healthcare. This is in spite of the extensive documentation of health problems relating to their employment situation (see the following chapter). Most said they had had no contact with the embassy, instead relying mainly on other Sri Lankan domestic workers in the same household or working in other households nearby or help and support obtained remotely from family back home, to attempt to deal with the often extensive problems that they faced. Our interviews with two Labour Attaches/Welfare Officers in a Sri Lankan Diplomatic Mission in a receiving country[81] as well as information provided by a labour market Consultant and evidence in other studies allow some account of the role of Sri Lankan embassies and officials within them with regard to protecting the health of migrant domestic workers. It is important to note however, that procedures for dealing with the welfare of migrant Sri Lankan workers vary depending on the receiving country's administrative and legal systems for different categories of labour migrants (ILO Country Office for Sri Lanka and the Maldives 2013).

The Officers interviewed stated that the main issues with regard to domestic workers that they deal with are: work and visitor visa over stayers who become irregular and then experience problems; those who escape from workplaces; non or under-payment of wages; excessive work and lack of rest periods; denial of proper medical treatment; sickness and medical unfitness to work; and physical and sexual harassment. They believed that a considerable problem is the lack of fitness to work of many domestic workers before they migrated and which had not been divulged by the migrant or detected in the pre-departure medical test.

> Yes, at present, the majority of grievances of domestic workers are related to medical unfitness. This situation could have been avoided if the Sri Lankan agent took extra precautions in selecting the candidates. Most of these sicknesses are reported to have been prolonged illnesses and developed before migration. Workers [are] also to be blamed for negligence of taking a two year foreign job without much concern to their medical fitness. It is unfortunate that some women at early pregnancy stage (presumably without knowledge of the pregnancy) also do come for employment, making severe losses to both the agents and employers (Labour Attache/Welfare Officer in a Sri Lankan Mission).

Once a migrant worker arrives in the embassy, action is taken to accommodate her in a safe house of the embassy and to enable medical treatment. In the UAE, there is a medical insurance policy through which sponsoring employers have to provide employees with a health card (see Chapter 3).[82] If the worker has this card in her possession hospital treatment can be provided free of charge. Otherwise the embassy has to bear the cost of private hospital treatment. Usually this, as well as the airline ticket for repatriation, is funded by the Workers' Welfare Fund created through job order approval fees to the embassies and the SLBFE insurance scheme registration fees. Where physical or sexual abuse is reported, the Mission 'takes immediate action' to report such cases to the Police in the receiving country. Repatriation creates particular difficulties, not only because of the cost of the

[81] Telephone Interviews, 20th October 2014 and 3rd November 2014.

[82] However, in our study two of the three women who went to the UAE said they were not given a health insurance card. It is possible that the employer retained it.

flight but also because employers demand the costs of recruitment back to grant consent for exit clearance under the *Kafala* system. The Labour Officer has the task of trying to persuade the employer to consent to exit clearance and to surrender the domestic worker's passport. If this attempt fails the case of the domestic worker has to be submitted to the relevant department dealing with immigration in the receiving country.

The Labour sections of Missions do collect numbers of domestic workers who escape and come to the diplomatic mission for help. It is estimated that at any given time, around 1,000 domestic workers are in Mission run 'safe houses' in the region's receiving countries. In December2010, in embassies in countries/cities with the largest number of migrant domestic workers, Kuwait and Riyadh, there were respectively 399 and 291 female domestic workers in safe houses. Overall, the average number of escaping domestic workers ending up in the Sri Lankan embassies is around 150 per day in the entire region (ILO Country Office for Sri Lanka and the Maldives 2013).

Deficiencies in the Sri Lankan diplomatic missions in dealing with problems experienced by migrant domestic workers have been reported in other studies. Key issues that have been raised include lack of adequate and qualified staff, unprofessional conduct of officers, poor co-ordination with both home and receiving country authorities, and lack of proper guidelines for dealing with migrant workers' problems or lack of implementation of procedures that exist (ibid; Transparency International Sri Lanka 2010). The significant point that is highlighted in our research is that although domestic workers interviewed had experienced serious health issues and lack of rights in their employment situations, these were not, for whatever reason, brought to the attention of the Labour Attaches/Welfare Officers in the embassies.

5.7 Institutional support on return

Institutional support for returning migrants with health and welfare-related problems is provided initially by *Sahana Piyasa*, a SLBFE run welfare reception centre and temporary hostel for women located close to the airport. Any returning domestic worker with problems refer themselves first to the doctor on duty at the airport or are identified by airport staff as needing help and are referred to the doctor. Those with serious or urgent medical conditions (for example AIDS) are transferred directly to hospitals. Others are transferred to *Sahana Piyasa*. Table 3 shows that far more women returnees are referred than are men in the categories designated 'mental health' and 'other illnesses'.

Table 3

Returning migrants referred to Sahana Piyasa by sex and reason for referral

January - December 2013

Reason for referral	Male	Female	Total
Mental health	08	48	56
Other illness (not specified)	46	118	164
Disability	22	24	46

Source: data provided by Sahana Piyasa

The staff we interviewed at *Sahana Piyasa*[83] said that among all returnees needing health/welfare assistance, each month, on average there are: five pregnant women, four to six women with babies, 15 - 20 with a health problem of some kind. The health issues are mainly broken limbs (often through attempted suicide or being pushed or the result of accidents at work), but also mental problems, and non-communicable diseases such as cancer.

Box 5

Twenty six year old woman, M, abandoned as a baby, and retrieved in a dustbin outside a shop. A shop keeper's family brought her up, used her to smuggle arrack bottles because a child is not usually suspected by the police. When she was around 13, she was sold in exchange for an arrack bottle to another dealer where she was 'kept' by the son of the family until 18. She escaped then and married someone who arranged with an agent for her to go abroad to a Gulf country as a domestic worker. While there, and before her contract was completed, she tried to escape by jumping out of the house she was in and was seriously injured. She ended up in the care of the Sri Lankan embassy in the country, and was eventually repatriated. When she arrived at the airport the Sahana Piyasa welfare providers took her over. She was totally silent, very disturbed and not inclined to talk about what had happened. Eventually the interviewee built up a relationship of trust with her, and also tried to work with her husband (who had originally 'sold' her to the recruitment agent) to facilitate a better relationship between them, so that M wouldn't have to migrate again. She is now back in her community, and the interviewee keeps in touch with her from time to time

Case study recounted by a Sahana Piyasa staff member, 7th April 2014.

In the case of pregnant women or those with babies, the staff attempts to connect them with their families but given the social stigma around unmarried mothers, there can be resistance by either the returning migrant or her family. If such women are destitute, their babies have been taken over in the past by the Salvation Army and adoption is arranged. More recently law courts are actively involved and babies are sent to children's homes maintained by the Department of Probation and Childcare Services.

Returning domestic workers who are considered to be mentally ill are transferred from *Sahana Piyasa* to the National Mental Health Institute near Colombo or to regional hospitals with mental health units.

[83]Stakeholder interview, 7th April 2014.

Box 6

P was referred to the Mental Health Institute by *Sahana Piyasa*. While she does not talk, her behaviour is very aggressive and disturbed. Because of that, information was obtained from her parents.

When she migrated to Kuwait in 2012 she was separated from her husband and left her child with her mother. After leaving the country she had been telephoning home for about eight months. She had said that she had moved to four houses because of problems she had with the employers. While the parents do not know anything about the household she worked in last, her telephone calls had also ceased. Because there was no contact with P her parents had contacted the sub agent who had gone with her to the agency and informed them of the problem. The agent had agreed to find out what had happened to her. However, as they did not receive any information from the agency, they contacted a relative who was employed as a domestic worker in Kuwait. She too had not been able to get any information about P. It was at this time that they received a telegram from *Sahana Piyasa* informing them that P had been admitted to the Mental Hospital for treatment. As P had never had any mental illness earlier her parents were puzzled as to what could have happened and went to see her in the hospital. P did not recognise anyone. However her mother had seen marks on her neck, face and arms that suggested that someone had tried to assault and strangle her. These had been recorded by the medical doctor when she was admitted to the hospital. It had also been recorded that she was four months pregnant. Physical, mental and sexual abuse was suspected. Subsequently she was discharged from the hospital and taken home by her parents. She gave birth in a Colombo maternity hospital.

On medical advice, before P was discharged, P's mother had complained to the SLBFE head office. Although P had been insured at the SLBFE, the Welfare Division had informed her parents that it did not have an allocation to make a payment. Her mother had gone to the SLBFE several times and had been given a cheque for Rs. 19,242/=. Before that P's mother had complained to the Human Rights Commission of Sri Lanka about the injustice done to her daughter. The HRC has instituted action against the SLBFE and the recruitment agency, which is no longer in operation. P's mother had taken the advice of the HRC to return the cheque given by the SLBFE.

The doctors have confirmed that P is incapable of looking after her child. They have also concluded that she will need long term treatment. Her behaviour becomes aggressive at times. P's parents are hopeful that justice will be done to P through the legal proceedings that have been instituted by the HRC.

Interview with P's parents 17th September 2014.

Such case studies and interviews with stakeholders at *Sahana Piyasa* and a Psychiatric Social Worker in the National Institute of Mental Health (NIMH) show that institutional support around health for returning migrant domestic workers does exist. However, in our sample of returnees only one woman among the 18 out of 40 who said they needed help had been referred to *Sahana Piyasa*, and one woman to the mental hospital. The majority (12) had sought medical attention from a doctor back in their area of residence and four women had entered a local hospital.

The social worker interviewed suggested that in many cases those who were considered to be mentally ill on return were already mentally ill before migration but this was not spotted for example in the pre-departure medical test.

> Often the problem starts before migration. Women hide evidence of mental illness-bi-polar condition -from the agent and goes abroad. Therefore relapses happen in the destination.[84]

Staff in the NIMH work in close knit teams, and skills such as on counselling are updated regularly. Families are often involved in counselling and home visits are done by the social workers. It is not possible to prevent discharged patients from going to work abroad again but they are encouraged to talk to the social workers before re-migrating and to take a supply of medicine with them. This stakeholder believed that all first time migrants should be advised and counselled by someone with a psychiatric training about what to expect at destinations, including the possibility of depression because they may not understand the language sufficiently and are away from family. They need to be conditioned about what to expect and how to deal with problems. Some women 'leave with their bag expecting a fairy tale and find themselves entering a hell in reality'.

As evident in the case study presented in Box 6 and earlier discussion in this chapter, SLBFE procedures and practices in helping returning migrant workers with health and other problems are not entirely positive and have been criticised (ILO 2013). For instance, the social worker we interviewed believed that staff in *Sahana Piyasa* tends not to involve themselves in what happens to women after they refer them to the mental hospital. Although the hospital is responsible for medical treatment, there is no designated channel through which the long term welfare of patients is followed through adequately.

In this chapter we have reviewed the main elements of the sending country migration governance framework surrounding health for domestic workers through the perspectives of pre-departure and returning interviewees, stakeholders involved in these processes and review of relevant official documents. The chapter brings out many of the gaps and weaknesses in the institutional framework that impact on the health of migrant domestic workers. In Chapter 6 we examine the interviewees' accounts of their health and access to healthcare throughout the entire migration process. The chapter provides important information about the health of domestic workers and illustrates the strengths and weaknesses of the regulatory framework.

[84]Stakeholder interview, 4th April 2014.

CHAPTER 6

Health Status, Health Choices and Access to Healthcare: Pre-Departure, Receiving Context and Return

This chapter focuses on the health experiences of Sri Lankan domestic migrant workers throughout the entire migration process. Based on their own accounts, it examines: 1) their health before migration and the part played by health in their migration decisions; 2) the impact of working and living conditions on their health in the receiving context, including their preventative and coping health strategies while in employment; 3) their access to healthcare in receiving countries; and 4) the impact of health on life after return and the part played by health in decisions about migrating again.

It is important to stress from the outset that the migrant interviews conducted in this study indicate that 'family health' is a holistic and pivotal issue before, during, and after migration. It is not solely family economic circumstances that frame migration and return; the physical and mental health of the migrant worker, her children, spouse, parents, and other family members are significant factors in the migration process. Health is clearly linked throughout the study to issues of poverty; male and female unemployment and under-employment; limited education and skill levels; levels of indebtedness (particularly for housing and education); male alcoholism; and domestic abuse that weave throughout the interviews. Furthermore, the migrant domestic worker views her health status in the receiving context in relation to the impact of migration on the health of the family members that she leaves behind. Family health plays a large role in decision-making, particularly the decision to migrate again notwithstanding the health consequences of previous domestic work abroad.

6.1 Pre-migration health factors

Most pre-departure migrants spoke of being in good health prior to migration. They had just been through the medical testing procedure; it is inevitable that they would claim good health as it is a fundamental requirement for employment as a domestic worker abroad. However, it is also clear that they knowingly leverage or trade their health to work abroad in very difficult conditions with the underlying fear that their families at home may fail to thrive while they are away. The primary goal of migrant domestic workers in this study is to make more money for their families than they are able to earn at home. It is a clear, if often times painful, economic choice as discussed in Chapter 4.

The health aspect of their pre-departure decision-making comes out clearly in the accounts of the returnees:

> I left home with a lot of dismay as I was leaving behind the loved ones, fear of headache and backache from anticipated hard work and the doubt whether my mother will be able to look after my child who was fairly grown up at that time (RKUR14).

> When I left this time I was very sad, especially to leave my two sons. They are always with me. Also I felt sorry to leave my father. He is very vulnerable. He doesn't have a leg. I felt sorry to leave my husband also. I had a bit of a health problem. I was scared that I will fall sick due to the heavy workload. I thought that I will get a back problem by climbing stairs and lifting heavy loads. Because I knew the country and the language I was feeling a little confident (RKUR06).

Despite the fact that the interviewees successfully completed the medical testing procedure, often their pre-migration health was not at an optimum level. For some women, their employment conditions before migration had already negatively affected their health, which in turn was made worse by receiving context work and living conditions. As one returnee explained:

> I worked with cement when in Sri Lanka. I mixed cement to make cement blocks and worked as a helping hand. I developed Asthma by inhaling that cement dust. I had a relapse when working abroad. I first developed it in Sri Lanka (RKAL01).

As described in Chapter 4, for some women mental anguish arising out of extensive poverty before migration was exacerbated by the physical and mental abuse they experienced from partners. One pre-departure migrant showed the way this experience had become a driver for migration, as seen in Chapter 4. Another interviewee, a returnee, highlights the health impact of domestic harassment and abuse and how it became a motivation for migration:

> I could escape from the condition at home to do a job with satisfaction free from physical and mental pressure that I experienced at home. Make amends to the mistakes made in my life by experiencing something new with regard to life (RKAL08).

More commonly, interviewees expressed mental distress about leaving families - especially young children - behind.

> These days I have a feeling of sadness about having to leave the children and husband for some time. When I think of it my heart burns: cannot even sleep properly. I would never have gone abroad if there was a way of solving the economic problems and helping the children's education. I am going because there is nothing else to do … But I dream of a better future and make up my mind. I cry without being seen by the children (PDKUR08).

> Yes, I was afraid that I would fall sick. I thought that I would fall sick because of the heavy work load; that I would die and then what would happen to my children. My son and daughter did not like my going abroad. They cried and begged me not to go. When I left the children I too was crying. I was really distressed when I left. I spent about Rs. 56,000 on phone calls to them (RKAL03).

6.2 Health in the receiving context

6.2.1 *Responsibility and self-help in health*

As shown in Chapter 5, the SLBFE training guidelines, as imparted through lectures and videos in training sessions, are clear that a domestic worker must maintain her health in order to fulfil her contractual obligations to her employer abroad.

> Although there was no mention of health insurance, we were told for two days to protect our health (RKUR15).

> There was no separate health insurance but they explained throughout the training period the importance of looking after our health. And if health fails, the whole contract gets upset. They stressed the importance of mental health and the importance of getting enough sleep and taking proper meals. They said these were our rights (RKUR08).

> On the day we left the country we were told to take care of our bodies. We were told how to maintain personal health, about food, rest, and living without getting sexually abused (RKUR05).

The domestic worker is advised to: take enough rest to stay well; not consume overly oily or sweet food; not dwell on home or any family worries that would cause her anxiety or depression; and avoid interaction with the household males to prevent sexual abuse. It is significant that the responsibility of ensuring good health is considered to lie firmly within the control of the domestic worker irrespective of the impact on her health of conditions of employment and the work itself.

> We were told that taking meals at the proper time, sleep, quieting the mind and the body are ways of protecting our health. We were asked to pay attention to cleanliness and always to use clean underwear. The mind becomes weak by constantly thinking of home problems. You tend to forget your responsibilities as a housemaid. You will not be able to carry out your duties properly. The mind becomes weak causing sickness of the body. You will not be able to earn money by working. You will be mentally sick through continuous worrying … We were asked to eat our food at any cost to protect our physical health. We were asked to eat whatever was available. Being hungry and without food can cause gastritis. We were asked to avoid as far as possible oily/sweet food. In this way they explained different ways of protecting our health (RKAL16).

Similar to advice sometimes given by the development officer at the local level and the doctor in the medical testing centre (see Chapter 5), the domestic worker is conditioned to bear ultimate responsibility in preventing health problems to optimise her ability to perform her work effectively, thereby presumably 'protecting' the investment of the employer and the recruitment fee of the agent.

Part of this approach is the stress on home remedies and self-medication during training; and it is strongly reinforced by the women themselves. Among the returnees, 31 of 40 (77.5 per cent) had brought medicines from home. In their accounts, headaches, leg and back pains, cramps, stomach pains, and slight fever were generally treated with Panadol, rest, and various over-the-counter remedies brought from home. Piriton syrup was used for cough, cardamom oil, *Siddhalepa* balm for aches and pains, and Vicks for pain in the feet, arms and legs. Cinnamon oil was used for toothache. The interviewees, particularly those who had migrated before, but also those who had learnt from the experiences of migrants in the local area, travelled well-equipped to deal with most kinds of minor medical eventualities. The practice of mindfulness, as well as prayer, was equally important.

> I took Panadol for minor ailments. I massaged my head for headache and drank warm water for cough … As a practice I used to take Panadol with me whenever I went somewhere. So I thought that I should take Panadol with me for an emergency in an unknown country. I drank warm water without the knowledge of Madam. I refrained from eating unnecessarily. I did not suffer mentally. Sometimes I retired into my room and rested. I remained in one position with eyes closed. I kept myself clean; was careful about bathing (RKUR15).

> I worked with a lot of patience. I did not have any illness other than coughing. My mother had conducted *Bodhi Poojas* back at home. I also worshipped the Buddha as far as possible. At every possible break from work I tried to sleep (RKUR04).

6.2.2 *Impact of working and living conditions on health*

Bringing medicines from home, taking as much precaution as possible not to fall seriously ill and trying to maintain a good mind-body balance, could not counteract the impact of very poor living and working conditions for many of the women we interviewed. This led to a deterioration of their physical health over time. The conditions ranged across habitually long working hours, insufficient regular rest time, food deprivation, heavy lifting and carrying that led to musculoskeletal strain and injury that remained with them long after return home, and use of chemical cleaning agents that resulted in respiratory difficulties and eye damage. Such adverse domestic work experiences as reported in other studies, both globally, and specifically in relation to Gulf country employment,

have been highlighted in a recent systematic review on 'the health issues of female foreign domestic workers' (Malhotra et al. 2013). Some illustrative quotes from the interviewees in our study vividly show the enormity and intensity of the problems they faced. Ironically, employers easily broke the employment contract (see Chapter 5) with regard to providing good working and living conditions to safeguard the health of the workers.

> I got fever while there; but at the beginning I did not get proper treatment. I lived on plain tea and *Roti*. Day after day I got thinner and thinner, and weaker. I got scared thinking I will die there … From the time I wake up I have to attend to washing, cleaning and cooking. I have 2-3 hours of rest during day time. I have to climb up and break cobwebs, most of the time clean using water; working for too long using water increased my phlegm related ailments. It is stressful to work when you are not well. When I had to work without having meals I thought of home; I felt very sad (RKAL12).

> I developed a headache inhaling washing powder used in cleaning vehicles and washing clothes. It was unbearable. I was hospitalized and treated for four days. Even now I get it occasionally. Even now I feel uneasy. I fell sick owing to this kind of tedious work … Hard work and constant climbing of stairs did aggravate my backache (RKAL13).

> Detergents used for cleaning the toilet went into my eye. The eye was smarting but I got no medicine. The madam asked me to wash the eye. Eye-sight failed little by little. Another problem was the swelling I got in my legs. Now I am taking treatment for both (RKUR08).

One interviewee recounted how her living conditions, resembling a bonded form of labour, affected her physical and mental well-being:

> I was not even given food properly. On the first day itself they took charge of my travelling bag, my clothes and my passport. There was no separate place for me to sleep. I was asked to sleep in the sitting room. When I go to sleep they lock the sitting room. I had no way of even going to the toilet. My experiences were totally different from what I expected … I developed a headache when it was too cold or when breaking rest (RKAL02).

However, while there were some accounts of verbal abuse by employers, only one woman said she had experienced actual sexual harassment.

Among the 40 returnees, 26 (65 per cent) said they were not allowed time off when ill. Most described how they dealt with this contravention of the employment contract as an infringement of both their human and worker rights to sick leave, by finishing their work as quickly as possible and retiring to their place of sleep to rest and to take home remedies.

> There is no leave. I worked with difficulty and walked limping. I had to finish all my work for the day if I want to take leave. At every available opportunity I go to the rest room and close the door. I close my eyes tightly and seek solace in the Noble Triple Gem. There was no point thinking of home and repenting. I always prayed that nothing untoward should happen to me till my term is completed (RKAL16).

Such accounts, if viewed in juxtaposition with statements and agreements enshrined in international human rights conventions and regional dialogue (see Chapter 2), vividly show how much progress there still remains to be made in practice to ensure decent work conditions and health protection for migrant workers.

It is important nevertheless to note that not all the returned domestic workers interviewed said that they were heinously treated by their employers. Almost always the work itself was arduous and

unrelenting, but there were instances of concern and kindness on the part of employers and quick responses to instances of injury or illness.

> I would work from 6.30 in the morning till 10.00 in the night and retire to my room. I got an adequate amount of food. There was no physical or verbal abuse. There was no sick leave as such, but I was allowed to retire to my room and rest when I wasn't feeling well. There was no work after 10.00 p.m. (RKAL09).

> They always brought the medication required for the glandular problem I had. When I say that I am not well or have a headache they give me balm to rub (RKAL03).

One interviewee had worked in the same household for many years through extending her contract repeatedly. She was treated more as a member of the employer's family:

> Madam is scared that I would get sick. She is always watchful. She supervises my medication. She [was] like a mother to me. They were very kind. Even the children helped in the housework. They would not allow me to work too much. They don't let me clean the rooms daily (RKAL18).

A key finding of this study is the incredible power that the employer has in the physical and mental health status of the migrant domestic worker as both employer and *kafeel* (see Chapter 3).

6.2.3 *Access to medical treatment*

Thirty one (31) out of the 40 returnees (77.5 per cent) said they received medical treatment for an illness or injury while in employment. In the case of 16 of the women, this was from a doctor (presumably General Practitioner (GP), 10 in hospitals, and for the remaining five women, medicines were provided remotely through the employer. Overwhelmingly - for 30 out of the 31 women - the employer paid for medical treatment either through their own insurance card at a state facility or privately. This is in line with the requirements of the employer as stated in the employment contract for domestic workers in most of the Gulf countries (see Chapter 5). It was not however clear from the interviewees' accounts, to what extent the money for medical treatment was deducted from their salaries. In many cases, the interviewees said they were paid less than originally promised but there was some ambiguity relating to deductions. Overall it appeared that many of the interviewees lacked clear knowledge of the amount of salary they were supposed to receive, and how much, if any, was held back for either healthcare or for the return flight ticket. There was further confusion about the difference between the insurance receipt given by the SBLFE and the health insurance card in the receiving context (RKUR20). There was general confusion among the interviewees of the difference between emergency health insurance and comprehensive health insurance.

In our sample, an area of concern included a lack of access to medical treatment although no one complained of an employer not paying for it. However, the primary concern of the interviewees was that the need for, and access to, medical care was not a priority for their employers. One migrant domestic worker was hit in the shoulder by a car, but she did not receive professional medical treatment (RKAL14). As discussed in Chapter 5, a woman who had been hired as a domestic worker in Saudi Arabia was made to work in a bakery where she burnt her hands in a gas oven, but she did not get medical care (RKAL11). Another interviewee was given time off when she contracted chicken pox, but only to avoid infecting the rest of the family (RKUR20). As one interviewee explained:

> They don't care much when you fall sick. You are taken to a doctor only when the illness aggravates. They give home medication using the juice of crushed leaves. They give crushed cloves. They didn't get treatment for my injured shoulder that was swollen when the vehicle

> hit me. It was so serious I could not even breathe. They fomented with hot water and applied a cream. Not that much of care (RKAL14).

On the other hand, some interviewees felt that the employer did respond satisfactorily to their needs when they were ill:

> They were very kind to me; whenever I requested for medical treatment it was arranged for (RKUR18).

> When I went this time my phlegm condition got worse as I had undergone an operation. I inhale tablets. One day I had forgotten and taken it twice and had difficulty in breathing. I was unable to breathe and fainted. They rushed me to the hospital and saved my life. After that I was more careful about the phlegm condition (RKAL18).

In general, the interviewees were happy with the kind of healthcare they obtained from the doctor or at a hospital; they felt it was equal to, or better than, the treatment they receive in Sri Lanka.

> I got treatment easily through employers' card. Like in Sri Lanka small hospitals do not have many facilities. Health officers are kind. Getting treatment in the night is a little difficult as in Sri Lanka. Have to waste time (RKAL19).

> There are private medical centres as in Sri Lanka where you have to pay. In our country medicines are not available [in hospitals] where it is [supposed to be] freely given. Have to waste a lot of time too. That is why we come to the Kurunegala hospital most of the time. But when I fell sick while abroad, madam gave me treatment from the free centre. All the facilities were there. Treatment was given quickly (RKUR01).

6.2.4 *Mental health and psycho-social support*

A key finding of this study is the lack of mental health care for migrant domestic workers in the destination countries. For the majority of interviewees the predominant factor affecting their mental health while working abroad was concern about their families back home. The mother of two of our interviewees died while they worked abroad. One of the employers did not tell the woman that her mother died and so she felt anguish that she had not performed the appropriate rites for her (RKAL14). One woman lost her husband while working overseas (RKUR17). Another woman worried about her wheelchair-bound husband (RKAL17). In particular, the interviewees were worried about what would happen to their families, particularly their children, if they fell seriously ill or died in a foreign country. There was tangible anxiety over who would care for their children if they died. This was a recurrent theme in almost all the interviews with returnees. This fear was compounded by poor Arabic skills, the isolated nature of their work, a lack of contact with home, and the stigma of using mental health services in receiving countries. Other studies of migrant domestic workers have also reported that social isolation and worries about families in countries of origin are major stressors and risk factors for mental health problems (Malhotra et al. 2013).

> Every time I fell sick I thought of home. Thought of my children, my husband; thought what if I die of this sickness here; at such times I go for medical treatment with my [employer]. It is not possible to follow medical advice. Invariably, I have to go up and down to do my work. Sometimes I cry. Again I console myself thinking I must do what I came to do (RKUR18).

> I could not sleep when I got knee pains and body aches. I was scared that I will not be able to go back to Sri Lanka using my two legs. I used to cry thinking of my husband, children and siblings (RKUR07).

They contrasted their feelings about being ill in Sri Lanka while living amongst their families to being isolated in the receiving country.

> I used to get panting [wheezing] at home too. But I was not scared of that there. When this happened abroad I got very scared. Because there was no one of mine there (RKAL17)
>
> Not at all the same as home. When I fall sick at home I go and get medical treatment. I do not cry. However, when you fall sick in that country [Qatar] you get really scared (RKUR18).
>
> I never experienced anything like this at home (RKUR04).

In this context, any psycho-social support they got in the receiving country was important. Seven interviewees said they received help and support from friends and relatives, often other migrant domestic workers who worked in the same house or nearby. Some of these migrant domestic workers were Sri Lankan. Eighteen women said they had multiple sources of support, including other migrant domestic workers, relatives who were in the same country, as well as their employers.

> They helped me every time I fell ill. A Sri Lankan housemaid there also helped me. The members of the household treated me well. If I go to my room and wait when I am sick they do not say anything. If I tell them that I needed medical treatment they will promptly attend to that. They provided all the help I needed (RKUR17).
>
> I got scared when the fever rose. I missed home. In the next house there were Sri Lankan sisters. Since they were there and because I got help and care the fear and the sadness subsided (RKUR20).

In some cases though, the only support came from frequent contact with families back home. Eight women said this was what sustained them throughout their time abroad, although at times they did not feel they could be honest about their working conditions and illness; they feared upsetting or alarming family members back home.

6.3 Health status upon return

A little over half of returnees - 23/40 (57.5 per cent) stated 'end of contract' was their main reason for return. However, eight women said they came back because of their health while six gave family reasons, and three gave other reasons. Their in-depth responses show that many felt that their health had significantly deteriorated while they were abroad. They were left with ailments that needed attention on their return. Physical conditions of post-migration health included headache, back and leg pain, asthma, high blood pressure, anaemia, cough, and stomach pains.

> My health condition is not very good. I get persistent back aches, pain in the knees and legs. Very often I get headaches. You have to carry heavy objects in that country and keep standing while working. Very often we fall sick as we do heavy work … Washing clothes [now] is a problem due to backache. I used to wash my mother's clothes. Now I can't bend down to wash. I only wash the clothes of the family members in separate lots as I can't wash the full load at the same time (RKUR14).
>
> I have no peace of mind these days: my poor health condition on the one hand and the problems at home on the other. I returned home as a sick person. I cannot see. My whole body aches and legs are bad after climbing stairs. My legs are swollen. I had a stomach problem in Kuwait and now they say it is a cancer. So I feel very sad and there is no peace of mind. I do not have money to get medicine and I do not go for treatment regularly (RKUR08).

Symptoms of physical ill health were sometimes expressed together with lack of mental well-being indicators. Where they exist, the latter were manifested in depression, anxiety, insomnia and loss of

appetite. These conditions often derive from family problems that continued or were exacerbated while the women were abroad. But they are also associated with the interviewees' frustrations around their own inability to realise the economic stability for their families that was their main aim for migration, as shown in Chapter 4, and that they worked so hard while abroad to achieve.

> My son fell sick suddenly. My husband too did not have a regular job. He does not get masonry work all the time. When I see all the problems when I come home, I feel very worried. I cannot fall asleep easily thinking about these things. I have no solutions for these problems yet. It is troubling my mind now ... When I work hard I get a backache. Though I went to work abroad many times I have not saved a cent for myself. When I was working abroad at one time my daughter eloped and got married at the age of 16. When I think of these things my mental anxiety increases (RKUR07).

Not all returnees, however, felt they have worse health after migration. For some, while their physical health had clearly suffered while abroad, they felt a sense of mental satisfaction for being able to improve the financial circumstances of their families. Relief at being back home again was also important.

> I built the house well. I feel happy when I see it. It is beautiful. A little more has to be done. I spent one lakh of rupees from the savings I brought home … Now I do not have money. I have to depend on what my son gives me. Things are very expensive here in Sri Lanka. However much you have is not sufficient. Then I feel like going abroad again. Now I attend to household work. I do not bother about food. Piles ailment has got worse. I consume fruits only once in a way. I take Thyroxin daily. However, we [mother, son and herself] spend a happy life. All have benefitted and changed (RKUR05).

> I am 100 per cent better than when I returned from abroad. When I came I was like a skeleton, my son and husband could not make me out. Now I do not feel weak at all. I can attend well to the work at home and to my husband's and son's requirements. I can walk and do any work. So I feel my health is good (RKUR12).

> I couldn't work at the beginning. I couldn't sleep properly after I came here. Now it is a bit better. When I am with my own people, I forget the ailments that I have (RKAL04).

6.4 Health as a determinant of future migration

As shown in Chapter 4, a majority of the returnees were caught up in a cycle of migration, with 31/40 having migrated before the current episode of migration. Fifteen women had worked in multiple countries in the GCC. As we also saw in Chapter 4, 16 women intended to migrate again. It seems clear that for these women, if their physical health allows they will continue to migrate for economic reasons as the following interviewees explained:

> I hope to see a doctor soon for the pain in my legs especially because I hope to go abroad again soon … Although my earning abroad has helped us to ease our problems gradually, it is a great mental stress to leave my three daughters with my husband. Yet, there is nothing else I can do. I do my work there with lot of pain within me. My husband is good, so I trust him and leave the children with him (RKUR18).

> I expect to go to Jordan once again. Therefore I am planning to consult a specialist doctor regarding Asthma and high blood pressure. I have a feeling that the heavy dust in those countries can aggravate Asthma. Therefore I intend taking medicine or an inhaler with me (RKAL01).

> We do not have sufficient training to do another job. We are not educated. Only people known to ministers get jobs in this country. We do not know any one like that. What we earn

> as a housemaid in a foreign country can never be earned in this country. When we go to work in a foreign house our salary is saved. We get board, lodging, and medicine in that country. We do not have to spend any money for those things. I received gifts and money for spending too in that country. I will never get things like that in Sri Lanka. Anyone working as a housemaid in Sri Lanka is not respected. In the villages, they consider working as a housemaid in a foreign country as a respectable thing. The only way I can find solutions to my problems is by doing a job like this (RKUR13).

The accounts of the interviewees in this chapter show that while the health of migrant domestic workers is determined by the harsh economic and social conditions they face at all stages of the migration process, they demonstrate considerable agency in the way they leverage and strategise their health to achieve the best possible outcome. The main beneficiaries of the migration process are not usually the women themselves. They migrate mainly for the welfare of their families. However, their remittances are a great benefit to the Sri Lankan state. Their strategies include preventative and curative tactics, and maintaining a mind-body balance to cope with adverse work conditions and their negative impact on health. However, while working abroad the women are heavily reliant on employers' willingness and compliance to secure decent working conditions and to allow them access to healthcare. The uncertainty this reliance engenders has a detrimental effect on both their mental and physical health. In this context, it is imperative that there are health protection measures that would guarantee migrant domestic workers their own decision-making power and independence in being able to access healthcare as a right.
As one interviewee summed up:

> I would work towards safeguarding my health. Health is the most important thing (RKUR02).

6.5 The importance of health insurance

The women themselves make a number of important recommendations, specific to health, to improve the migration process:

> It is better to have health insurance especially when elderly housemaids like us migrate; it will be very useful. Because of our age, we may develop high blood pressure or diabetes later(RKUR07).

> It is unjustifiable not to have a health insurance policy (RKAL08).

> There should be health insurance. Women especially are subject to various forms of harassment. The lack of health insurance for protection is a big loss (RKA10).

> Women who run away from their work place have health problems. I have helped by phoning the husband and informing him. It is good if the state can make a formal arrangement in such instances to inform the next of kin. Some have gotten ill, some have become pregnant. They cannot come back to Sri Lanka. They cannot stay in that country either. Their situation is pathetic. The state should find out the condition of these women. It is essential that such women are helped (RKAL03).

They also give pertinent advice on how the state could ensure their overall welfare, before, during and after migration:

> We will not have to worry about our future if there were some special pension schemes for people like us who have gone abroad many times and brought foreign exchange into this country (RKUR07).

> It is good if a pension scheme is available for us to use in our old age (RKAL03).

Some women migrate again two to three months after returning. If they can be encouraged to get involved in some self-employment scheme, which will bring in some money, it will be possible to stop them from returning (migrating) time and again (RKUR01).

I think it would be very good if there were hostels for children of mothers who go abroad like me so that they can be looked after well, attend school, and be happy (RKUR10).

For someone going abroad on work for the first time, it would be good if they went to a place where they already have someone that they know. Then she would not have to face any problems related to language or anything. It is better to go for work in houses where there are Sri Lankan domestic workers (RKAL06).

'Wherever you go you must learn the language of the people before going there (RKAL12).

CHAPTER 7

Conclusion and Recommendations

The focus of this report was the health of Sri Lankan women migrating for domestic work to GCC countries and Jordan and Lebanon. It considered their health status, barriers in access to healthcare and gaps and anomalies in the provision of health protection, across the entire migration process. The report was based on 60 qualitative interviews with pre-departure and returned migrants in two districts in Sri Lanka and with a range of stakeholders in Sri Lanka and the receiving countries, within a framework incorporating relevant policy documents and academic and grey literature.

7.1 Key findings

The main points that emerged from the analysis of findings in this study are:

i. **Migrant domestic workers' health requires viewing holistically, connecting the entire migration journey, and family health as well as the individual migrant's health.**
Health challenges for both the women and members of their families are present prior to migration, arising for the most part from levels of poverty that mean basic family needs are not met. Physical and mental symptoms derive from worry, anxiety and fear. But the women also knowingly leverage or trade their health through multiple cycles of migration for poorly regulated and gruelling work predominantly to attempt to meet family economic, social and health needs. Remittances are sometimes used to pay for healthcare and medicines of family members.

ii. **There are many gaps and anomalies in the governance framework around health that have a negative impact on the women's health and health rights.**
The gaps and anomalies are manifest in both origin and destination contexts and cover several areas across the migration process. These include recruitment, training, medical testing, employment contract, insurance, Sri Lankan embassy involvement in receiving countries and health support on return. This study challenges the efficacy of the current Sri Lanka migrants' welfare insurance scheme.

   a. There is a mismatch between information on health rights and protection given as part of the SLBFE training programmes and the extent to which domestic workers have the power to apply this information and exercise their rights in their actual employment situation in the receiving country. This is because they lack sufficient institutional support and access to redress mechanisms.

   b. According to the interviewees' accounts, they are compelled to put up with employer violations of many of the health-related provisions in the standard employment contract signed by both the employer and the domestic worker, such as adequate food and rest times, limitations on working hours, and humane treatment generally. This is largely because there is no systematic and effective monitoring of working conditions to ensure employer compliance with contract terms in many of the receiving countries. The difficulty faced by domestic workers in defending their rights is exacerbated by the lack of national labour law coverage of domestic work in these countries.

   c. The compulsory foreign employment welfare insurance scheme operated by the SLBFE has clear gaps in the requirements to meet the health needs of domestic workers in the

receiving context. Only medical expenses after repatriation, as a result of illness or accident, pregnancy due to rape (but not for those escaping from abusive situations in employer households), and compensation for disability arising from accident or injury at work, are covered. Despite many interviewees in this study experiencing such situations, there is general confusion around the current insurance framework. Little connection is made by them between their actual experiences and the protection that is formally afforded not only through the welfare insurance scheme but also as stated in the employment contract. Relatively few of the returnees who had experienced harassment by the employer or illness because of their employment conditions actually returned before the contract ended. There is a need to address the gaps and discrepancies in both the employment contract and the insurance policy to ensure that migrant domestic workers receive comprehensive health protection.

d. There is an assumption and expectation among Sri Lankan state officials and some stakeholders of the inherent lack of responsibility of migrant domestic workers. Actions deriving from this assumption range from attempts in pre-departure local processes to control the movement of women through the requirement of the husband's signature in the family background report irrespective of whether the women have children or not, to denial of their right to consent for medical testing, for interventions such as contraceptive injections, and the individual right to obtain a copy of the medical report. The National Labour Migration Policy action point on pre-departure health testing to be regulated 'to ensure dignity, privacy and confidentiality' is clearly not adhered to at present. The main aim of the medical test, both pre-departure and at destination, is clearly to ensure that the women are 'fit' to work as domestic workers thus protecting the employers' investment in them. A human right to good health is not a primary concern.

e. For the women interviewed in this study Sri Lankan embassy support in the receiving context appeared to be limited. We found that most of the women put up with serious health issues and lack of rights rather than seeking help from welfare officers despite the provision in the employment contract that problems should be referred to the embassy or foreign mission. Among the domestic workers there are perceptions of poor quality embassy facilities and lack of staff support, deriving predominantly from experiences of others, which may have influenced their own negative orientation. There is also evidence of reliance for support instead from fellow domestic workers nearby.

f. Post-migration institutional health and psychological support exists in Sri Lanka but according to stakeholders there are limitations in the current framework including the need for better pre-departure assessment of departing migrants' mental health and long term health conditions. There does not appear to be a designated channel through which long term welfare of returnees is followed through despite the action point in the National Migration Health Policy regarding the need to integrate health of returning migrants into the existing re-integration framework. Most women we interviewed sought hospital or private medical treatment for physical health problems they returned with or relied on support of their families. But we also found that health problems on return do not prevent re-migration or circular migration. In the interviewees' accounts civil society organisational support at all stages of the migration processes appears limited.

iii. The domestic workers' working conditions and lack of health support lead to significant deterioration of their health in destination countries.

A domestic worker is made aware of, and is responsible for, her health status during training as part of her contractual obligations, but she does not receive material support from the public or private sector in the receiving context. Few women said that their employer allows sick leave whilst abroad. Health care regularly falls under the private employer's remit since these workers do not have health insurance policies of their own. In our findings, employers pay for medical tests when the worker arrives in the destination country. It is arbitrary when, where and how they access health care services thereafter.

The importance of home remedies for illness and mindfulness as preventative and curative strategies, are stressed in training and in practice by the workers themselves while working in receiving country households. But there is an inherent paradox in their situation that at once makes them wholly responsible for their health status and yet gives them poor physical working conditions, and no material support to manage their health abroad. Access to medical treatment is at the whim of the employers and the interviews revealed cases of serious neglect. But there were also accounts of fair and just employer practices to protect the health of the worker and enable immediate access to healthcare when required. Isolation and worry about family health and wellbeing frame the domestic workers' own negative experiences in employers' households. Having an insurance scheme that enables agency of the domestic workers in properly targeting their health would help eliminate inconsistencies in employer-controlled access to medical treatment.

iv. The women sacrifice their health in continuing the cycle of migration.

In our findings, even when women's physical health is deemed to be good in order to migrate or re-migrate after return, there is demonstrable mental illness that goes undetected during the migration process such as depression, manifested through anxiety, insomnia, and loss of appetite. Sometimes these conditions allay once the women return home, but they also resurface when the reasons for migration remain unresolved and/or they prepare to migrate again. The mental distress resulting from forced separation of families, with anguish arising from the social conditions of sexual abuse, alcoholism and domestic violence at home is evident among the interviewees.

7.2 Practices in health protection in other countries in the region.

The Philippines is generally considered the gold standard where action for protecting the situation and rights of its domestic workers abroad is concerned. Welfare and health issues of Filipino migrant domestic workers are underpinned by The Migrant Workers and Overseas Filipinos Act (1995, and 2010 amendment). It is the only country in Asia that has ratified the ILO Domestic Workers Convention C.189. In addition, a national law, the Domestic Workers Act (Batas Kasambahay) came into effect in 2013 to protect domestic workers within the Philippines, a landmark piece of legislation bringing the labour rights of domestic workers in line with those of workers in the formal sector.

Unlike the standard employment contract for Sri Lankan domestic workers currently deployed in GCC countries as discussed in Chapter 5, the standard contract for Filipino domestic workers in Kuwait for example stipulates conditions such as a paid rest day per week, a month's paid leave at the end of the two years, a minimum wage, and a payment to families in case of the death of the worker (International Human Rights Clinic 2013).

Like the Sri Lankan insurance scheme, in the Philippines there is insurance coverage for migrant domestic workers provided by the Overseas Workers Welfare Administration (OWWA). Apart from payments for death, disability and medical repatriation, it also formally includes psycho-social counselling and a network of centres offering assistance not only at origin, but also attached to Philippines embassies in destination countries. The OWWA is an agency that is attached to the Department of Labour and Employment but it does not receive allocations from the state. Instead it is funded from the US$ 25 membership fee paid by the employer/recruitment agency, but which is in practice often passed on to migrant workers.[85] Migrant rights groups in the Philippines oppose the provision of mandatory insurance, (which includes repatriation and death and disability benefits but not health insurance) through private insurance providers as set out in the 2010 amendment (RA10022) to the Migrant Workers and Overseas Filipinos Act (RA 8042). While this premium is to be paid by the employer through the recruitment agent, there is concern that as in the case of the US$ 25 OWWA fee, this much larger premium for a two year contract would be illegally passed on to the migrant worker as there is no mechanism to ensure that the law is implemented correctly. Further, this insurance provision excludes migrant workers who are not recruited through agencies (Centre for Migrant Advocacy 2012). Unlike the SLBFE however, the OWWA does include migrant participation on the Board (Jones 2015; International Human Rights Clinic 2013).

A national contributory medical insurance scheme, Phil Health, was set up under the Republic Act 7875 to provide comprehensive health insurance for all Filipinos including migrant workers abroad and returnees, and their dependants. It covers in-patient hospital and out-patient treatment, emergency and transfer services and prescription medicines both abroad and at home (De Castro 2010). However, health and related benefits may only apply to active members who have paid the membership contribution and whose employment contract has not expired, thus excluding some migrant returnees and undocumented migrant workers (Kanlungan Centre Foundation 2006).[86] A national re-integration centre assists returning migrants including irregular migrants and those with health problems. Migrant rights groups believe that the State should assume primary responsibility for funding and providing welfare and health insurance for migrant workers.

The Indian Community Welfare Fund (ICWF) has been cited as a successful example of welfare and healthcare provision to migrant workers, including domestic workers. Funded not by the workers themselves, but through Indian overseas missions, voluntary contributions from Indian communities abroad, and the Indian government, it provides emergency medical, welfare and legal assistance abroad for 'overseas Indians in need'. The government has also established a compulsory contributory insurance scheme for Indian migrants, the Pravasi Bharativya Bima Yojana, which provides medical cover, maternity benefits and disability or death compensation for all, not only those 'in distress'. There is also a contributory pension fund and life insurance, with government top-up including an additional amount for women, that returning migrants could draw upon (Agunias et al. 2011; Jones 2015).

Other practices may include the introduction by the Bangladeshi government of a smart card (a tag with a computer chip) containing information in migrants' passports and details of the recruitment agency. The migrants insert this card in a card reader at the airport so that the information is contained in the system and can be used to contact migrants who may have problems, and to provide information in legal redress processes where passports have been confiscated by employers (Agunias et al. 2011).

[85]Personal communication with a stakeholder in a NGO, Philippines.

[86]We are grateful to Kanlungan for providing access to the executive summary of this publication.

7.3 Recommendations

Based on the findings of the study and discussions with stakeholders in the public sector and civil society organisations in Sri Lanka, we propose the following recommendations to the Sri Lankan government and the SLBFE.

Recommendations to Government and the SLBFE

1. **Examine and address serious gaps and anomalies relating to the health of migrant domestic workers in the existing SLBFE insurance scheme.**
   Current gaps and anomalies include coverage of medical expenses only after repatriation as a result of illness or accident, and lack of even this coverage for those escaping from abusive situations in employer households. If workers do not re-register with the SLBFE and pay the renewal insurance premium if they seek to extend their employment or seek new employment after the two years stipulated in their employment contract, they are not entitled to insurance claims.

   An insurance scheme properly targeting health and women's agency and independence in addressing their health needs in destination countries would help eliminate inconsistencies in employer-controlled access to medical treatment. The upcoming Migration Employment Act should include specific measures for regular health protection of migrant domestic workers in addition to emergency welfare measures. The feasibility of funding health insurance through the SLBFE registration fee paid by private recruitment agencies on behalf of the domestic workers, obtained from sponsorship fees paid by employers in destination countries, should be examined. However, strict monitoring is required to ensure that recruitment agents or employers do not deduct the cost from domestic workers' salaries. The poor socio-economic backgrounds of women who migrate for domestic work, as shown in this and other studies, preclude the viability of contributory insurance schemes such as those in operation in the Philippines.

2. **Press for a revised standard employment contract for domestic workers** which includes requirements for employers to provide healthy working and living conditions and which guarantee workers the right to at least one paid rest day per week. The employment contracts for overseas domestic workers that the Philippines government has negotiated with some Gulf States could provide a model.

3. Use **the existing platform of intra-regional dialogue** afforded by the Colombo Process and the Abu Dhabi Dialogue to put pressure on **receiving country governments to monitor and enforce employer adherence to the terms of the employment contract** to safeguard the health of domestic workers and provide necessary healthcare in a timely manner.

4. Provide **clear and detailed information to women at pre-departure stage** on: i) health-related conditions of work and healthcare coverage in the employment contract; ii) what healthcare they are entitled to according to policies and health systems in different receiving countries; iii) separately, what healthcare and health support is provided by the SLBFE welfare insurance scheme and the period of coverage. In all three cases, information given should include **redress**

mechanisms in the case of violations by employers, recruitment agents and Sri Lankan officials implementing the regulatory framework.

5. As outlined in the Labour Migration Policy and the Migration Health Policy, **enhance inter-ministerial co-ordination and collaboration** in order to address the health, and complex psycho-social problems of migrant domestic workers. This process should include the local (district and divisional) level where relevant officers (Development Officers, Women Development Officers, Child Rights Protection Officers, Early Childhood Development Officers) should work together to better support migrants and their families.

6. Families - taking into account the specific circumstances of the migrants - should be considered in the entire migration cycle to prevent and address psychological health issues and facilitate a successful social re-integration for migrants. Separation and **ways of keeping in touch should be discussed as part of local level governance processes before migration**, contrary to pre-departure training advice to the domestic workers to focus on the work and not think about families. Access to communication with families should be assured while working in the receiving country households, through the employment contract and as part of the 'job order' dialogue between the employer, recruitment agent and Sri Lankan embassy in the country.

7. There is an urgent need for government to better regulate and monitor the pre-departure medical testing women migrants are subject to so as to ensure that **their dignity, privacy and confidentiality are respected**. This should be initiated by the Ministry of Health working with the SLBFE and directed primarily towards the GCC Approved Medical Centres Association (GAMCA) which is responsible for regulating medical testing for migrant workers, as well as managers and health professionals in medical testing centres.

8. **Remove the STD including HIV exclusion clause in the current SLBFE welfare insurance scheme** for migrant workers. Include medical treatment for STDs, including HIV, in health insurance. Support removing HIV exclusion clauses in life insurance schemes for returning migrants in line with ILO and Sri Lanka AIDS Foundation advocacy on this.

9. Pre-departure training provided by the SLBFE and other SLBFE regulated providers should be conducted in **safe, hygienic, comfortable, relaxed environments where the needs and contributions of trainees are respected**.

10. Address the situation of women who do not escape difficult or downright abusive employment situations and do not contact Sri Lankan embassies in receiving countries, but who instead suffer and put up with illness and abuse. **Develop and pursue technological means of collecting and providing information necessary to keep contact with migrants** so that they can easily communicate with Welfare Officers in embassies if they have problems.

11. Extend the creation of **accessible migrant resource centres associated with all embassies and missions in destination countries**, following the Philippines welfare assistance model, and disseminate information about these to migrant domestic workers.

12. Enable and/or increase **the representation of migrant workers on the SLBFE board and Sri Lankan migrant resource centre advisory groups in receiving countries** in order to recognise the agency and decision-making capacity of migrant domestic workers within difficult circumstances in both sending and receiving contexts, and to ensure their voice is heard in policy making and implementation processes at local, national and international levels.

13. Provide a framework to **strengthen civil society, trade union and government linkage between origin and destinations** for increasing advocacy on behalf of migrant domestic workers, and to provide information and support to workers specifically in relation to health and access to healthcare throughout the whole migration process.

14. Implement the action point in the National Migration Health Policy to meet **both the mental and physical needs of returning migrants, through long term follow up after return**. A confidential psychological assessment for returnees co-ordinated by the Ministry of Health working with local hospitals and health professionals is desirable.

15. **Ensure better educational, skills-training, and employment and self-employment opportunities** in general and on return for women migrating as domestic workers thus directly impacting on their physical and psychological wellbeing.

16. Sri Lanka **should ratify and implement the ILO Domestic Workers' Convention** (C.189). This would enable more leverage internationally and regionally, to ensure the health and labour rights of women migrating for domestic work abroad.

References

Abdulrahim, Sawsan (2010) *Servant, daughter or employee? A pilot study on the attitudes of Lebanese employers towards migrant workers.* [Online] Beirut, KAFA (enough) Violence and Exploitation. Available from: http://www.kafa.org.lb/StudiesPublicationPDF/PRpdf9.pdf.

Agunias, D. R., Aghazarm, C. & Battistella, G. (2011) *Labour migration from Colombo Process countries: good practices, challenges and ways forward*. Washington D.C.: International Organization for Migration.

Ahmad, Attiya (2010) *Migrant workers in Kuwait. The role of state institutions*. [Online] Washington, The Middle East Institute. Available from: http://www.mei.edu/content/migrant-workers-kuwait-role-state-institutions.

Albawaba Business (2015) *GCC new unified labour contract turns up the heat on Qatar*. [Online] January 12th. Available from: http://www.albawaba.com/business/gcc-new-unified-labour-contractturns-heat-qatar-643540.

Alphen Capital (2011) *GCC Healthcare industry*. [Online] Available from: http://itac.ca/wpcontent/uploads/2013/03/Alpen-Capitals-GCC-Healthcare-report-2011.pdf.

Amnesty International (2013) *The dark side of migration. Spotlight on Qatar's construction sector ahead of the World Cup.* London.

--- (2014) *'My Sleep is My Break'*. [Online] London. Available from: http://www.amnesty.org.uk/webfm_send/358.

Aspen Institute, The (n.d.) *Policy brief for the Global Policy Advisory Council. The Gulf Cooperation Council (GCC) and health worker migration.* [Online] Available from: http://www.aspeninstitute.org/sites/default/files/content/images/GCC%20and%20HWM%20Policy%20Brief.pdf.

Calderon, J., Rijks, B. & Agunias, D. R. (2012) *Asian labour migrants and health: exploring policy routes.* Washington D.C.: International Organisation for Migration and Migration Policy Institute.

Caram Asia (2007) *State of health of migrants: mandatory testing*. Kuala Lampur.

Centre for Applied Research and Training (2012) *Sri Lanka migration health study: study on outbound migration*. Colombo, Ministry of Health.

Centre for Migrant Advocacy (2012) *Submission to the UN Committee on Migrant Workers*: for the list of issues prior to reporting of the Philippine Government in preparation for the Committee on Migrant Workers, 16th Session.

De Bel-Air, Françoise (2014) *Demography, migration and labour market in Qatar*. [Online] Florence, Migration Policy Centre. Available from: http://cadmus.eui.eu/bitstream/handle/1814/32431/GLMM_ExpNote_08-2014.pdf?sequence=1.

De Castro, A. (2010) *Expanding social security for migrants: extending the coverage of the employees compensation program to land-based OFW*. Manila, Institute for Labour Studies.

Del Rosario, T. (2008) *Best practices in social insurance for migrant workers: the case of Sri Lanka.* ILO Asian Regional Programme on Governance of Labour Migration, Working Paper No.12. Bangkok, International Labour Organization.

Deloitte (2015*) Global healthcare outlook* [Online] Available from: http://www2.deloitte.com/content/dam/Deloitte/global/Documents/Life-Sciences-Health-Care/gx-lshc-2015-health-care-outlook-global.pdf.

Department of Census and Statistics (2012) *Census of population and housing 2011*, Colombo.

--- (2014a) *Sri Lanka labour force survey - annual report 2013*. Colombo.

--- (2014b) *Household income and expenditure surveys 2006, 2009, 2012/13.* Colombo.

Dito, Mohammed Ebrahim (2008) GCC labour migration governance. *UN Expert Group of International Migration and Development in Asia and the Pacific,* Thailand, September 20-21.

Egypt Independent (2012) *Saudi Labor Ministry began steps to abolish sponsorship system, paper says* [Online] 14/05 Available from: http://www.egyptindependent.com/news/saudi-labor-ministry-began-steps-abolish-sponsorship-system-paper-says.

Fargues, Philippe (2006) International migration in the Arab region: trends and policies [Online] *United Nations Expert Group Meeting on International Migration and Development in the Arab Region: Beirut, May 2006*. Available from: http://www.gcc_legal_and_policy_brief_domestic_workers_final_text_clean_282_29.pdf.

Fattahova, Nawara (2013) Sponsor system on the way out - new authority in place to streamline transfers. [Online] *Kuwait Times,* September 19. Available from: http://news.kuwaittimes.net/sponsor-system-kuwait-way-new-authority-place-streamline-transfers/.

Frantz, Elizabeth (2014) *Breaking the isolation: information and media among migrant domestic workers in Jordan and Lebanon.* [Online] New York, Open Society Foundations, Arab Regional Office and International Migration Initiative. Available from: http://www.opensocietyfoundations.org/sites/default/files/migrant-workers-information-report-20140223.pdf.

Gamburd, M. (2000) *The kitchen spoon's handle: transnationalism and Sri Lanka's migrant housemaids.* Ithaca, New York, Cornell University Press.

GCC: Kafala [Online] *Migration News* (2012) 19(1) January. Available from: https://migration.ucdavis.edu/mn/more.php?id=3740.

Global Leadership Meeting on Population Dynamics in the context of the Post-2015 Development Agenda (2013) *Dhaka Declaration*. [Online] Dhaka. Available from: https://www.iom.int/files/live/sites/iom/files/What-We-Do/docs/Dhaka-Declaration.pdf.

GMA News Online (2013) *New Saudi rules ensure rights, safety of foreign household workers.* [Online] October 31 Available from: http://www.gmanetwork.com/news/story/333439/pinoyabroad/news/new-saudi-rules-ensure-rights-safety-of-foreign-household-workers.

GNRD News (2014) *Harmonization of the Jordanian healthcare system with human rights* [Online]. April 02. Available from: http://gnrd.net/seemore.php?id=277 ; http://gnrd.net/seemore.php?id=277#sthash.Jk2zBH5Z.dpuf.

Gosh, Palash (2014) Sri Lanka and Saudi Arabia ink migrant labour rights deal, more than one year after the execution of female domestic worker. [Online] *International Business Times* March 07. Available from: http://www.ibtimes.com/sri-lanka-saudi-arabia-ink-migrant-labor-rights-deal-more-one-year-after-execution-female-domestic?rel=rel2.

Government of Sri Lanka (2014) Sri Lanka, Saud Arabia sign landmark deal on migrant workers. *News Line* [Online] Available from: http://www.priu.gov.lk/news_update/Current_Affairs/ca201401/20140116sl_saudi_arabia_sign_landmark_deal_migrant_workers.htm.

--- & International Organization for Migration (n.d.). *Migration, health and development in Sri Lanka*. [Online] Available from: http://migrationhealth.lk/.

Gulf News (2011.) *Qatari citizens wants sponsorship rules tightened further-survey.* [Online] January 8. Available from: http://gulfnews.com/news/gulf/qatar/qatari-citizens-want-sponsorship-rules-tightened-further-survey-1.742530.

Gulf Research Centre (2012) *Socio economic impact of GCC migration*. [Online] Cambridge. Available from: http://grm.grc.net/index.php?pgid=Njk=&wid=Mjc#sthash.WIWfJIVX.dpuf.

Gunaratne, N. (2014) Violations of rights of Sri Lankan female domestic workers in the Middle East: a perspective on challenges encountered and progress made. *Law and Society Trust Review*, 1-20.

Gunasinghe, M. (2011) Abandoned and forgotten: returnee migrant women workers in Sri Lanka. **In** Santhakumar, B. (ed) *Rights, remittances and reintegration: women migrant workers and returnees in Sri Lanka.* Colombo, Law & Society Trust.

Hamill, K. (2011)*Trafficking of migrant domestic workers in Lebanon: a legal analysis*. Beirut, KAFA Violence and Exploitation.

Hamyeh, Rajana (2014) *Lebanon: the State fails the healthcare system*. [Online] Alakhbar-English. Available from: http://english.al-akhbar.com/node/18553.

Human Rights Council (2013) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* [Online] Anand Grover Geneva, Human Rights Council, (A/HRC/23/41). Available from: http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G13/135/98/PDF/G1313598.pdf?OpenElement.

Human Rights (2007) *Exported and exposed. Abuses against Sri Lankan domestic workers in. Saudi Arabia, Kuwait, Lebanon and United Arab Emirates*. [Online] November 13, New York. Available from: http://www.hrw.org/reports/2007/11/13/exported-and-exposed-2.

--- (2008) *As if I am not human, abuses against Asian domestic workers in Saudi Arabia.* [Online] Available from: http://www.hrw.org/reports/2008/07/07/ifi-am-not-human.

--- (2010a) *Slow reform: Protection of migrant domestic workers in Asia and the Middle East.* New York.

--- (2010b)*Without protection. How the Lebanese justice system fails migrant domestic workers*. [Online] New York. Available from: http://www.hrw.org/sites/default/files/reports/lebanon0910webwcover.pdf.

--- (2011) *Domestic plight: how Jordanian laws, officials, employers and recruiters fail abused migrant domestic workers.* [Online] New York. Available from: http://www.hrw.org/sites/default/files/reports/jordan0911webwcover.pdf.

--- (2013) *World Report 2013*. New York.

--- (2014) "*I already bought you" Abuse and exploitation of female domestic workers in the United Arab Emirates* [Online] New York. Available from: http://www.hrw.org/sites/default/files/reports/uae1014_forUpload.pdf.

--- (2015) *Kuwait: new law a breakthrough for domestic workers. Guarantees crucial rights but gaps remain*. [Online] June 30. Available from: https://www.hrw.org/news/2015/06/30/kuwait-new-law-breakthrough-domestic-workers.

ILO Country Office for Sri Lanka and the Maldives (2013) *Strengthening grievance and complaint handling mechanisms to address migrant worker grievances in Sri Lanka*. *A review and analysis of mechanisms. Geneva*, International Labour Office.

International Human Rights Clinic (2013) *The protection of the rights of migrant domestic workers in a country of origin and a country of destination: case studies of the Philippines and Kuwait.* Washington D.C., Johns Hopkins School of Advanced International Studies.

International Labour Office (2013). *Domestic workers across the world: global and regional statistics and the extent of legal protection.* Geneva.

International Labour Organization (2013) *C189-Domestic Workers' Convention, 2011 (No. 189).* [Online] Geneva. Available from: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:2551460.

--- (2011) *R201-Domestic Workers Recommendation, 2011 (No. 201). Recommendation concerning decent work.* [Online] Geneva. Available from: http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_ILO_CODE:R201.

International Organization for Migration (2012) *Abu Dhabi Dialogue*. [Online] Available from: https://www.iom.int/abu-dhabi-dialogue.

International Trade Union Confederation (2014). *Facilitating exploitation: a review of labour laws for migrant domestic workers in Gulf Cooperation Counties* [Online] Available from: http://www.ituc-csi.org/IMG/pdf/gcc_legal_and_policy_brief_domestic_workers_final_text_clean_282_29.pdf.

Iredale, R., Piper, N. & Ancog, A. (2005) *Impact of ratifying the 1990 UN Convention on the Rights of All Migrant Workers and Members of Their Family: case studies of the Philippines and Sri Lanka*. (Working Paper No.15). Canberra, Asia Pacific Migration Research Network.

Jayaweera, Swarna (2012) Marginalisation of women workers in the context of economic rights. *Economic Review* 38, 16-21.

--- & Dias, Malsiri (2011) *Gender roles and support networks of spouses of migrant workers.* Colombo, Centre for Women's Research.

---, --- & Wanasundera, Leelangi (2002) *Returnee migrant women in two locations in Sri Lanka*. Colombo, Centre for Women's Research.

Joffres, C. E. A. et al. (2008) Sexual slavery without borders: trafficking for commercial sexual exploitation in India. *International Journal for Equity in Health* 7.

Jones, K. (2015) *Recruitment monitoring and migrant welfare assistance: What works?* Dhaka: International Organisation for Migration.

Jordan. Ministry of Labour (2009) *Regulation No 90/2009 of Domestic Workers, Cooks, Gardeners and Similar Categories Published on page 5348 of Official Gazette No 4989 dated October 1, 2009* Promulgated by Virtue of Section 3/B of Labour Code No 8/1996 and amendments thereof. [Online] Available from: http://www.ilo.org/dyn/travail/docs/642/Regulation%2090.2009.pd.

Kanlungan Centre Foundation (2006) *Prescriptions for health and well-being of women migrant workers.* Manila, Kanlungan Centre Foundation.

Kottegoda, S. et al. (2013). *Transforming lives: listening to Sri Lankan returnee women migrant workers.* Colombo, Women and Media Collective.

Kuwait Times (2013 *Health insurance company plans being finalised - hospitals for expats*. [Online] August 18. Available from: http://news.kuwaittimes.net/health-insurance-company-plans-being-finalized-hospitals-for-expats/.

Lebanon. Code of Labour (2010) A comprehensive English translation of the Lebanese Code of Labour [Online] Beirut, Bureau de Documentation Libanaise dt Arabe *L'Argus de la Legislation Libanaise* 56 (1) First Quarter. Available from: http://www.ilo.org/dyn/travail/docs/710/Labour%20Code%20of%2023%20September%201946%20as%20amended.Publication%202010.pdf.

Malhotra, R., Arambepola, C., Tarun, S., De Silva, V., Kishore, J. & Ostbye, T. (2013) Health issues of female foreign domestic workers: a systematic review of the scientific and gray literature. *International Journal of Occupational and Environmental Health,* 19 (4), 261-277.

Malit, F. Jr. & Youha, Al Ali. (2013) *Labor migration in the United Arab Emirates: challenges and responses.* [Online] Washington D.C., Migration Policy Institute. Available from: http://www.migrationpolicy.org/article/labor-migration-united-arab-emirates-challenges-and-responses/.

Manal, Ismail (2012) How to get health insurance for your domestic worker. [Online] *The National UAE* July 25. Available from: http://www.thenational.ae/news/uae-news/how-to-get-health-insurance-for-your-domestic-worker#ixzz37cPW6VuT.

Mendoza, Dovelyn Rannveig (2011) *Running in circles: progress and challenges in regulating recruitment of Filipino and Sri Lankan labor migrants to Jordan*. [Online] Washington DC, Migrant Policy Institute. Available from: http://www.migrationpolicy.org/research/regulating-recruitment-filipino-sri-lankan-migrants.

Migrant-Rights.org (2013) *Probing Kuwait's segregated health services*. [Online] August 22. Available from: http://www.migrant-rights.org/2013/08/probing-kuwaits-segregated-health-services/.

Ministry of Foreign Employment Promotion and Welfare (2009) *National labour migration policy for Sri Lanka*. [Online] Colombo. http://www.ilo.org/dyn/migpractice/migmain.showPractice?p_lang=en&p_practice_id=27.

Ministry of Health (2013) *Sri Lanka National Migration Health Policy.* Colombo, Ministry of Health & International Organisation for Migration.

Mosca, Davide, Rijks, Barbara & Schultz, Caroline (2013) Health in the post-2015 development agenda: the importance of migrants' health for sustainable and equitable development **In** Laczko, Franck & Lonnback, Lars Johan (ed.) *Migration and the United Nations post-2015 development agenda. G*eneva, International Organization for Migration.

NCB Capital (2009). *Healthcare in the GCC. Toward a brighter future.* [Online] GCC Economics Available from: http://www.ncbc.com/uploads/library/20090630123912eGCC%20Healthcare%20-%20NCBC%20Research.pdf.

Pallot, Peter (2014a) Qatar makes medical insurance compulsory for expats. [Online] *The Telegraph* 17 October. Available from: http://www.telegraph.co.uk/finance/personalfinance/expat-money/11154852/Qatar-makes-medical-insurance-compulsory-for-expats.html.

--- (2014b) Qatar provides free health care-but red tape can cause stress. [Online] *The Telegraph 15 July.* Available from: http://www.telegraph.co.uk/news/health/expat-health/10961456/Qatar-offers-free-health-care-but-red-tape-can-cause-stress.html.

Peninsular, The (2015) *Emir signs law on wage protection.* [Online] February 19. Available from: http://thepeninsulaqatar.com/news/qatar/322615/emir-signs-law-on-wage-protection.

Plant, Roger (2008) *Temporary contract labour in the Gulf States: perspectives from two countries of origin*. [Online] Geneva, ILO. Available from: http://www.ilo.org/global/docs/WCMS_090662/lang--en/index.htm.

Qatar Legislations (2009) *Law No. 4 of 2009 regarding regulation of the expatriate entry, departure, residence and sponsorship 4/2009*. [Online] Available from: http://www.almeezan.qa/LawView.aspx?opt&LawID=2611&language=en.

Rathnayake, L., Perera, L. & Cader, A. A. (2010) *Migration in Sri Lanka. Opportunities and lessons,* Colombo, Centre for Poverty Analysis.

Republic of the Philippines. Department of Labor and Employment (2013) *A first between Saudi Arabia and a country of origin.* [Online] Available from: http://www.dole.gov.ph/ro_polo_updates/view/63.

Ruhs, Martin (2010) Migrant rights, immigration policy, and human development. *Journal of Human Development and Capabilities: A Multi-Disciplinary Journal for People-Centered Development* 11 (2), 259-279.

--- (2013) *The price of rights: regulating international labour migration*. Princeton N.J., Princeton University Press.

Saudi Arabia. Ministry of Labour (2009) The Cooperative Health Insurance Law (No. 71) [Online] Available from: http://gulfmigration.eu/saudi-arabia-the-cooperative-health-insurance-law-no-71/.

Saudi Gazette (2015) *Expats risk losing iqamas with 14 days left for mandatory health cover for dependents*. [Online] January 06. Available from:

http://www.saudigazette.com.sa/index.cfm?method=home.regcon&contentid=20150107229767.

Shah, Nasra (2005) Restrictive labour immigration policies in the Oil-Rich Gulf: effectiveness and implications for sending Asian Countries. *UN Expert Group Meeting on Social and Economic Implications of Changing Population Age Structure: Mexico City, August 31-September 2, 2005*. New York, United Nations, 2005, 8.

--- (2007) *Migration to Kuwait: trends, patterns and policies. Migration and refugees movements in the Middle East and Africa.* [Online] Paper prepared for the Migration and Refugee Movements in the Middle and North Africa. The Forced Migration and Refugee Studies Program, The American University in Cairo, Egypt. Available from: http://www.aucegypt.edu/GAPP/cmrs/Documents/Nasra_Shah.pdf.

--- et al. (2002) "Foreign Domestic Workers in Kuwait: Who Employs? How Many?" *Asian and Pacific Migration Journal* 11 (2), 247-269.

Sidahmad, Mazin (2014) Lebanon's migrant workers under pressure. [Online] *Aljazeera* 10 October. http://www.aljazeera.com/news/middleeast/2014/09/lebanon-migrant-workers-pressure-201495111252217645.html.

Sonmez, S. E. A. (2011) Human rights and health disparities for migrant workers in the UAE. *Health and Human Rights: An International Journal* 13, 17-35.

Sri Lanka Bureau of Foreign Employment (2011) *Common competencies in the workplace, trainer guide.* Colombo.

--- (2012) Annual statistical report of foreign employment - 2012. Colombo.

Tamkeen Center for Legal Aid and Human Rights (2010) *The weakest link. Migrant labor in domestic and QIZ sectors in Jordan 2010.* [Online] Aman, Tamkeen Center for Legal Aid and Human Rights, 2011. Available from: http://www.tamkeen-jo.org/download/the_weakest_link.pdf .

--- (2011) *Domestic Plight: how Jordanian law, officials, employers, and recruiters fail abused migrant domestic workers* [Online] New York, Human Rights Watch. Available from: http://www.hrw.org/sites/default/files/reports/jordan0911webwcover.pdf.

--- (2012) *Between a rock and a hard place: migrant workers' caught between employers' abuse and poor implementation of the law. The status of domestic workers and Egyptian workers in Jordan*. [Online] Aman. Available from: http://www.tamkeen-jo.org/download/between_rock_hard_place.pdf

Toumi, Habib (2011) Qatari citizens want sponsorship rules tightened further- survey. [Online] *Gulf News Qatar* January 1. Available from: http://gulfnews.com/news/gulf/qatar/qatari-citizens-want-sponsorship-rules-tightened-further-survey-1.742530.

Transparency International Sri Lanka (2010) *Integrity in foreign employment: An analysis of corruption risks in recruitment.* Colombo.

Ukwatta, S. (2010) *Economic and social impacts of the migration of Sri Lankan transnational domestic workers on families and children left behind.* Adelaide, University of Adelaide.

United Nations. Department of Economic and Social Affairs, Population Division (2009). *International Migration, 2009 Wallchart*. [Online] New York, United Nations. (United Nations publication, Sales No. E.09.XIII.8). Available from:

http://www.un.org/esa/population/publications/2009Migration_Chart/ittmig_wallchart09.pdf .
---. Office of the High Commissioner for Human Rights (2009) *Creative solution: a unified to protect migrant domestic workers in Lebanon*. [Online] Geneva, UNHCR. Available from: http://www.ohchr.org/EN/NewsEvents/Pages/UnifiedContractLebanon.aspx.

United Nations Committee on the Protection of the Rights of All Migrant Workers (2011) *General Comment No. 1 on Migrant Domestic Workers.* [Online] CMW/C/GC/1. Available from: http://www.refworld.org/pdfid/4ed3553e2.pdf%20.

United Nations General Assembly (1948) *The Universal Declaration of Human Rights.* 10th December, 217 (A) III. [Online] Available from: http://www.un.org/en/documents/udhr/.

--- (1965) *International Convention on the Elimination of All Forms of Racial Discrimination.* [Online] Treaty Series Vol. 660. p.195. Available from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx.

--- (1966) *International Covenant on Economic, Social and Cultural Rights*. [Online] Treaty Series Vol. 993, p3. Available from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx.

--- (1979) *Convention on the Elimination of All Forms of Discrimination against Women.* [Online] Treaty Series Vol. 1249, p. 13. Available from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx.

United Nations Human Rights Council (2009) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. [Online] Geneva, United Nations Office of the High Commissioner for Human Rights (A/HRC/23/41). Available from: http://daccess-dds-y.un.org/doc/UNDOC/GEN/G13/135/98/PDF/G1313598.pdf?OpenElement.

Wansa, Sarah (2014) A judicial blow to Lebanon's sponsorship system: employer must return domestic worker's passport. [Online] *The Legal Agenda.* Available from: http://english.legal-agenda.com/article.php?id=639&folder=articles&lang=en.

Whitman, Elizabeth (2015) Gulf countries' migrant workers: health care workers are mostly foreigners in Saudi Arabia and neighbouring countries. [Online] *International Business Times,* February 12. Available from: http://www.ibtimes.com/gulf-countries-migrant-workers-health-care-providers-are-mostly-foreigners-saudi-1814550.

Wickramage, K. et al. (2015) Risk of mental health and nutritional problems for left-behind children of international labour migrants. *BMC Psychiatry*, 15: 39.

Wilcke, Christoph (2011) Migrant domestic workers in Jordan. Where there's a will, there's a way. [Online] New York: Huffington Post. Available from: http://www.hrw.org/news/2011/10/12/migrant-domestic-workers-jordan.

World Health Assembly (2008). *Health of Migrants* [Online] 61st, 24th May (WHA61.17). Available from: http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R17-en.pdf.

Zimmerman, C., Kiss, L. & Hossain, M. (2011) Migration and health: A framework for 21st century policy-making. *PLos Medicine,* 8(5).

ANNEXE 1

Methods

The field work with migrant domestic workers was undertaken in two districts, Kurunegala in the North Western Province, and Kalutara in the Western Province. These districts have a substantial number of women migrating for domestic work. In 2012, 13,572 women in Kurunegala and 5,127 women in Kalutara migrated as domestic workers - respectively 11.4 per cent and 4.3 per cent of the total category of migrant domestic workers. Among all the districts in Sri Lanka, Kurunegala had the highest number of women migrating for domestic work (SLBFE 2012). Limitations of time and budget meant that it was not possible to access districts further afield, such as in the Eastern Province, where for instance more Muslim migrant domestic workers are located. Thus, while the sample broadly reflects the ethnic representation of the national population,[87] it is not ethnically representative of migrant workers as other surveys of migrants have shown that there is particularly a higher proportion of Muslims among migrant workers than in the national population (Centre for Applied Research and Training 2012). This trend relates to the religious preferences of employers in predominantly Muslim countries in the region.

To obtain access to the samples of 20 pre-departure first time migrants and 40 migrants who had returned within the 12 months prior to interview, the field researchers first contacted key informants in local government and the Migrant Services Centre[88] in the two local areas, Kurunegala and Kalutara. While this process was helpful, the researchers found it easier and more effective as time went on, to directly visit households known to contain migrant women workers in both sample categories, and to use a snowballing strategy to identify interviewees. Interviewees were identified in all three sectors - urban, rural and estate - in the two districts. The Sinhala population in the two areas is distributed across the urban and rural sectors, the Tamil women who migrate are largely in estate communities and Muslim women are in low income urban families, therefore sampling was undertaken accordingly. In Kurunegala, access to Tamil women in the estate sector was also facilitated through the estate workers' union, the Ceylon Workers' Congress.

There was considerable difficulty in finding pre-departure migrants compared to returnees. Given an objective of the project was to examine the governance framework around health in migration, the pre-departure migrants were required to be first time migrants who had already completed the formal migration processes including medical testing, training, and contract and insurance procedures. Although many who were initially contacted agreed to be interviewed it was often the case that by the time the researchers re-visited them for the interview itself, they had already left the country. The field researchers were also compelled to move beyond the two designated districts, to Colombo to complete recruitment of the pre-departure sample in the limited time available for the fieldwork.

[87] According to the Census of Population and Housing 2011, the Sinhalese ethnic group made up 74.9%, Tamils (Sri Lanka + Indian) 15.4%, and Sri Lanka Moors (ethnic Muslims) 9.2% of the population (Department of Census and Statistics, 2012, p. Table A2).

[88] The Migrant Services Centre is a Sri Lankan civil society organisation that both advocates for governance and legislative changes to improve rights of migrant workers, especially those migrating abroad for low-skilled work in exploitative and unprotected employment situations, and provides concrete assistance to migrants at local level. It operates a network of Migrant Workers' Associations across districts from which most migrants emigrate and works towards eliminating corrupt local recruitment practices, provides a hotline service for migrants experiencing problems abroad and their families, and acts as a liaison between families of migrants and the SLBFE where migrants are trapped in difficult circumstances in receiving countries. http://www.ituc-csi.org/sri-lanka-a-worker-center-offers-a?lang=en [Accessed: 24th May2015].

Table 4

The sample by area

	Pre-departure migrants (n=20)	Returned migrants (n=40)
Kalutara	09	20
Kurunegala	09	20
Colombo	02	-

Interviews were also undertaken with 20 stakeholders representing state, civil society and international organisations. These included relevant government ministries, the SLBFE, recruitment agents and sub-agents in the local areas, development officers in local areas, trades unions representing migrant domestic workers, migrant community organisations, ILO, IOM, regulatory bodies related to health governance structures, and welfare and psychiatric service providers for returnees. Emerging findings and recommendations were discussed with relevant stakeholders from the above organisations in a workshop held in Colombo before finalising the report.

All the pre-departure and returned migrant interviews followed a semi-structured questionnaire format while stakeholders were interviewed according to a topic guide that was individualised for each interviewee depending on his or her organisation and role. All migrant interviews were conducted in Sinhala or Tamil, and where audio-taped with the permission of the interviewees were transcribed and translated by researchers associated with CENWOR. All migrant interviewees were given pseudonyms based on whether pre-departure or returned and the districts in which they originated. These pseudonyms are used to attribute individual case stories and quotations in the report. Most stakeholders were interviewed in English but where the interviews were undertaken in Sinhala a similar transcribing and translation process to that of the migrant interviewees was followed. Where migrant and stakeholder interviews were not audio-taped, detailed notes were taken by the field researchers, which were then translated.

The socio-demographic information from the migrant interviews was entered into SPSS Version 20 and analysed using frequencies and crosstabs. The qualitative responses to questions eliciting subjective perspectives of the migrants were coded and analysed in NVIVO Version 10 according to key themes - e.g. migration motives, feelings about health insurance, feelings about health status while in destination households and so on. Ethical approval for the research was obtained from the Oxford University Central Research Ethics Committee prior to the start of the fieldwork.

Provisions to ensure access to healthcare are failing Sri Lankan women who migrate for domestic work, both in their own countries and abroad. There are serious gaps and anomalies in relation to health in the current Sri Lankan policy and governance framework for migrant domestic workers. Massive power imbalances between migrants and their employers create an immense obstacle to their ability to receive care and access justice in receiving countries.

Based on primary qualitative research with migrant domestic workers and a range of key stakeholders, and a review of relevant international, regional, and national (sending and receiving country) policies, this report examines the health protection needs, access to healthcare and health status of Sri Lankan women who migrate for domestic work in Gulf Corporation Council (GCC) countries, Jordan and Lebanon. Women domestic workers form around two fifths of total outgoing Sri Lankan migrant workers annually, with nearly all going to Kuwait, Saudi Arabia, Jordan, the United Arab Emirates (UAE), Qatar, Lebanon, Bahrain and Oman. The report examines the health experiences of Sri Lankan domestic workers throughout the entire migration process. This includes the impact of the Sri Lankan labour migration governance framework relevant to health, as well as the impact of receiving country policies and employer practices on migrants' access to healthcare and health status. While there is much documentation of the violations of human rights of Sri Lankan domestic workers, particularly in Gulf States, relatively little attention has been paid so far to their health and barriers in access to healthcare. The report makes recommendations for improvements in both policy and practice that may lead to better health and realisation of human rights for Sri Lankan migrant domestic workers