Health at Stake
Access to Health of Overseas Filipino Workers
2005 REPORT
Health at Stake:
Access to Health of Overseas Filipino Workers
2005 Report

Action for Health Initiatives Inc. (ACHIEVE Inc.) / Coordination of Action Research on AIDS and Mobility (CARAM-Philippines)

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Access to Health of Overseas Filipino Workers
2005 REPORT
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Cherry Tactacan-Abrenica, MD of the STD/AIDS Central Cooperative Laboratory for her valuable inputs on the issue of HIV testing;

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Raquel Ignacio for documenting focus group discussions;

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Most importantly, all the migrant domestic workers, entertainers, and migrant workers living with HIV who have generously shared with us their thoughts and experiences. Without them, this report would not have been possible.
FOREWORD

Good health is the working capital of migrants. A well functioning body and mind are a precondition for surviving in a different situation. Are migrants insured? Is access to health information in the language they speak available? Can they visit a doctor if they need one and at a time that suits them? Worldwide, the answer to these questions is not very positive. But how is it in the Philippines?

The Philippines is often seen as an example of a country with good intentions and policies for migration. Early on, the advantages of migration were discovered and over time policies were developed to improve the migration process and the conditions of migrant workers themselves. That’s one of the reasons why the Philippines is ahead of many other countries. It leads to copying Philippine policies in other labor exporting countries. Does the Philippines have a pre-departure orientation seminar (PDOS)? Other countries think they should do something similar. Is information on reproductive health and HIV and AIDS provided during the PDOS? Policy makers in other countries think that it is a good idea to have them in their own countries also.

Migration is not a one country process. Good intentions and policies are not sufficient to guarantee proper access to health and care. In the framework of the State of Health (SoH) of Migrants action research, initiated by CARAM-Asia, NGOs from 13 countries developed an alternative report on migrants’ access to health. There is one joint report and each country also has its own national report. This is the Philippine SoH report. It shows that behind good policies and intentions the realities may be different, and recommendations are made. There is still a lot to be done and most of it has to be done at a regional level. Migration goes beyond borders, just like the way HIV and AIDS does.

Ivan Wolffers, Ph.D.
Vrije University Medical Center/State of Health Task Force
# LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACHIEVE</td>
<td>Action for Health Initiatives</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AMCOW</td>
<td>Association of Medical Clinics for Overseas Workers</td>
</tr>
<tr>
<td>AMTP</td>
<td>AIDS Medium Term Plan</td>
</tr>
<tr>
<td>ARMM</td>
<td>Autonomous Region in Muslim Mindanao</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral</td>
</tr>
<tr>
<td>ATN</td>
<td>assistance to Nationals</td>
</tr>
<tr>
<td>BCC</td>
<td>behavior change communication</td>
</tr>
<tr>
<td>CARAM</td>
<td>Coordination of Action Research on AIDS and Mobility</td>
</tr>
<tr>
<td>CBA</td>
<td>Cordillera Brotherhood Association</td>
</tr>
<tr>
<td>CBOs</td>
<td>community based organizations</td>
</tr>
<tr>
<td>DBM</td>
<td>Department of Budget and Management</td>
</tr>
<tr>
<td>DFA</td>
<td>Department of Foreign Affairs</td>
</tr>
<tr>
<td>DoC</td>
<td>Declaration of Commitment</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DOLE</td>
<td>Department of Labor and Employment</td>
</tr>
<tr>
<td>DSWD</td>
<td>Department of Social Welfare and Development</td>
</tr>
<tr>
<td>FGD</td>
<td>focus group discussion</td>
</tr>
<tr>
<td>FSI</td>
<td>Foreign Service Institute</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HAIN</td>
<td>Health Action Information Network</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education, communication</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labor Organization</td>
</tr>
<tr>
<td>NGOs</td>
<td>non-government organizations</td>
</tr>
<tr>
<td>NSO</td>
<td>National Statistics Office</td>
</tr>
<tr>
<td>OFW</td>
<td>overseas Filipino worker</td>
</tr>
<tr>
<td>OUMWA</td>
<td>Office of the Undersecretary for Migrant Workers Affairs</td>
</tr>
<tr>
<td>OWWWA</td>
<td>Overseas Workers Welfare Administration</td>
</tr>
<tr>
<td>POEA</td>
<td>Philippine Overseas Employment Administration</td>
</tr>
<tr>
<td>PDOS</td>
<td>Pre-departure Orientation Seminar</td>
</tr>
<tr>
<td>PEOS</td>
<td>Pre-employment Orientation Seminar</td>
</tr>
<tr>
<td>PLWH</td>
<td>people living with HIV</td>
</tr>
<tr>
<td>PMRW</td>
<td>Philippine Migrants Rights Watch</td>
</tr>
<tr>
<td>PNAC</td>
<td>Philippine National AIDS Council</td>
</tr>
<tr>
<td>PSAP</td>
<td>Philippine Seafarers Assistance Program</td>
</tr>
<tr>
<td>RITM</td>
<td>Research Institute for Tropical Medicine</td>
</tr>
<tr>
<td>RH</td>
<td>reproductive health</td>
</tr>
<tr>
<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>UAE</td>
<td>United Arab Emirates</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>WIDFI</td>
<td>Women in Development Foundation, Inc.</td>
</tr>
</tbody>
</table>
INTRODUCTION

The framework of this study emanates from the concept of the right to health of all human beings. The experiences of migrant workers throughout the years have shown that when they leave their home countries and enter new ones, their human rights are being compromised. They are treated differently from the citizens of the countries where they work. It is the same with their right to access health information and services. Thus the need for a regular report that looks at different aspects of the health situation faced by migrant workers.

Coordination of Action Research on AIDS and Mobility in Asia (CARAM-Asia) began this research in the latter part of 2004 and was conducted simultaneously in eleven countries by its partner organizations. This was envisaged to be a yearly report on different topics within the broad concept of state of health of migrant workers. For 2005, the theme was, “Access to Health of Migrant Workers.”

In the Philippines, the state of health of migrant workers is a relatively new area of research. Not many studies have been conducted on the impact of labor migration on the health of Filipino migrant workers and their access to health information and services. Common areas of study are focused on human rights violations experienced by migrant workers or the economic contributions of migrant workers or the social costs of migration, particularly among the families of migrant workers left behind. Health in the context of migration is a relatively unexplored area of research.

This study looks specifically into the accessibility of preventive health information, and health care and services to Filipino migrant workers before they leave for work abroad, while they are in their countries of destination and when they return to the Philippines. This research is very important in a major sending country like the Philippines. The
need for better policies is urgent to ensure that the health and well-being of Overseas Filipino Workers (OFWs), who contribute significantly to the Philippine economy, are protected.

**Objectives**

The research aims to improve conditions in migration that promote and protect the health and well-being of OFWs. It hopes to influence the creation and/or improvement of such policies and programs for OFWs. Specifically, this research aimed:

1. To determine the level of accessibility of health-related information and healthcare services to Filipino migrant workers

2. To determine whether existing laws and policies promote and/or protect migrant workers’ access to health-related information and services

3. To generate a set of recommendations from different stakeholders on how to improve access of Filipino migrant workers to health-related information and services

**Methodology**

The parameters of this study were decided upon by the partner organizations of CARAM-Asia through a series of workshops held in Chennai, India and Jakarta, Indonesia. The study scanned current health indices in each of the countries covered by the research, taking special care to determine indicators related to the health of migrant workers [such as the incidence of HIV and AIDS among migrant workers]. The study also looked at existing laws, policies and programs that relate to migration and health, as well as international conventions signed or ratified by the countries covered by the study. The actual experiences of migrant workers regarding health-related information and services are the main focus of this study.

To generate as much relevant information as possible, several methods were employed. These included a review of related literature; cataloguing of relevant existing laws and policies; interviews with key informants in government agencies; study of related official documents such as reports and proceedings of stakeholder forums and training seminars.

To plumb the first-hand experiences of OFWs, focus group discussions (FGDs) and individual interviews were conducted. Some were conducted within previously scheduled trainings in communities of migrant workers. Because these trainings also touched on the issue of health and migration, the workshop outputs and the documentation report of these trainings were also utilized to augment the data for this research. Previous researches were also reviewed and validated with groups of former OFWs to determine whether the information from such studies still hold true for current migrant workers.
Finally, interviews were also done with other stakeholders such as government officials, a manager of a recruitment agency, a member of the academe, and the president of the association of diagnostic clinics to gain a better understanding of the health situation of OFWs.

**Limitations of the Study**

Due to resource and logistical constraints, this study only provides an indicative picture of the current situation of Filipino migrant workers and their access to healthcare in the Philippines and at the destination countries. While there was an attempt to involve all categories of OFWs, not everyone was equitably represented. Many of them are migrant domestic workers and returnees who are living with HIV and AIDS. The main reason for this is that Action for Health Initiatives (ACHIEVE), Inc./CARAM-Philippines works mainly with the above-mentioned groups of migrants in its other programs.

Migrant workers’ perspectives were balanced with inputs from other stakeholders such as government agencies, NGOs, recruitment agencies and medical clinics. However, ACHIEVE was able to interview only two representatives from recruitment agencies because of time and scheduling constraints. To overcome this limitation, we opted to interview the President of the biggest association of medical clinics that cater to OFWs.

ACHIEVE, Inc./CARAM Philippines is also currently conducting a survey on reproductive health (RH) issues faced by migrant domestic workers. While some portions of the survey results were used, the report remains a purely qualitative study.
THE PHILIPPINE LABOR MIGRATION LANDSCAPE

The Philippines is one of the leading labor sending countries in the world, both for land-based workers, as well as seafarers. According to the Philippine Overseas Employment Administration (POEA), there are about 7.76 million Filipinos overseas in 197 countries. This figure is comprised of 2.86 million immigrants or permanent residents, 3.38 million documented OFWs, and 1.5 million irregularly documented overseas workers.

Table 1. Destinations of Overseas Filipino Workers in 2005

<table>
<thead>
<tr>
<th>New Hires</th>
<th>Number of Migrants</th>
<th>Rehires</th>
<th>Number of Migrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saudi Arabia</td>
<td>65,259</td>
<td>Saudi Arabia</td>
<td>129,091</td>
</tr>
<tr>
<td>Japan</td>
<td>38,803</td>
<td>Hong Kong</td>
<td>76,935</td>
</tr>
<tr>
<td>Taiwan</td>
<td>34,369</td>
<td>United Arab Emirates</td>
<td>48,070</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>33,969</td>
<td>Singapore</td>
<td>24,403</td>
</tr>
<tr>
<td>Kuwait</td>
<td>24,917</td>
<td>Italy</td>
<td>21,167</td>
</tr>
<tr>
<td>Qatar</td>
<td>17,671</td>
<td>Kuwait</td>
<td>15,389</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>17,633</td>
<td>United Kingdom</td>
<td>15,001</td>
</tr>
<tr>
<td>Lebanon</td>
<td>13,210</td>
<td>Qatar</td>
<td>13,750</td>
</tr>
<tr>
<td>Korea</td>
<td>6,920</td>
<td>Taiwan</td>
<td>12,368</td>
</tr>
<tr>
<td>Bahrain</td>
<td>4,817</td>
<td>Brunei</td>
<td>7,889</td>
</tr>
<tr>
<td>TOTAL (All Countries)</td>
<td>289,709</td>
<td>TOTAL (All Countries)</td>
<td>450,651</td>
</tr>
</tbody>
</table>

Source: Philippine Overseas Employment Administration 2005 Annual Report
In 2005 alone, a total of 988,615 overseas workers were deployed, of which 740,632 (75%) were land-based workers while 247,983 (25%) were seafarers. Filipino seafarers comprise about 28% of the seafarers’ market share in the global shipping business. Of the total number of Filipinos deployed to work overseas, 289,709 are first-timers or newly hired workers. The following table shows the destinations of OFWs by world group.

Table 2. Destination of OFWs by World Group (2004-2005)

<table>
<thead>
<tr>
<th>World Group</th>
<th>2005</th>
<th>2004</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asia</td>
<td>255,084</td>
<td>266,609</td>
<td>-4.3%</td>
</tr>
<tr>
<td>Middle East</td>
<td>394,419</td>
<td>352,314</td>
<td>12.0%</td>
</tr>
<tr>
<td>Europe</td>
<td>52,146</td>
<td>55,116</td>
<td>-5.4%</td>
</tr>
<tr>
<td>Americas</td>
<td>14,886</td>
<td>11,692</td>
<td>27.3%</td>
</tr>
<tr>
<td>Trust Territories</td>
<td>7,596</td>
<td>7,177</td>
<td>0.0%</td>
</tr>
<tr>
<td>Africa</td>
<td>9,103</td>
<td>8,485</td>
<td>7.3%</td>
</tr>
<tr>
<td>Oceania</td>
<td>2,866</td>
<td>3,023</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Others</td>
<td>135</td>
<td>1</td>
<td>13,400.0%</td>
</tr>
<tr>
<td>Total Land based</td>
<td>740,360</td>
<td>704,417</td>
<td>5.1%</td>
</tr>
<tr>
<td>Total Sea based</td>
<td>247,983</td>
<td>229,002</td>
<td>8.3%</td>
</tr>
<tr>
<td>Workers with special exit clearance</td>
<td>272</td>
<td>169</td>
<td>60.9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>988,615</td>
<td>933,588</td>
<td>5.87%</td>
</tr>
</tbody>
</table>

Source: Philippine Overseas Employment Administration 2005 Annual Report

The POEA also reported an increase in the deployment of skilled workers in 2005. Although there was no significant increase in the deployment of professional workers, there were more teachers deployed in 2005 than in 2004. The table below shows the distribution of newly hired OFWs by skill category.

Table 3. Deployment of OFWS by Skill Category in 2005, New Hires*

<table>
<thead>
<tr>
<th>Occupational Group</th>
<th>2005</th>
<th>2004</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Professional &amp; Technical Related Workers</td>
<td>63,941</td>
<td>94,147</td>
<td>-32.1%</td>
</tr>
<tr>
<td>Teachers</td>
<td>789</td>
<td>542</td>
<td>45.6%</td>
</tr>
<tr>
<td>Nursing Personnel (NEC)</td>
<td>674</td>
<td>323</td>
<td>108.7%</td>
</tr>
<tr>
<td>Engineers Civil</td>
<td>625</td>
<td>492</td>
<td>27.0%</td>
</tr>
<tr>
<td>Technicians Medical X-Ray</td>
<td>524</td>
<td>408</td>
<td>28.4%</td>
</tr>
<tr>
<td>Engineers Mechanical</td>
<td>452</td>
<td>384</td>
<td>17.7%</td>
</tr>
<tr>
<td>Draughtsman</td>
<td>442</td>
<td>327</td>
<td>35.2%</td>
</tr>
<tr>
<td>Dental Assistants</td>
<td>344</td>
<td>255</td>
<td>34.9%</td>
</tr>
<tr>
<td>Aviation Related Workers</td>
<td>211</td>
<td>146</td>
<td>44.5%</td>
</tr>
<tr>
<td>Other Professional Workers</td>
<td>59,880</td>
<td>91,270</td>
<td>-34.4%</td>
</tr>
</tbody>
</table>

*Data includes workers deployed through Employment-based Immigration scheme.
Table 3. Deployment of OFWS by Skill Category in 2005, New Hires* (continued)

<table>
<thead>
<tr>
<th>B. Skilled Workers</th>
<th>133,420</th>
<th>123,525</th>
<th>8.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction Workers</td>
<td>30,078</td>
<td>22,039</td>
<td>36.5%</td>
</tr>
<tr>
<td>Factory Workers</td>
<td>39,477</td>
<td>25,481</td>
<td>54.9%</td>
</tr>
<tr>
<td>Building Caretakers &amp; Related Workers</td>
<td>12,607</td>
<td>10,137</td>
<td>24.4%</td>
</tr>
<tr>
<td>Sewers &amp; Embroiders</td>
<td>4,452</td>
<td>3,985</td>
<td>11.7%</td>
</tr>
<tr>
<td>Wiremen Electrical</td>
<td>2,991</td>
<td>2,620</td>
<td>14.2%</td>
</tr>
<tr>
<td>Tailors and Dressmakers</td>
<td>2,906</td>
<td>2,870</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other Skilled Workers</td>
<td>40,909</td>
<td>56,393</td>
<td>-27.5%</td>
</tr>
<tr>
<td>C. Household &amp; Related Workers</td>
<td>85,088</td>
<td>62,890</td>
<td>35.3%</td>
</tr>
<tr>
<td>D. Other Skills</td>
<td>1,836</td>
<td>1,250</td>
<td>46.9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>284,285</td>
<td>281,812</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

*Data covers central office only.

**Includes workers deployed through Employment-based Immigration scheme.

Source: Philippine Overseas Employment Administration 2005 Annual Report

The POEA also reported that majority of Filipinos migrating for work are between 29 to 39 years old. About 40% of OFWs have reached college level. Of the number of overseas workers deployed in 2004, 75% were women, showing the increasing feminization of Philippine labor migration. Majority of women OFWs go abroad as domestic workers.

The Philippine economy depends highly on the remittances of overseas Filipino workers to keep it afloat. With nearly 10% of the Philippine population working overseas, the impact on the country’s economy is also tremendous. The late Foreign Affairs Secretary Blas F. Ople has this to say:

“[OFWs] build more low-cost houses than all the housing projects of the government put together; they send more children to college than all our scholarship programs combined; and they provide the mass purchasing power that delivers a large market to the products of our industries.”

With the amount of remittances from overseas Filipinos pouring into the Philippine economy, it is understandable why the Government is actively promoting overseas migration as an option for employment. Part of the Department of Labor and Employment’s (DOLE) commitment to the President’s agenda on alleviating poverty is to generate one million jobs overseas per year. Marketing missions are led by the POEA to promote the hiring of Filipino workers abroad. The following tables show the steady increase in the remittances of overseas Filipinos and the distribution of these remittances by world group.
Table 4. OFW Remittances (in thousand U.S. dollars)

<table>
<thead>
<tr>
<th>Year</th>
<th>Land based</th>
<th>Seafarers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>4,937,922</td>
<td>1,093,349</td>
<td>6,031,271</td>
</tr>
<tr>
<td>2002</td>
<td>5,686,973</td>
<td>1,199,183</td>
<td>6,886,156</td>
</tr>
<tr>
<td>2003</td>
<td>6,280,235</td>
<td>1,298,223</td>
<td>7,578,458</td>
</tr>
<tr>
<td>2004</td>
<td>7,085,441</td>
<td>1,464,930</td>
<td>8,550,371</td>
</tr>
<tr>
<td>2005</td>
<td>9,019,647</td>
<td>1,669,358</td>
<td>10,689,005</td>
</tr>
</tbody>
</table>


Table 5. OFW Remittances by World Group (in thousand U.S. dollars)

<table>
<thead>
<tr>
<th>World Group</th>
<th>2005</th>
<th>2004</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asia</td>
<td>1,172,373</td>
<td>918,329</td>
<td>27.7%</td>
</tr>
<tr>
<td>Middle East</td>
<td>1,417,491</td>
<td>1,232,069</td>
<td>15.0%</td>
</tr>
<tr>
<td>Europe</td>
<td>1,433,904</td>
<td>1,286,130</td>
<td>11.5%</td>
</tr>
<tr>
<td>Americas</td>
<td>6,605,231</td>
<td>5,023,803</td>
<td>31.5%</td>
</tr>
<tr>
<td>Trust Territories</td>
<td>-</td>
<td>-</td>
<td>0.0%</td>
</tr>
<tr>
<td>Africa</td>
<td>4,546</td>
<td>3,439</td>
<td>32.2%</td>
</tr>
<tr>
<td>Oceania</td>
<td>54,573</td>
<td>42,600</td>
<td>28.1%</td>
</tr>
<tr>
<td>Others</td>
<td>887</td>
<td>44,001</td>
<td>-98.0%</td>
</tr>
<tr>
<td>Total Land based</td>
<td>9,019,647</td>
<td>7,085,441</td>
<td>27.0%</td>
</tr>
<tr>
<td>Total Sea based</td>
<td>1,669,350</td>
<td>1,464,930</td>
<td>14.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10,689,005</td>
<td>8,550,371</td>
<td>25.0%</td>
</tr>
</tbody>
</table>

Source: Philippine Overseas Employment Administration 2005 Annual Report

According to the POEA, the relatively high percentage of remittances coming from the Americas may be attributed to the common practice of remittance centers in different cities all over the world of coursing OFW remittances through correspondent banks in the United States. It is also important to note that a large chunk of the remittances from the Americas may be coming from permanent immigrants who send money to their relatives in the Philippines. On the other hand, Filipinos continue to look to overseas work as a sure way to fulfill their dreams for themselves and their families. But there are also other reasons that push Filipinos to seek work abroad. The continuing armed conflict in Mindanao pushes Filipinos to find a better life elsewhere. In fact, a survey conducted by the Income and Employment Division of the National Statistics Office (NSO) from April to September in 2004 showed more than 100% increase in the deployment of OFWs from the Autonomous Region in Muslim Region (ARMM). Unfortunately, because of the situation in that part of the country, illegal recruitment is rampant and many others simply resort to crossing the Sulu Sea or the Celebes Sea in boats to reach Malaysia. Another push factor for women migrants: working abroad can be a means to get out of their limiting, if not abusive, domestic environment.

Since labor migration has become a permanent economic strategy of the Philippine Government and with the remittances that continue to pour into the country, it is crucial
that the Government step up and fulfill its obligations to ensure that OFWs are safe and protected. Various problems continue to plague OFWs and their families, including illegal recruitment and trafficking, human rights violations, labor violations, among others.

The 1990s saw the tragedies of Filipina migrant workers: Maricris Sioson, an entertainer who died in Japan, allegedly, killed by the Yakuza; Sarah Balabagan, a fifteen year old domestic worker raped by her employer and imprisoned when she killed the latter in her attempt to defend herself, and; Flor Contemplacion, a domestic worker in Singapore, sentenced to death by the Singaporean authorities for allegedly killing Delia Maga, another Filipina domestic worker. These cases were significant, not only because their cases generated international outcry but also because the result was the enactment of the Republic Act 8042 or the Migrant Workers Act of 1995. This law was promulgated to make sure that Filipino migrant workers are safe and protected, and their welfare is promoted. Government structures and mechanisms were put in place, specifically for these purposes. However, a major concern in labor migration, the health rights of migrant workers, was not significantly addressed by RA 8042.

**Philippine Labor Migration and Health**

The Philippines has been exporting human resources for the past three decades and through the years, issues related to labor migration have been brought to the forefront by militant groups, migrant support organizations and people’s organizations. Human rights violations faced by OFWs are a long-standing issue that still warrants strategic and permanent solutions. However, the issue of health rights of migrant workers remains an under-explored area of concern.

OFWs face a wide range of health-related problems - occupational, mental, reproductive and sexual health, among others. Not many studies have been conducted on health in the context of migration. Unfortunately, interventions are also not yet comprehensive enough to ensure better protection and health services for Filipino migrant workers.

Still, the burden to ensure availability of health services for migrants rests in the hands of the migrants themselves. For instance, although the Overseas Workers Welfare Administration (OWWA) provides health benefits for migrant workers and their dependents, funding for such interventions comes from the contribution of OFWs. They pay a membership fee to the OWWA, entitling them to the benefits provided by the agency for as long as they are active OFWs. The benefits, according to the OWWA Omnibus Policy, include insurance.
and healthcare benefits, access to loans, education and training benefits, repatriation and reintegration assistance, and on-site services. Whether these benefits are fully enjoyed by the migrants is another story and will be discussed in succeeding sections.

The most recent health emergency that affected migrant workers, not only in the Philippines, was the Severe Acute Respiratory Syndrome (SARS). The first Filipino migrant worker to die from SARS was a domestic worker in Hong Kong. Because of the nature of the illness, her body was not allowed to be returned to the Philippines for burial. Instead she was cremated and her parents were flown to Hong Kong to claim her remains.

Another casualty was a Filipina nursing aide who came home from Canada, believed to have been infected after coming in close contact with a woman whose Filipino doctor also died of SARS in Canada. Eleven others were believed to have contracted SARS, nine in Singapore and two in Hong Kong. Most of them were domestic workers. Fortunately no more deaths have been reported.

The impact of SARS was instantly felt in the Philippines. Migrants were told not to come home because they might be bringing the SARS pathogen with them. Some local governments came up with a directory of OFWs from their localities to monitor the entry and exit of the OFWs. Whole villages were quarantined after a migrant worker came home and was later found positive for SARS.

Because Government response to the SARS epidemic was uncharacteristically immediate, the disease did not spread. This, however, drew a strong reaction from the community of people living with HIV and AIDS. Because one of the hospitals with an AIDS ward was turned into a SARS ward, this temporarily displaced the AIDS patients who were confined at that time. The question was then raised, “If the Government can respond so rapidly to the SARS situation, why can’t it show the same towards HIV/AIDS?”

Currently, one of the biggest health issues in the context of labor migration in the Philippines is HIV and AIDS. The Department of Health (DOH) -HIV/AIDS Registry reports a steadily increasing number of OFWs getting infected with HIV. The latest figures show that of the total number of reported cases of HIV infection in the Philippines, 34% are OFWs. Although actual figures are low, and are biased against OFWs on account of the mandatory testing for HIV that is part of their medical requirements, the trend of increases in reported cases, as well as the growing awareness of the unique vulnerability of migrant workers to HIV infection, has pushed the Government and other key stakeholders to strengthen interventions to prevent the further spread of HIV, particularly among the migrant sector.

There are policies that govern the development of these interventions. The first one is the 1998 Philippine AIDS Law, which states:

“All overseas Filipino workers and diplomatic, military, trade, and labor officials and personnel to be assigned overseas shall undergo or attend a seminar on the cause, prevention and consequences of HIV/AIDS before certification for overseas assigned.” (Article 1, Section 7)
A module for basic HIV and AIDS information has been included in the mandatory Pre-departure Orientation Seminar. Only very recently, a similar module has also been included in the pre-departure orientation of Foreign Service Personnel before they are deployed to Philippine Embassies and Consulates abroad.

The second policy framework emanates from the 2001 UNGASS Declaration of Commitment (DoC) signed by the Philippine Government. Specifically, the DoC provides,

“By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services.”

Although there has been headway in providing HIV and AIDS information to targeted stakeholders, Government has yet to develop comprehensive mechanisms and structures that would provide the social services component required by the DoC. Currently, provision of HIV- and AIDS-related social services is largely led by civil society and communities, rather than Government initiated. In fact, Government funds for the implementation of HIV and AIDS programs is nearly insignificant compared to resources coming from International donors. For a long time, the national Government has ignored the threat of HIV because figures have remained low. Thus, for many years, the HIV and AIDS situation in the Philippines has been characterized as “low and slow”. This resulted in very low government spending for HIV prevention and treatment even after the AIDS law was promulgated. Programs for HIV prevention were also largely concentrated on “traditional” most-at-risk populations such as sex workers, men who have sex with men, and injecting drug users.

Recent trends in the HIV and AIDS situation forced a paradigm shift. Today, the HIV and AIDS situation in the country has been re-classified as “hidden and growing”. Instead of relying on the number of reported cases to guide the development of policies and programs, more emphasis is now being put to understanding vulnerabilities and risk factors. With the consistently high incidence of sexually transmitted infections in the country, where younger women are getting infected by older men, and the consistently low rate of condom use, experts and stakeholders have come to recognize the vulnerability of other segments of society. The target groups of current programs on HIV and AIDS have now included children, young people and OFWs.

As contained in the 4th AIDS Medium Term Plan (AMTP 2005-2010), the first strategy calls for scaling up preventive interventions among groups identified to be highly vulnerable. The first Key Result Area states that, “All migrant workers are provided with preventive information and services.” HIV programmes are mostly preventive in nature. The approach is also multi-sectoral, involving all major stakeholders in program and policy planning, implementation, as well as evaluation.

Hopefully, the vigor of present initiatives to combat the spread of HIV will soon be seen in other health-related programs for migrant workers.
Health-seeking Behavior of Filipino Migrant Workers

“We do not go to the doctor when we feel pain or discomfort. We rationalize that we do not need the doctor for minor ailments. We ignore it for as long as the pain or discomfort is bearable. If not, we resort to buying drugs that can be easily bought over the counter. Worse we simply ask our neighbors or relatives and resort to self-medication.” (Corazon, domestic worker)

There are economic, socio-cultural and political factors that perpetuate this kind of health-seeking behavior among Filipinos. Health care is expensive in the Philippines. Although there are government-run health centers even in the villages and the consultation free, many will not avail of health services. In households with very limited resources, health is the last priority.

However, it is also observed that being able to afford health care services does not always guarantee utilization. In situations where services are available, affordable, and physically accessible, many Filipinos still do not utilize the services. Some attributed this to the attitude of healthcare practitioners. Experiences of being treated insensitively by nurses or doctors discourage further interaction with the health care system. Others insist that they are better off not knowing what their problems are, insisting that they will only get depressed when they find out that they are seriously ill.

The role of media is also a crucial factor. Print and broadcast media are bombarded by advertisements of medicines for all types of common ailments. And the main message is always, “If symptoms persist, consult your doctor,” which promotes the practice of going directly to the pharmacies and buying the drugs that are popular without knowing if they are the most appropriate.

Political factors include Government’s low budget for health, which is not among the top five Government Departments - Education (PhP111 Billion), Public Works and Highways (PhP49.5 Billion), National Defense (PhP46.2 Billion), Interior and Local Government (43.9 Billion), and Agrarian Reform (PhP14.7 Billion) - with the highest budgetary appropriations. (National Expenditure Program, Fiscal Year 2005) Government hospitals and their facilities are generally sub-standard. There are still towns in the country without doctors. Meanwhile more and more doctors are going back to school to become nurses so they could migrate to other countries for higher pay. An anthropology professor once commented that the people’s taxes have paid for the education of these doctors but the Filipino people do not benefit from the fruit of their labors. The impact of the so-called brain drain in the Philippines is heavy and crippling especially for the delivery of health care.

The next section will discuss access to health information and services of Filipino migrant workers in the three phases of migration: pre-departure, on-site, and reintegration.
PRE-DEPARTURE

This section looks at the accessibility of preventive health information and services to migrant workers before they leave the country. Before an OFW leaves the country to work abroad, s/he goes through a series of steps in the application process, as provided for in the regular documentation procedure followed by the POEA.

After the OFW submits his/her application forms with the required documents, s/he is then referred for medical examination to a Department of Health-accredited diagnostic clinic.

Once the medical certificate is issued, the worker is required to attend the pre-departure orientation seminar. Depending on the job category and the recruitment agency, the worker may be required to attend other trainings or orientations.

At the end of the process, the worker is issued a PDOS certificate. After all requirements have been fulfilled, s/he then pays the appropriate fees.

During this whole process, it is through the pre-departure orientation seminar (PDOS) and the medical examination where a more structured form of health education and information dissemination can be provided. Apart from the required HIV prevention module in the PDOS, any other information that could help OFWs stay healthy during their employment overseas is not available. On their part, migrants themselves attest that even when this kind of information is provided, they are not interested anyway because their minds are focused on leaving the country and working overseas to be able to help their families.
The Pre-departure Orientation Seminars

The PDOS for OFWs is conducted by the Government through the OWWA, 365 private agencies and 20 non-government organizations accredited by OWWA. Ideally, the PDOS should be able to equip OFWs with a basic understanding of their employment contracts, information regarding the country of destination, and orientation on necessary values and attitudes for effective employment abroad. The one-day seminar also discusses the laws and restrictions in the destination countries, the climate and the culture, and how to remit money home. Other issues that affect the lives of migrants are also integrated in the PDOS, such as human trafficking and smuggling, and HIV and AIDS. The inclusion of HIV and AIDS education in the PDOS is a recent development mandated by the Philippine AIDS law. However, there are still OFWs who say they have not been given HIV and AIDS orientation during their PDOS.

At present, HIV and AIDS are the only health-related topics present in the PDOS. There is one NGO, the Women in Development Foundation, Inc. (WIDFI), that provides reproductive health information in their pre-departure program for female migrant domestic workers. However, there are more groups, especially accredited private recruitment agencies that do not include HIV and AIDS orientation.

Participants of an FGD conducted by ACHIEVE (including migrant workers living with HIV) said topics discussed during their PDOS included, “do’s and don’ts, how to remit money”. ‘Do’s and don’ts’ refer to the restrictions in the destination countries. Other migrant workers recalled, “…about the work, that we should work hard.” Migrant domestic workers remember they were also taught how to operate household appliances; how to dress and behave properly. Health is not a topic the migrant workers would remember even if it were included. The closest topic they could relate to health is regarding the climate of the country of destination. This gave them an idea about appropriate clothing to enable them to adjust to the warmth or the chill. One domestic worker said, “I could not remember if there was anything on it about health or HIV.” Even if HIV was discussed, the migrant workers do not remember it.

The official HIV and AIDS module being used in the PDOS runs for 45 minutes. It contains information on the modes of transmission, ways of prevention and a discussion on the common myths regarding HIV, AIDS or people living with HIV (PLWH). So far the PDOS is the only official venue where migrant workers get information about HIV and AIDS. However, the migrant workers themselves, as well as, the stakeholders recognize the ineffectiveness of the PDOS as an avenue for HIV information. An OFW who used to work
as a store manager in the Middle East shared his insight:

“Let’s talk about the PDOS. The [HIV/AIDS module] is barely an hour. You wouldn’t be interested to listen to it because you’re already contemplating on what will happen to you when you are abroad or whatever. You will not absorb it. It will never register in your mind, really.” (Lory, store manager)

With feedback from the migrant workers, question is now being raised on whether the PDOS can still be overhauled to make it the appropriate venue to provide outgoing OFWs with information on HIV and AIDS or health, in general. Dr. Roderick Poblete of the Philippine National AIDS Council (PNAC) describes the PDOS as follows:

“The PDOS is not curable. My analogy for the PDOS is that it’s like riding a plane. We know that when we board the plane, there is the danger that it might crash. And we know that if it does crash, the PDOS is like the safety demonstration given by the flight attendants, wearing the life vest, blowing into the cylinder... That’s the PDOS for us. Very few people actually listen to what the flight attendant is saying. When we look at it, there is an illusion of safety in the PDOS because if the plane crashed you still die even if you have a life vest.”

There is a move by some NGOs, in partnership with communities and other stakeholders, to find other avenues of reaching the migrant workers and providing them with HIV and AIDS information even before they embark on the application process for overseas work. Government, on the other hand, has not been proactive in this regard.

**Medical Testing Requirements**

During the entire application process, migrants only worry about their health when they are about to undergo their medical exams. Any health problem detected during this procedure would mean either a long delay before they can leave the country or worse, disqualification from ever working abroad.

A medical certificate is required for all workers applying for overseas work to establish whether they are “fit” to work. Although there is a set of basic medical examinations conducted for all workers, the kinds of examinations required may vary depending on the job category, the requirements of the employer or the country of destination. All women migrant workers are required to have a pregnancy test. There are employers who may also require a drug test.

The components of the medical examination for migrant workers required by all countries of destination are the following:

- Physical examination
- Stool exam
- Optical exam
- Psychological exam
- Hepatitis
- Chest x-ray
- Urine exam
- Dental exam
- HIV/AIDS
- Venereal Diseases
The cost is borne by the workers. Based on a survey published by the Philippine Migrants Rights Watch, an OFW might pay between PhP1,500 to PhP35,000, depending on the country of destination, the kinds of tests required, and the number of times the worker undergoes medical examination. (Asis, “Preparing to Work Abroad: Filipino Migrants’ Experiences Prior to Deployment” 2005)

The number of times an OFW undergoes a medical exam may vary. Some OFWs are immediately made to undergo medical exam once they pass the pre-qualification stage. However, the medical certificate issued by the accredited diagnostic clinics is only valid for three months. This means that if the processing of the OFW’s application takes more than three months, s/he will have to undergo medical exams again once his/her visa is issued. Some agencies may even require that an OFW undergo medical exams again prior to departure. This means more expenses for the OFW.

A big issue is mandatory testing for HIV. The Philippine AIDS Law prohibits testing as a requirement for employment. Also, the law prescribes the following conditions for HIV antibody testing: 1) it must be voluntary; 2) it should have informed written consent of the person being tested; 3) it should guarantee anonymity and confidentiality; and, 4) it must be accompanied by pre-test and post-test counseling. Migrant workers face a unique situation because they are required to undergo HIV antibody testing, not by the Philippine Government, but by the Governments of their countries of destination. Worse, many OFWs are not aware they have been tested for HIV because none of the procedures they undergo are explained to them. Those who are aware they are being tested for HIV find out because they read the medical examination report. Informed consent thus becomes irrelevant because migrants are required to take the test as a pre-requisite for their employment application.

The clause on anonymity and confidentiality is breached in the process of medical testing because the diagnostic clinics are required by their clients, the recruitment agencies, to forward all medical test results to the agency, not to the worker. The migrant worker is made to sign the medical examination report giving his/her permission to furnish the agency with the findings of his/her examination.

“They don’t show us the medical results. The captain was the one who explained the medical results.” (John, seafarer)

Despite the requirement of pre-test and post-test counseling in HIV Antibody testing, this is not commonly practiced by the diagnostic clinics. This should have been the perfect opportunity to provide the migrants with health information. But according to Dr. Rolando Villote, President of the Association of Medical Clinics for OFWs (AMCOW), there is simply no feasible way of incorporating counseling into their existing medical testing procedures. What they suggest is to provide information, education, and communication (IEC) materials on HIV and AIDS. Still, they do not have such materials in their clinics. They are however open to distributing such materials if these are available for distribution from NGOs and the DOH.

This illustrates the wide gap between having a law and monitoring its implementation. The absence of implementing guidelines from the DOH on HIV counseling in diagnostic
clinics creates a situation where diagnostic clinics can insist on their own procedures despite the existence of a law. Another gap is the absence of monitoring mechanisms to ensure compliance with the law. Until such guidelines are put in place, the government cannot concretely implement the letter of the law.

On the part of OFWs, medical testing is viewed simply as a routine requirement. Without it, they cannot work abroad. And generally they do not mind having to undergo all the abovementioned tests, for as long as they keep getting “clear” results. And because it does not occur to them that they may be vulnerable to HIV or other sexually transmitted infections (STIs), they do not mind that they have been tested without their knowledge or consent. The only part of the medical examination procedure that a number of migrants have expressed discomfort about is the physical examination.

“They call for you to prepare. Then you enter a cubicle. For us, for example, there were 12 of us. They instruct you to take off your pants. All of us would undress. Then we have to take off even our underpants. We do it at the same time. The doctor checks us one by one but we’re all standing next to each other. It’s really embarrassing.” (Erwin, factory worker)

“It’s really embarrassing, even though you’re all men. You’re all in one cubicle. What’s even worse is when the doctor gives his remarks as he checks each one. For example, one has ball bearings in his penis or one has a tattoo. The doctor would say, “Your ball bearings, you to take that out.” It’s shameful, everyone else can hear.” (John, seafarer)

“The younger women, it’s ok because they have nice bodies. They’re flawless. So we once complained to the doctor, ‘Why did you group us with these kids when we’re already 40?’ They got angry, ‘Then don’t work abroad!’ Or they tell your agency about you. Then the agency will also tell you not to fuss. Sometimes, we have to beg for some consideration. That’s really how it is... you keep begging the agency. Then there are also others who would tell you, ‘Don’t worry, they don’t check everything. They touch your breast, that’s all.’ The doctor’s also a woman.” (Alicia, domestic worker)

But even with these experiences, no formal complaint has been lodged to improve the testing procedures to make them more sensitive towards the migrant workers. When given this feedback from the migrants, Dr. Villote stated,

“The reason it’s done that way is to speed up the process. If our procedures take a long time, the migrants will complain to their agency that medical exams here take very long. Imagine if you have one person going inside the examination room one at a time. Each one enters, takes off his clothes, is examined, puts on his clothes, goes out. Then the next one goes through the whole thing. It’s very long, unlike when you have three at a time. Here, the women wear lab gowns and the men wear briefs.”
Overseas Filipino workers spend about half to one day in the diagnostic clinic. A considerable portion of this time is spent waiting for their time to be examined. This is a good opportunity to provide preventive healthcare information. As far as the diagnostic clinics are concerned, the most practical way of providing this kind of information is through IEC or behavior change communication (BCC) materials. The end of the medical examination also ends the interaction of the worker with the clinic. If the results are satisfactory then the worker can proceed to the next step in the application process, and so on until s/he leaves the country. On the other hand, if the OFW fails in the medical exam, s/he will be asked to undergo treatment - in the case of treatable conditions like tuberculosis - before they can apply for work again. In case of an HIV positive result, the OFW is referred by the recruitment agency to the San Lazaro Hospital or the Research Institute for Tropical Medicine (RITM).
For migrant workers, life abroad is very different from the one they left back home. They go through a period of adjustment to the climate, the environment, the people, the food, the work, and the new culture. Difficulties faced by migrant workers during this period may vary depending on the migrant herself/himself and on presence or absence of enabling factors. For some, this is not very difficult because they are able to establish support networks among their peers right away. For others, it can be very difficult, e.g. domestic workers, because their environment is relatively more limited and they only get to meet their peers when they are allowed days off.

No matter what job category they belong to, OFWs agree that it takes hard work to be able to fulfill the dreams they sought overseas. However, it can be hard for some and worse for others. Different jobs have their own characteristics and complications. Seafarers face a different situation from land-based workers. Professionals and skilled workers may not experience the hardships experienced by service workers. Women migrants face different challenges from those faced by men.

For seafarers, one of the most difficult moments they have, is the long periods of isolation out at sea, lasting for weeks or months particularly on cargo ships and tankers. For those on cruise liners, they can dock almost everyday and interact with people other than their shipmates. Because of the limited facilities on board the ships, their forms of recreation are also very limited. At sea, there is hardly any respite from the hard work or the boredom. So when they do get a chance to disembark, it’s almost always to the bars and clubs for drinking binges and casual sex. Such activities have a great impact on their health but this is hardly a concern for many of them. It is even alarming that getting infected with sexually transmitted infections is so common; it’s no longer a cause for worry, unless they get infected with HIV.
Female domestic workers have a different situation. They are confined in the private households of their employers. Their work does not have clear cut boundaries and hours, even though they have employment contracts. They can be made to perform almost any chore and they are available for work around the clock, unless they do not live with their employers. Depending on their employers, living standards vary for domestic workers. There are domestic workers who are given their own rooms. There are those who sleep with the children and there are those who have to sleep on the floor in the kitchen. Their days off also vary depending on the employer, with some allowed weekly days off and some, once a month. Some have to wait until they have fully paid their placement fees and there are those who do not experience days off during the whole duration of their contract. Because of the set up of their working and living environment, migrant domestic workers are highly vulnerable to physical, sexual and psychological abuses.

There are migrant workers who endure working under the scorching sun in the Middle East countries. There are those who have to work with potentially harmful chemicals. There are medical practitioners who may be exposed to various dangers in their line of work. This is just a picture of the difficult experiences of many Filipino overseas workers. There are countless other migrant workers in the same kinds of jobs described above who may, conversely, be in very good situations. Relative to health, however, all OFWs may at some point in their migrant lives encounter problems, ailments, and illnesses with varying degrees of seriousness. How they cope and their capacity to access information and services to relieve these problems may depend on the kind of conditions they find themselves in. The following sections discuss accessibility of health information and services by migrant workers on-site.

**Access to Preventive Health Information and Services**

In the major destination countries, another round of medical tests is required before the OFW starts working. In some of these countries, domestic workers in particular are required to undergo a regular medical examination every six months, every year, or every time the domestic worker renews her contract or changes employers.

These medical tests include screening for HIV and pregnancy. There are also countries that require HIV screening for seafarers when they disembark. When found to be positive, the result is immediate deportation. These medical requirements in the destination countries, when not borne by the employers, are paid for by the workers outright, through salary deduction, or as part of the fees they pay to the recruitment agencies.

Just like the medical test in the Philippines, these procedures are not designed to provide preventive health care or information to migrants. These are just requirements to make sure that the OFW is “fit” to work.

Most migrant workers go through an orientation when they reach the destination country. This may be provided by the counterpart agencies or brokers on site or by their employers or supervisors. It also serves to familiarize the worker with the work s/he is about to do and to warn migrant workers about the rules they need to follow. A domestic worker recalls that the brokers would always remind them to work hard and not to complain about anything if they do not want to get terminated.
While abroad, the migrants also do not actively seek information regarding health. They have passed all necessary medical examinations. They are excited about their jobs, their new environment, and the prospect of earning big for their families at home. In most cases, the workers become too busy with work to worry about their health.

“...I had to go to the hospital. The doctors there said they did not have time to read them anyway.” (Josephine, domestic worker)

Although migrant workers do not get health-related information from the “structures” they encounter during their migration, it does not mean they have no knowledge about health care. Filipino migrant workers have loads of information on how to cope with the new environment. They brought this information with them from the Philippines. In the course of their lives abroad, they would encounter situations where they would need information that may impact on their health, such as the climate and weather in the destination country. In these cases, the advice they need in order to cope with their new environment would come from their employers or their peers, especially those who have stayed in that particular country longer. These new inputs, coupled with those they already know, would be applied when the need arises.

**Access to Health Care and Services**

Accessibility of health care and services for migrant workers in the destination countries varies greatly and is dependent on several factors. These include: type of work, place or country of work, employers, language, immigration policies, legal status, costs, availability of services and quality of services. These enable or hinder migrant workers’ access to health information, care and services. Another important aspect is utilization of services, which brings forward the issue of health-seeking behavior of migrant workers.

Many Filipino migrant workers bring medicines from the Philippines so they don’t have to buy medicines when they get sick on-site. Filipino migrant workers bring with them the level of health-consciousness they have in the Philippines. If they are used to just buying over-the-counter drugs without consulting a physician then that is usually how they behave on-site.

**The Experience of Women Migrant Domestic Workers**

It is interesting to note that, when asked if they ever got sick while abroad, the initial reaction of the OFWs interviewed for this study is always “No, just the usual...”. When asked what this means, they would answer, “You know, colds, headache, fever...”. This indicates that, even though they get sick, OFWs do not consider it serious and just brush it aside. As long as they can endure the discomfort or the pain, as long as they can still continue working, they do not consider themselves sick. Many also resort to self-medication when they feel sick, especially if these are just minor ailments like coughs, colds, fever, or body pains.
Migrant domestic workers experience a range of health problems while they are on-site. Many of them encounter reproductive health problems. A 2002 survey conducted by WIDFI among domestic workers in Hong Kong showed that the most common RH problems experienced by the women were genito-urinary tract infection, pelvic inflammatory disease and menstrual problems, (such as painful, irregular, or cessation of menstruation altogether). During the time of their study, WIDFI also recorded a significant number of domestic workers getting pregnant and resorting to unsafe abortion, which in turn caused more complications.

ACHIEVE, Inc. conducted a survey among Filipino migrant domestic workers in 2005. The results also reflect the WIDFI findings, though the respondents in this more recent survey worked in a wider selection of countries. Out of 302 respondents, 23 became pregnant while working overseas. Of this figure, only 11 had pre-natal care; only seven had free hospitalization; only three enjoyed maternity leave benefits; and only two had post-natal care. Three of the women had miscarriages while one developed ectopic pregnancy. Although none of the 23 participants were terminated from their jobs, a number of them decided to just run away to hide their condition from their employers, and eventually become undocumented workers.

Some respondents reported having irregular menstruation, dysmenorrhea and painful urination. There were also women who had more serious conditions (four had to undergo hysterectomy while on-site; one reported that she developed myoma).

The results were summarized in the following table.

### Table 6. RH Problems Experienced

<table>
<thead>
<tr>
<th>RH Problems</th>
<th>Frequency</th>
<th>Consulted a doctor/ health service provider</th>
<th>Did not consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysmenorrhea</td>
<td>77</td>
<td>4</td>
<td>73</td>
</tr>
<tr>
<td>Irregular menstrual period</td>
<td>53</td>
<td>5</td>
<td>48</td>
</tr>
<tr>
<td>Abnormal vaginal discharge</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Painful urination</td>
<td>15</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Painful intercourse</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Induced abortion</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Lump in the breast</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>169</strong></td>
<td><strong>20 (11.8%)</strong></td>
<td><strong>149 (88.2%)</strong></td>
</tr>
</tbody>
</table>

*Source: Survey of RH Status and Needs of Female Overseas Migrant Workers, ACHIEVE, Inc., 2006.*

When asked why they do not consult doctors or go to health clinics for their health problems, domestic workers would describe their limitations, mostly due to the nature of their work and their living conditions. One worker described the situation in her presentation during a consultation held by ACHIEVE, Inc. on the issues faced by Filipina migrant domestic workers.
“Migrant domestic workers have little or no access to quality healthcare in their countries of destination. For those who have health insurance, many do not know the provisions of their insurance coverage. In some receiving countries like Malaysia, migrant workers are charged higher hospitalization fees. It is therefore not surprising that when we get sick, we resort to self-medication. Worse, we cover up ailments for fear of losing our jobs.

“Domestic workers in particular, have little access to reproductive health information and services. Most clinics are closed during our days off. Many of us do not even know how to get to the clinics. Those who get pregnant and continue with their pregnancy risk getting terminated by their employers. To avoid termination from work, some domestic workers resort to unsafe yet expensive abortions.

“In order to attend to our health needs, we end up self-medicating or putting off treatment until we get very sick. Such attitudes have also made detection of STIs and HIV infection difficult especially when we are still asymptomatic or not showing any sign of infection.” (Josephine, domestic worker)

As mentioned above, the health insurance of the migrant worker should be a facilitating factor to access health services. The problem is, not all migrant domestic workers have health insurance, even though it is indicated in their contracts. Among the domestic workers who participated in the ACHIEVE survey, only nine (9) out of the 302 have medical insurance. For those who do have health insurance, the OFWs are not aware of its provisions and coverage. There are migrant domestic workers whose medical insurance are paid for by their employers but there are also those who pay for their medical insurance through salary deduction.

Another reason for delaying consultation for their ailments is the fear of being terminated. They are told by the brokers that if their employers get disappointed with them they can easily be terminated so they need to be very careful, especially during the probationary period of three months. As a result, when the domestic workers get sick during the early part of their contract, they feel that their only recourse is to endure it rather than be terminated and sent back to the Philippines with their debts left unpaid and their dreams unfulfilled.
“In my case, I really hid my condition from my employers. I went abroad in September and it was really cold and this (ankle) became swollen so at night I would wrap it with ginger. My fear then was that if I told my employer, they might terminate me. I was still on three-month probation. So I did not go to the doctor until I could no longer walk.” (Alicia, domestic worker)

Some domestic workers feel relieved to know that they will not get terminated when they tell their employers that they get sick. In the experience of the domestic workers who participated in the FGD for this report, most of them found themselves in situations where their employers facilitated their access to health services.

“Toothache only. I told my employer. They told me they will take me to the dentist. The dentist took out the [tooth]. My employer paid for it.” (Lenny, domestic worker)

“Flu. In Taiwan and Hong Kong, I had flu. My employer paid when I went to the doctor.” (Pearl, domestic worker)

“My employer would call their doctor when I’m not feeling well. They just called then I would walk to the clinic because it was very near my employer’s house.” (Gemma, domestic worker)

For some however, although their employers did provide assistance when they got sick, their options regarding health services and care were still limited, as illustrated by the following testimonies.

“Sometimes, no, [I don’t always tell my employer] especially when you’re sick often. It’s embarrassing. You feel ashamed. Also, you’re afraid of what they will say. My shoulder and my side were always aching. My last employer was an herbalist. She told me, ‘You’re in trouble of kidney.’ One time I fainted. She gave me herbal medicine. She told me that if I go to the doctor, they will just give me a lot of pills that have side effects and make me drowsy. She said the herbal medicines were better.” (Nita, domestic worker)

“My employer finally noticed that I was in pain though I was still working, I was crawling in order to make milk for the baby. They took me to the doctor and I was limping. They paid for it but I was not allowed sick leave. I still had to work.” (Ellen, domestic worker)

“[I had] Flu and allergy. When I iron clothes, I did not notice that my hands were already bleeding because of the detergent, especially during winter. They [employer] brought me to a private doctor and they paid for it. When I went to another doctor, my employer got angry with me. ‘You should be the one to pay,’ because I did not go to their own doctor. My employer refunds my medical bill only if I go to their own doctor.” (Nita, domestic worker)
When asked why she decided to go to another doctor, Nita answered, “Because I was not getting better.” One important element in access is choice; meaning migrant workers should have options where and how they want to be treated. This implies that they need to be equipped with the information and the means to reach the facilities and services they need. For many domestic workers, unfortunately, their choices are very limited and in many instances, decisions are made for them by their employers.

There are domestic workers who are not allowed to seek medical assistance when they need one.

“In Singapore, I had stomachache after eating jackfruit. It was bad for me because I had menstruation, I was feeling dizzy. I called my employer at work. They told me to stay at home because they did not want me to go out.” (Gemma, domestic worker)

The challenge with domestic work is that it is not recognized as formal work in many destination countries. This being the case, it is difficult to ensure standards of protection and provision of services. Under Memorandum Circular No. 11, Series of 1999, POEA has set as a guideline for the deployment of domestic workers:

“Household workers shall be allowed to leave for employment only in countries where the rights of Filipino migrant workers are protected and any of the following is a guarantee on the part of the receiving country for the protection and rights of these overseas workers.

a. It has existing labor and social laws protecting the rights of Filipino migrant workers;

b. It is a signatory to multilateral conventions, declarations or resolutions relating to the protection of migrant workers;

c. It has concluded a bilateral agreement of arrangement with the government protecting the rights of overseas Filipino workers; and

d. It is taking positive, concrete measures to protect the rights of migrant workers.”

Reality is, of course, very far from the intent of this policy. For one, guarantee “d” is a catch all phrase most commonly invoked by government when promoting overseas employment. Unfortunately, this criterion is very difficult to verify. Guarantees “a”, “b” and “c”, are quite easily verifiable but currently, a high percentage of Filipina domestic workers are regularly deployed to countries that do not fulfill them. For instance, of the top ten destination countries of OFWs (see Table 1), domestic workers are most highly concentrated in Saudi Arabia, Kuwait, UAE, Hong Kong and Taiwan. None of these countries have ratified the Migrant Workers Convention; and only Kuwait has ratified the International Covenant on Economic, Social and Cultural Rights, which embodies the right to health. (www.ilo.org) One major flaw in current Government policy is its penchant for banning deployment to certain countries where cases of abuse against Filipino migrants have been sensationalized. After what happened to Flor Contemplacion in Singapore, the Government banned the deployment of domestic workers to that country temporarily. The impact of such protectionist policies, however, is that they
open the door for corrupt recruiters aiming to profit by encouraging illegal recruitment activities.

**The Experience of Seafarers**

The experiences of seafarers are very different from the experiences of land-based workers. According to a study conducted by Philippine Seafarers Assistance Program (PSAP), a non-stock, non-profit foundation whose aim is to support seafarers in the quest for better living and working conditions, “Seafaring is the most risky profession in the world.” Seafarers are constantly exposed to various dangers while at sea, including diseases and accidents.

“I had an accident on the ship. A big rope snapped. The rope was this big… (Demonstrates the width of the rope with his hands.), nylon that’s really thick…you might have seen that on a ship…it snapped and hit me here (points to his thighs). Good thing my co-workers were not hit; they were able to get out of the way. Otherwise, someone would have died. Even our chief mate, if he hadn’t jumped out of the way in time, he would have died. Me, I was hit here (points) two of us were hit. I couldn’t work for a week.” *(Karlo, seafarer)*

Physical accessibility of health care facilities would be a big problem for seafarers like Karlo who had to wait until the ship has docked before he could be taken to a hospital. This also applies to other ailments.

“So for example, you get sick on board and you’re out at sea, the captain will tell you, ‘Ok when we get to the port…’ But what if you’re already having chills? They just give you first aid… but not from a doctor, we only have a second mate.” *(John, seafarer)*

Sometimes, the situation gets worse if the captain of the vessel refuses to detour to the nearest port so a seafarer can see a doctor.

“It depends on the captain. There are very strict captains who do not allow [you to see a doctor] because of the additional expense. It wouldn’t look good to the principal. They start asking questions like, ‘Why are your crew members always sick?’” *(John, seafarer)*

But there are shipping companies that provide better medical facilities for their seafarers. There are those who have medical officers on board. During emergency cases, they are also able to airlift seafarers who are in need of immediate medical assistance.

There are instances when the seafarer would refuse to seek medical attention and treatment because of certain policies of the manning agency. Instead he/she would opt to endure the situation rather than risk being repatriated.

*Principal is the term used to refer to the person or company that owns the ships.*
“They wanted to take me to the hospital but I didn’t want to go because if they take you to the hospital, the ship will sail and leave you behind. The agent in that port will take care of you, and then deport you back to Manila, to the Philippines. That goes down on your record. I was afraid of having that in my record so even if it’s really, really painful, I forced myself to work, to walk. I was so scared of being left behind at the pier. And that was in Africa, they would leave me in Africa after I get well. All I would need is the agent to assist me there but after that I go straight back to the Philippines.” (Karlo, seafarer)

PSAP notes that, although the Philippine Government has signed international conventions that promote the welfare of seafarers, it has remained weak in its policies promoting the health or reducing the health vulnerability of this sector of Filipino migrant workers. (www.psap-parola.org)

In the Philippine context, one of the biggest health vulnerability of seafarers is to sexually transmitted infections and HIV and AIDS. The Philippine HIV/AIDS Registry shows that of the total number of cases of HIV and AIDS among OFWs, seafarers account for 35%. The factors that affect their vulnerability are similar to those that impact on the HIV vulnerability of other migrant workers. However, among seafarers, their attitudes and behaviors towards sex stand out.

A study conducted by the Health Action Information Network (HAIN) revealed that one of the reasons why young men studying in maritime schools chose this field is so they can sample women from different nationalities. The culture of sexual promiscuity among seafarers persists even in the face of the HIV epidemic and the high incidence of STIs in the Philippines. Seafarers describe the reality they face.

“You know, on the ship, you don’t hear anything else besides sex, how many did you have sex with (laughs)? How many women did you have? How many contracted gonorrhea? When we get to the bars after leaving the pier, almost all of us got infected with an STI. Then the captain would get mad. “You don’t know anything better than to f***! Now, your medicines are a big problem!” Because almost everyone got infected…” (Karlo, seafarer)

The captains and the principals react strongly when a seafarer gets seriously ill because seafarers are insured and therefore the cost of medical treatment and health care will be shouldered by them. A seafarer recounts that when he got injured on the ship and needed surgery, the principal paid for his emergency surgery abroad, paid for his plane ticket home because he was given a two-week sick leave, and shouldered his medicines. His leave was also paid. POEA, in its Rules and Regulations Governing the Recruitment and Employment of Seafarers, clearly provides that all manning agencies who wish to be licensed by the POEA, among other things, need to:

- Ensure that the vessel/s and the crew are adequately covered by P & I Club or similar insurance thru the submission of the certificate of insurance coverage;
• Assume full and complete responsibility for all claims and liabilities which may arise in connection with the use of the license;
• Assume joint and solidary liability with the employer for all claims and liabilities which may rise in connection with the implementation of the employment contract, including but not limited to wages, death and disability compensation and their repatriation...

These provisions are, of course, very supportive of the welfare of Filipino seafarers. Meanwhile, there is still no in-depth study conducted to assess the health issues faced by seafarers in the Philippines and whether the presence of policies, such as the one mentioned above, really promote and protect the welfare of Filipino seafarers.

Quality of Health Care and Services

“In Korea, there was no problem. If you’re sick, they will treat you. I was in Korea for four years before I went to the doctor because it was already affecting my work. Even my hips were aching. My employer accompanied me to the hospital. They performed an ultra-sound. They told me, “You have myoma.” I said, “Me? Why?” They said, “We don’t know.” I had therapy for a month, sauna and massage. It was still painful. My employer said, “We’ll take you back to the hospital.” We went to five different hospitals. My employer paid for everything. I had the surgery in a private clinic. Then I was on medication for nine months. I also underwent acupuncture because of my rheumatism.” (Arlene, factory worker)

The story of Arlene mentions several factors related to the quality of health-related services and care, particularly the range of available services that may be provided in combination to treat the health problem she experienced. There is mention of modern devices and procedures, ultra-sound, machine-operated enema, surgery, medication; and there is also mention of alternative remedies like sauna, massage and acupuncture. But does this automatically qualify as ‘quality health care’? For Arlene, this is quality service.

Determining the quality of health-related services is rather difficult as it is not a simple matter of asking people what they think of the quality of the services they receive. There are internationally accepted guidelines that measure the quality of health care services but these may not be the same bases used by individuals when they think about the quality of the health services given to them. It is also not simply based on the level of satisfaction because this can also be very subjective. People from remote villages may be satisfied by the mere fact that a doctor has come to their village to conduct immunization, which pertains to accessibility and availability of a particular health service rather than its quality. Quality then looks at several factors which may include, but are not limited to, efficiency of services, efficacy of health-related goods, sanitation, and level of knowledge, skills and attitudes of health care providers.

For migrant workers who have had the chance to access healthcare on-site, the tendency is to compare it with the kind of services they have experienced in the Philippines. The most striking observation from OFWs who have worked in countries with advanced
technology is that there is an abundance of machines in the hospitals where they went. Although they commend the efficiency of the procedures thanks to the high-tech equipment, other concerns and issues emerge.

“One time I said to the doctor, ‘It’s always machines here.’ There is no doctor who will look you over or interview you first before handing you over to the machines. When I had problem with my eyes, it was straight to the machine. It was expensive.” (Lorena, entertainer)

The availability and quality of services may also depend on the country. The above experience happened to Lorena in Japan. Yet there are also stories from another migrant worker who worked in Hong Kong who said that the doctor there checked her thoroughly. They were more meticulous than the doctors she encountered in the Philippines.

Language poses a barrier not only in accessing appropriate health care but also in the quality of health care delivery. Based on the feedback from migrant workers, this is one of the most common problems they face when accessing health care services in the destination countries.

“In Taiwan, even doctors speak very poor English. When you tell them you have a headache, they say it’s because of the change in the weather. My employer’s child was always sick, that’s what the doctors kept saying: change of weather... I had the flu. The doctor gave me seven kinds of pills. What I did was I just bought paracetamol and Neozep. I also tried the pills they gave me, but not all. They did not explain to me what the pills were for. The doctor couldn’t speak in English.” (Penny, domestic worker)

Other migrant workers do not face this kind of problem because they can speak the language in the countries where they work. They may encounter other problems in the health care facilities they access like those experienced by Erwin who was detained in a government hospital in Jeddah for 11 months. Erwin regularly donated blood to augment his income while he was working in Saudi Arabia. A woman who received blood that was traced back to Erwin tested positive for HIV. When the woman sued the hospital for transfusing her with infected blood, the authorities detained Erwin, supposedly to be a witness in the case. He was told that while the case was ongoing, he needed to stay in the hospital. But after 11 months of detention, Erwin was never called to testify. He was never told about the progress of the case either. Here, he relates his experience while staying at the hospital that was his prison.

“The room where I was detained was dirty and smelly. All HIV cases among migrants or expatriates were confined in that room. I asked the janitor for cleaning detergents. I cleaned the room thoroughly while I was there because I was not satisfied with the way the janitor was cleaning it.

“Others stayed for about a week to two months. There were about 67 patients who came and went while I was there. I stayed the longest. The room had two doors, one was made of thick smoked glass then about two meters into the room, there was another door made of iron bars.
People outside the room couldn’t hear us even if we shout. One patient was having an attack so we were shouting for help but they couldn’t hear us. We went to the toilet where there was a window with iron bars. We waited for people to pass so we could ask for help. It took about fifteen minutes before we were able to ask a passerby to inform the nurse to come and help one of the patients. By then the patient was already vomiting blood.

“The nurses neglected the patients in that room. There were those who needed their diapers changed, the old or bed-ridden patients, but the nurses wouldn’t do it. I think they found us disgusting. I ended up doing these things. In my 11 months stay, I became the caregiver for about 14 of the patients who were either weak or bed-ridden.

“The room had a capacity for five beds. There were eight at the time. The water was not clear because of the rust from the pipes. We were provided with food but we had no choice. If you’re not used to their food, it’s not easy to eat. Drinking water was not enough. They only gave us one bottle every meal.” (Erwin, executive assistant)

Although the quality of services largely depends on the available resources and policies in any given country, the more pressing issue is whether migrant workers are able to access the best quality of whatever is available. In most instances, migrant workers do not enjoy the same standards as those enjoyed by the citizens. In some cases, like in Malaysia, even when migrant workers are able to pay first class rates, they still only get third class service.

It is important to note that those OFWs who were able to access relatively good quality health services all had support from their employers. One factor that contributes to an enabling environment for migrant workers to access quality health care services is the availability of support systems in the destination countries.

**Support Systems On-Site**

Filipino migrant workers easily develop support networks on-site. They form these networks with people they encounter during work or when they are on their days off or holidays. They would always form friendships with other Filipinos and they learn from the experiences of those who have worked in those countries longer.

In times of need, OFWs turn to fellow OFWs for help. Filipinos would often offer help to other Filipinos in distress. In many countries, Filipinos have socio-civic organizations that serve as support groups. Some of these are religious, some are ethnicity-based, and others are sports-oriented.

“I had a lot of help from my employer and from our organization, the Cordillera Brotherhood Association (CBA), an umbrella organization. Helping out other Filipinos was mandatory. CBA helps all Filipinos in distress, those who die, those who are sick. Stroke was common among
the Filipinos there. They drink, eat then have a stroke because of too much eating. Or they die in their sleep.”

(Arlene, factory worker)

Having friends in the right places can also facilitate access to certain services, Erwin related, “Other OFWs who have friends who are doctors or nurses can just ask for free medicines.” Other stories tell of Filipino migrant workers who facilitated the escape of a peer from an abusive employer until they were able to reach the Philippine Embassy.

There have been many stories of migrants who found themselves in trouble and were able to find help from religious groups or faith-based organizations. These groups provide spiritual support and counseling. Some visit migrants who are imprisoned, bringing food and other necessities. An undocumented worker in Korea was spared from possible brutal treatment by Immigration Officials because he was accompanied by nuns when he surrendered.

Some religious groups also facilitate financial assistance either through their funds or by mobilizing their communities to help out through donations. A domestic worker was able to buy a passport for her baby in Hong Kong and send her home through the help of her friends from a Christian group.

“During that time, the passport for the child was very expensive, HK $700. So I asked help from my friends. I told them I wouldn’t be able to bring home my baby because I had no money. So they contributed.”

(Daisy, domestic worker)

The advantage of having these networks is quite obvious. However, there are also instances when these network of friends unwittingly cause more harm than good. For instance, the experiences of seafarers show how friends and co-workers pressure each other into high-risk sexual behavior, making them vulnerable to sexually transmitted infections.

“My mother talked to me about that, ‘Don’t do this, don’t do that...’ But you can’t refuse. Once you’re there, they will pressure you. They’ll say, ‘Fag!’ ‘You don’t have [balls]!’ ‘What, you prefer men?’ They will laugh at you. You’re all men there. They can really insult you. Then if you really don’t have money, they will lend you. ‘Go ahead. I’ll take care of it.’”

(Karlo, seafarer)

On the one hand while these social networks that OFWs build when they are on-site help them in a number of ways, these same networks can also lead them to potential harm. Yet these networks are very important to the migrant workers. The challenge is how to reach these social networks and provide them correct information so that they become a more positive support mechanism for the migrant workers.

The same can be said about the families of Filipino migrant workers who are left behind. With the advancements in communication technology, it has become easier for migrant workers on-site to stay in touch with their families in the Philippines. Thus they can
maintain a support system that can help the migrant workers cope with the life they face abroad. There are OFWs who consult their families back home when they get sick overseas. Instead of going to the doctors who are more expensive, and in a number of cases, insensitive and are unable to communicate with the OFWs, they prefer to ask their families.

But just like the social networks on-site, the families can also create pressures that contribute to the stress experienced by the OFWs.

**Medical Insurance**

Medical insurance is another scheme that can promote the health of migrant workers. The question is whether they have full access to the benefits of their medical insurance. In the case of OFWs, this largely depends on how well policies and bilateral agreements on this matter are being implemented. For instance, seafarers, generally, are able to enjoy their insurance as long as their claims fall within the coverage of their insurance policies. Because there are guidelines that cover the insurance of seafarers and violations of such guidelines are quite steep for the principals and shipping companies, the seafarers are better protected.

Other categories of migrant workers are not as lucky. Medical insurance is stipulated in the employment contracts of Filipino migrant workers because the Standard Employment Contract prescribed by the POEA requires employers to provide free medical and dental insurance, even medicines. But in the case of migrant domestic workers, and entertainers, contracts are easily changed or not honored when they arrive in the country of destination. These categories of work are difficult to monitor so even when violations of contract provisions happen often, the employers and the brokers are not held responsible. There are cases where medical insurance is not shouldered by the employers but are deducted from the worker’s salary.

> “That’s really taken out of your salary. 3,000 Taiwan dollars in four months. They also deduct the T$10,000 for the agency. My salary was only T$15,000.00.” (Gemma, domestic worker)

From discussions held with Filipino migrant workers, however, the bigger problem is that they are not even aware if they have insurance or not. They have not read their contracts or the provisions were not explained to them. They would just assume that they have insurance because when they get sick, their employers shouldered their medical expenses. This lack of awareness can be traced to inadequate information to prepare them for overseas work prior to departure. As repeatedly shared by OFWs, they don’t worry much about their documents as long as they are assured of getting deployed. Filipinos, perhaps because of the poor economic conditions in the country, are prepared to risk their safety, even their lives, in order to find a better life overseas.

**Role of the Philippine Posts Abroad**

Systemic problems call for structural interventions and solutions. Ideally, the most immediate source of support for OFWs overseas are Philippine Embassies and Consulates
under the Department of Foreign Affairs [DFA]. Philippine foreign policy is anchored on three pillars: 1) “the preservation and enhancement of national security”; 2) “the promotion and attainment of economic security through mobilization of external resources for economic advancement and social development”; and, 3) assistance to nationals (ATN) which entails “the protection of the rights and the promotion of welfare and interests of Filipinos overseas”. (Hon. Delia Domingo Albert, Structure, Content, Form and Substance and the Three Pillars of Philippine Foreign Policy, 2004)

The third pillar mandates government to ensure the provision of services for OFWs onsite. Furthermore, the Migrant Workers Act stipulates the following provision:

SEC. 19. ESTABLISHMENT OF A MIGRANT WORKERS AND OTHER OVERSEAS FILIPINOS RESOURCE CENTER. - Within the premises and under the administrative jurisdiction of the Philippine Embassy in countries where there are large concentrations of Filipino migrant workers, there shall be established a Migrant Workers and Other Overseas Filipinos Resource Center with the following services:

(a) Counseling and legal services;
(b) Welfare assistance including the procurement of medical and hospitalization services;
(c) Information, advisory and programs to promote social integration such as post-arrival orientation, settlement and community networking services for social integration;
(d) Institute a scheme of registration of undocumented workers to bring them within the purview of this Act. For this purpose, the Center is enjoined to compel existing undocumented workers to register with it within six (6) months from the effectivity of this Act, under pain of having his/her passport cancelled;
(e) Human resource development, such as training and skills upgrading;
(f) Gender sensitive programs and activities to assist particular needs of women migrant workers;
(g) Orientation program for returning workers and other migrants; and
(h) Monitoring of daily situations, circumstances and activities affecting migrant workers and other overseas Filipinos.

Further, the law also provides that this Center should be jointly maintained by the DFA, the DOLE and other Government agencies represented in the Post abroad. This Center should be open 24 hours everyday, including Saturdays and Sundays, and it should be manned by appropriate personnel, such as lawyers and social workers.

However, based on reports and feedback from the migrant workers, there are conflicting views as to the effectiveness of the Embassies and Consulates in providing support and assistance to OFWs on-site. DFA reports show that the Posts abroad are able to provide assistance to a significant number of OFWs, although these are undermanned and have a
very limited budget. In a letter addressed to ACHIEVE, Inc. early part of 2005, the Office of the Undersecretary for Migrant Workers' Affairs (OUMWA) - DFA, reported:

“From January to September, this Office handled 3,431 new ATN cases and closed 3,070 such ATN cases. These cases ranged from legal assistance to Filipinos in distress abroad, individual and mass repatriation, follow-up of employment benefits, insurance and death benefit claims, shipment of remains and personal effects of deceased Filipinos, work-related problems, tracing of whereabouts and other assistance to imprisoned, detained, injured and sick Filipinos overseas.”

In Singapore, Filipina domestic workers shared in a focus group discussion that Embassies “are not doing anything” or “matters will just get worse because they return you to your employers” or “you need to show that you’ve been beaten black and blue before they believe you.” One domestic worker had a chance to seek help from the Embassy in Singapore after running away from her employer:

“It was ok. The first time, they were yelling at me. They assumed that I was lying. They interrogated me. Why I ran away from my employer. When they were satisfied that I was telling the truth, they treated me better.” (Elsa, domestic worker)

A common perception among OFWs is that undocumented workers cannot access any assistance from the Embassies because they will be arrested and turned over to the Immigration authorities in that country or be returned home to the Philippines. The Migrant Workers Act, as well as DFA policy guidelines, actually mandates the Posts to protect and provide assistance to undocumented or irregularly documented OFWs on-site. One concrete exercise of this mandate is for Embassy officials to not turn over undocumented OFWs to authorities of the destination country. Still, the Posts have a long way to go before they can change the negative perception of Filipinos towards the work they do.

The foreign service personnel accept that it is very difficult to change the OFWs’ perception of the Embassies, the Consulates or the Embassy Officials and staff. However, they acknowledge that it is their responsibility to be more vigilant in reaching out to the communities of Filipinos working abroad to spread information about the services available for OFWs in the Embassies and Consulates.
HIV and AIDS and Human Rights of Migrant Workers On-Site

When a migrant worker is diagnosed positive for HIV abroad, most likely they are immediately deported, without benefit of counseling and with no chance to organize their things or claim their salaries and other benefits from their employers. Although there have been several cases of Filipino migrant workers who were deported due to HIV, the Philippine Embassies and Consulates in those countries are not aware this is happening.

“I did not go to the doctor because I was scared that they might find what was wrong with me and I will be sent home. I have heard of another Filipino pharmacist working there who was detected to be HIV positive. He was arrested by the police because of it. We did not see him anymore after that so we assumed that he was deported.” (Erwin, executive assistant)

There are some instances where the migrant is not immediately deported due to a variety of reasons: the agency and the employer need to first settle who pays for the plane ticket; all flights are fully booked; or because they became involved in legal cases as a result of their HIV status. While they remain in the destination country, they are either detained by their employer, company or in the case of Erwin, in a government hospital.

“I was contacted by the Ministry of Health in Jeddah that I needed to undergo blood testing. Later on I found out that the woman who received the blood I donated tested positive for HIV and had filed a complaint against the hospital. Supposedly, I was a witness for the case. The representatives from the Ministry of Health accompanied me to the Hospital, to confirm my status. When we were there, I was told that I had to be confined in the hospital until they could talk to my employer. They said they had to conduct other tests but they did not tell me what those tests were. They told me they needed three weeks to process my documents so I can go home and in the meantime I had to stay in that hospital. But I ended up confined in that hospital for 11 months. I was never informed about the progress of the case. I was never called to testify. A friend brought my things. I was detained for 11 months, in a room with migrants from all nationalities who were also HIV positive and was never allowed to go out. After a week, I attempted suicide.” (Erwin, executive assistant)

The impact of such an incident on the person is multi-layered. There is the psychological burden of finding out about his HIV status, aggravated by the fear, frustration and depression for being locked up in a hospital room. Being detained for 11 months deprived him of his income. And because he was detained in a hospital, he was constantly exposed to infections that further compromised his health.

There are international guidelines that protect the rights of migrants and people living with HIV. Migrants living with HIV are in need of even more protection. In the case of Erwin, none of these were upheld. Worse, there are still no sanctions for countries that
violates such rights. In cases such as this, sending countries like the Philippines remain powerless to demand for the protection of the rights of its citizens in the destination countries. Thus, the intervention has to come from the international community.
REINTEGRATION

Depending on the job category, overseas workers’ contracts last for three months to two years. In some cases, renewal for another contract can be done at the destination country so the migrant worker need not come home to the Philippines to process documents. For others, processing needs to be done in the country so they have to come home. But regardless of the duration of their employment contracts, OFWs come home, whether to renew their contract, to look for another job, to try working in another country, to have a vacation, or to settle back for good. There have also been OFWs who experienced what is known among the migrant community as A-to-A or airport to airport. This means that the OFW was able to leave the Philippines but upon reaching the destination country, problems came up right at the immigration and so s/he is directly sent home.

Although Government agencies that are concerned with labor migration like OWWA and OUMWA keep track of the number of cases they served, there is no available data on what happens to migrant workers who come home sick. They are often lost from the health care system unless they decide to access services. No monitoring is done by these agencies after the available services have been rendered. It is therefore difficult to assess their access to health care in the home country since it would be no different from the local citizens or the general population.

The Impact of HIV Infection on the Migrant Worker

Because migrant workers are required to undergo HIV antibody testing during their application process, this is also where most of them are detected. But recently, more and more Filipino migrant workers are getting repatriated due to HIV infection. As
mentioned earlier, when a migrant worker tests positive for HIV abroad, s/he is almost immediately deported. In most cases, the Philippine Posts are not informed about the deportation and so they have no way of providing assistance to facilitate repatriation. It is also unusual for an OFW to approach the Embassies voluntarily for fear of being arrested or discriminated against by the Embassy officials. This can be largely because the OFWs are not aware of the services available to them at the Embassies.

Based on the inputs of the migrant workers who participated in this study, none experienced having been deported back to the Philippines due to any other health condition, except for HIV. This section will then focus on the experiences of migrant workers who have come home for good, not by choice but because of HIV infection.

For those who were diagnosed with HIV, the immediate reaction is disbelief. This period of denial varies from person to person. There are those who find it easy to accept their condition and there are those who would take months, even years to finally accept their HIV status.

“I was in denial even after I saw my results. I demanded for another round of tests. They said, “If you want, we can take some more blood for confirmation.” Then after they took more blood, they told me that the results will come out after a week when they’ve had it confirmed at the RITM. That week while I was waiting for the result, I prayed so hard. I prayed to all the saints I knew... Then when I finally got the result, they gave it to me and it was really HIV positive. It was like a whole ton of cement was dropped on me. I felt weak, I felt numb.” (Dan, seafarer)

If the migrant worker did not receive any form of counseling before taking the test or right after learning of the result, the psychological trauma is worse, especially if the person involved has very low awareness about HIV and AIDS. One of the first questions most commonly asked is, “When will I die?” or “How many years do I have to live?” After being reassured that they are not dying anytime soon, they start to ponder about the loss of job opportunity, what will happen to their families, the loss of their dreams.

An HIV positive result in the medical examination automatically disqualifies a person from overseas employment. Because of this, the heaviest impact of HIV infection among migrant workers remains to be economic. Jobs are already very difficult to come by in the Philippines and with the added limitations imposed on them by this condition; their options are further narrowed down. Presently, most of the OFWs living with HIV who are employed are employed by NGOs. Given the nature of resource availability among NGOs, these very limited job opportunities are not sustainable.

HIV infection does not only impact on the individual, it also affects families and communities. In the Philippines, female spouses of migrant workers particularly, are also getting infected with sexually transmitted infections and HIV. With both parents living with HIV, the family’s income is further compromised because medical expenses rise. As a result, the education of the children may also be sacrificed.
Access to Health Care and Services in Home Country

A big problem faced by PLWH in the Philippines is the lack of sustainable access to health care services, including prophylaxis, treatment and management of opportunistic infections, and anti-retroviral (ARV) drugs. When OFWs return infected with HIV or fail their pre-departure medical requirements, the issues they face in terms of access the treatment, care and support are the same as those faced by other categories of PLWH.

Before 2003, when the OWWA Omnibus Policy was promulgated, OFWs infected with HIV were able to claim an amount of PhP10,000 assistance from the OWWA General Assistance Fund. When an OFW died due to AIDS-related complications, the OWWA provided burial assistance, as well. There were also opportunities for loans for livelihood and income generating projects. The most important criterion then was that the OFW is an OWWA member, meaning s/he paid his US $25 contribution everytime s/he leaves the country on a new contract. But with this new Omnibus Policy, OFWs living with HIV are no longer eligible to receive the benefits stipulated in the Policy because the assistance available are now only for OFWs with existing employment contracts and their families.

Government-run health insurance corporations like PhilHealth only provides services when the member is hospitalized. Out-patient services are not covered. There was also a time when OFWs living with HIV could not access their sickness benefits from the Social Security System because the OFW had no opportunistic infections yet.

Only two Government Hospitals, the San Lazaro Hospital and the RITM cater to the specialized needs of PLWH. Along with these two hospitals, the DOH has also built the capacity of four more hospitals across the country to serve as HIV and AIDS treatment hubs where ARVs can be accessed. These are the Philippine General Hospital (Manila), the Ilocos Training and Regional Medical Center (La Union), the Davao Medical Center (Davao City), and the Vicente Sotto Memorial Medical Center (Cebu City). There are other hospitals that serve PLWH but their services are only limited to treatment of opportunistic infections.

ARVs are not easily accessible to migrants living with HIV, primarily because they no longer have the financial means to sustain them. The country’s trade agreements limit the government from accessing generic ARVs produced in neighboring Asian countries. Meanwhile, ARVs manufactured by big pharmaceutical companies is the Philippines are too expensive, ranging from $400 to $1200 per month. With the economic problems that face migrant workers living with HIV, these branded ARVs are beyond their reach.
ARVs in small quantities are imported from other countries through NGO partners and friends. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has allotted free ARVs for 200 PLWH. However, the challenge of sustaining the supply of ARVs rests on Government. It needs to fulfill its mandate as enshrined in the Philippine AIDS Law and provide the appropriate services for PLWH and migrant workers who can no longer work overseas because of HIV and AIDS.

The Philippine AIDS Law provides for health care and support services for PLWH. However, as with other laws, these provisions still need to be fully implemented.

**ARTICLE IV. HEALTH AND SUPPORT SERVICES**

**SECTION 22. Hospital-Based Services** - Persons with HIV/AIDS shall be afforded basic health services in all government hospitals, without prejudice to optimum care which may be provided by special AIDS wards and hospitals.

**SECTION 23. Community-Based Services** - Local Government units, in coordination and in cooperation with concerned government agencies, non-government organizations, persons with HIV/AIDS and groups most at risk of HIV infection shall provide community-based HIV/AIDS prevention and care services.

**SECTION 24. Livelihood Programs and Trainings** - Trainings for livelihood, self-help cooperative programs shall be made accessible and available to all persons with HIV/AIDS. Persons infected with HIV/AIDS shall not be deprived of full participation in any livelihood, self-help and cooperative programs for reason of their health conditions.

**SECTION 25. Control of Sexually Transmitted Diseases** - The Department of Health, in coordination and in cooperation with concerned government agencies and non-government organizations shall pursue the prevention and control of sexually transmitted diseases to help contain the spread of HIV infection.

**SECTION 26. Insurance for Person with HIV** - The Secretary of Health, in cooperation with the Commission and other public and private insurance agencies, shall conduct a study on the feasibility and viability of setting up a package of insurance benefits and, should such study warrant it, implement an insurance coverage program for persons with HIV. The study shall be guided by the principle that access to health insurance is part of an individual’s right to health and is the responsibility of the State and of society as a whole.

The problem with hospital-based care in the Philippines is that even the Government Hospital that is specialized to provide services for PLWH cannot provide optimum care. Initially, OFWs living with HIV and AIDS can still afford better facilities if they still have
their savings. But their savings easily run out because after they have lost their job opportunities, their families have no choice but to use up whatever savings were set aside. Migrants living with HIV have these to say about the situation in government hospitals:

“I've seen others... When they check in at the hospital they look healthy, but then somewhere along the way, just before their lives are snuffed out, they become like towels wrung dry... I just hope I don’t go through the process.” (Dennis, taken from For Good: Life stories of Filipino migrant workers living with HIV/AIDS)

“I wish the government gives us medicines like vitamins and anti-retroviral drugs. And hopefully they can subsidize our medical expenses in case we get hospitalized. The government should provide those who come from the province with decent accommodations where they can really rest.” (Faye, taken from For Good: Life stories of Filipino migrant workers living with HIV/AIDS)

At present, private insurance companies still deny coverage for people living with HIV. Government insurance is accessible if the OFW is a paying member. At the same time, s/he is covered by the benefits offered by such Insurance companies. The problem is if the OFW is not yet a member and is without any alternative sources of income or local employment. Then, it becomes very difficult to maintain payment of the insurance premiums.

Community-based care and support services for people living with HIV and AIDS and their families are mostly provided by NGOs and the organizations of people living with HIV. Local government initiatives on HIV and AIDS are limited and are mostly found only in project sites of these organizations. Funded mainly by international donors, services provided by NGOs include individual and family counseling, home and hospital visits. Trainings for palliative care are given to affected families and volunteers.

Although there is no formal referral system, NGOs, organizations of people living with HIV and certain Government Hospitals and agencies conduct referrals based on the need of the affected individual. Currently, there are efforts to strengthen referral systems to make service delivery more efficient and humane. The Government, NGOs, and community of people living with and affected by HIV and AIDS face the challenge of providing more comprehensive services, from prevention to treatment, care and support and sustaining such efforts in the long run.

**Stigma and Discrimination**

Because of the lack of awareness on the issue of HIV and AIDS, discrimination against PLWH is still high among the general public. The migrant worker community is currently experiencing the stigma previously experienced by the gay community and sex workers. Newly diagnosed HIV positive individuals recall that one of the questions immediately asked of them during pre-test or post-test counseling during HIV testing is whether they worked overseas. The advocacy to create awareness on the vulnerability of migrant
workers to HIV and AIDS may have inadvertently caused this kind of labeling. Advocates need to be more careful, therefore in the messages they deliver to ensure that the migrant community will not be stereotyped and blamed for the spread of the virus.

In addition to the inherent stigma present in HIV and AIDS, migrant workers, because they can no longer work abroad, experience a ‘fall from grace’. It is the experience of almost all migrant workers that while they were still active in their overseas work, they held a certain status in their families and communities. They were looked up to and envied, especially the successful ones who were able to put up large houses and accumulate other luxurious possessions. It is therefore very hard for them when they suddenly lose the opportunity to continue working abroad.

“I ran out of money. Soon after I realized that if you lose your job, you lose your prestige, your family and even your friends. People would say, ‘Look at him, he grew old but his money was not put to good use.’ Then people looked at me differently. When I passed by their houses before, they would call or greet me. Now, they would close their doors when they see me approaching. They think I want to borrow money from them. I cannot even hear my siblings say ‘hello’ or ‘how are you’ anymore. And so I asked myself, ‘What remains to be my purpose in this life?’ (Dennis, taken from For Good: Life stories of Filipino migrant workers living with HIV/AIDS)

Having lost the opportunity for overseas work due to HIV infection renders a heavier blow. It becomes very difficult for migrants to keep warding off questions from friends and relatives as to why they have not embarked on another contract abroad yet. They come up with alibis and they think of reasons that will not add to their already diminished status in the family and community. It is common among migrant workers who were diagnosed with HIV while they were processing their papers to say that they have cancer or leukemia. It seems people don’t probe too much when the reason is a serious illness as long as there is no stigma attached to it.

Of the OFWs who have been deported due to HIV, there are those who chose not to go home to their families anymore. Some are lucky to have been housed in hospices or are taken in by friends or peers. Consequently, they feel very restricted in their movements because they cannot go to certain places in the city to avoid running into a relative or family member.

There are OFWs living with HIV who have decided never to disclose their status to their families and friends. There are also those who have opened their situation with their families. Some were eventually forced to leave home but there are also those who have supportive families. According to them, counseling leads to acceptance of their condition and has not only helped them but also their families.

HIV and AIDS advocates believe that if stigma and discrimination are addressed, we also lessen the spread of the epidemic. Admittedly, this is not an easy undertaking as people’s perceptions and attitudes do not change overnight. It takes a lot of time, effort and resources to continuously challenge existing norms and fight discrimination. Again,
it is very important to develop interventions that involve all stakeholders because this is the only way limited resources can be shared and managed, and it is a surer way to sustain interventions.
CONCLUSIONS AND RECOMMENDATIONS

As illustrated in the early part of this report, health is not a priority among Filipinos. It is also not a priority of the Philippine government as evidenced by the appropriation of only 9.8 Billion for the Health Department out of a total of 907 Billion national budget appropriation in 2005. (www.dbm.gov.ph). Only about one percent of government spending goes to the health sector. Furthermore, the PNAC, which coordinates the implementation of the country’s HIV and AIDS responses, had a budget appropriation of only 9.4 million. This could explain the conditions of government hospitals, the lack of access of returning migrants to health care and HIV-related services and the lack of health-related information programs.

Laws and policies are important to guarantee that people’s rights are promoted and protected. In the scope of this study, the issue is access to health care information and services, specifically for Filipino migrant workers. In this regard, the study found that laws and policies are in place. But the experiences shared by the respondents show that having laws and policies do not necessarily guarantee that health care and services are accessible. It may be because the existing laws and policies are not very strong in the aspect of health care as a primary need for migrant workers. Or it may be because such laws and policies are not strictly implemented. Such is illustrated by the lack of appropriate health-related information during the pre-departure stage or the non-compliance of medical clinics in conducting pre-test and post-test counseling during medical testing, specifically for HIV.

On the other hand, the business of exporting labor is such that policies are easily circumvented. Although there are health-related provisions in the standard employment contracts of migrant workers, many still do not have coverage. A great number of migrant workers who do have health insurance are made to pay for their insurance through salary deduction.
From the point of view of migrant workers, several issues need to be taken into consideration. Generally, health is not a priority concern among Filipino migrant workers. Migrant workers will endure illness in order to continue working. Work always comes first because earning money for the welfare of their families is the number one priority. When the health problem can no longer be ignored, they turn to their support networks for assistance — either employers or friends.

In the destination countries, there is no question about the availability of health care services. According to the migrants, services are available. Whether migrant workers can access them is another matter. In the sharing of the migrant workers who participated in this study, accessibility of health care services is like a continuum. It can be very easily accessible to some, and virtually inaccessible to others. Several factors affect these varying levels of accessibility: nature of work, costs, insurance coverage, language, nature of ailment or illness, attitude of the employers and attitude of the migrant workers towards their health. It is therefore, very important to consider how enabling the environment is for migrant workers so that they are able to have full access to the available health services.

Looking at the nature of ailment, reproductive health especially among women migrant workers is an issue that needs more serious attention. This is very urgent considering that 75% of Filipino migrant workers are women and are of reproductive age. In addition, incidents of HIV and AIDS have increased among OFWs in the last few years. It is important to note that the issue of HIV and AIDS has pushed forward the re-evaluation of the whole system of labor migration, looking into the level of preparation of migrant workers before departure, the presence of labor standards, the living conditions, and the realities faced by migrant workers in all the phases of their migration. Further, a number of HIV prevention strategies have been instituted. However, the Philippine Government is still incapable of providing optimum care for migrant workers who are already living with the virus. Most receiving countries, unfortunately, continue to brand migrant workers as carriers of this disease, denying them of health care and the right to continue working.

The issue of health among migrant workers is slowly gaining ground and permeating the consciousness of stakeholders in the Philippines. But such interventions need to be strengthened and resources need to be allocated by government to sustain the efforts started.
On Preventive Health Information

For the first time, Government recognized the specific vulnerability of migrants to HIV infections. This is now enshrined in the 4th Philippine AIDS Medium Term Plan (2005-2010). Its first strategy states, “Scaling-up and quality improvement of preventive interventions targeted at population segments with risk behaviors and those identified as highly vulnerable,” and the first key result area under this strategy is: “All migrants are provided with STI/HIV and AIDS preventive information and services.” The operationalization of this provision needs to take into account current realities in order to be more effective:

- The PDOS, as currently implemented, is no longer a practical means to provide health information for departing migrant workers. There are too many topics crammed in this one-day session. Based on feedback from OWWA, many migrants also prefer a shortened PDOS. It might be better to find other avenues where such information can be provided.

- The POEA is mandated to conduct the Pre-Employment Orientation Seminar (PEOS) but this is not regularly done. PEOS is more “community-based” so if it is regularly implemented, it will be more strategic in providing health information to those in the communities who might be planning to apply for overseas work. And this kind of initiative can be done in collaboration with NGOs, community based organizations (CBOs) and local governments.

- According to migrant workers, their families should also be included in these orientation seminars so that they also realize the realities faced by the migrant workers while working abroad. This way, they can better support their relatives abroad.

- A standard module on health needs to be included in these orientation seminars. Such modules need to be customized to fit the context faced by migrant workers. This can be made more effective with the involvement of migrant workers in the development of the modules and during the conduct of the seminars.

On Better Access to Health Services On-site

- Healthcare information and services should be included as one of the core services provided by the Philippine Embassies and Consulates. This can be done through the provision of information materials at the Embassies, Consulates or the OFW Resource Centers. If doctors are not available at the posts, then there should a functional referral network linking the Embassies with healthcare providers in the destination countries. This would entail building partnerships and networks with NGOs and CBOs, and even with the relevant Government Ministries in the destination countries.
• Capacity-building for Embassy personnel on the issue of health and HIV and AIDS among Filipino migrant workers need to be sustained and strengthened.

• There have to be stiffer penalties for recruitment agencies that fail to ensure the provision of free medical and dental insurance to the migrant workers.

On Data and Further Research

• Concerned Government Agencies need to be more vigilant in documenting health problems encountered by migrant workers. There is currently a lack of retrievable information regarding health problems faced by OFWs on-site. There is also no monitoring done on the cases of OFWs who have been repatriated due to health-related reasons.

• There is a need for more in-depth research on several areas of health among migrant workers, such as occupational health, mental health, and sexual and reproductive health.

On Laws and Policies

• The Philippine AIDS Law is currently undergoing review for amendment. Among the recommendations is to strengthen the provision related to providing HIV information in the PDOS. There should be specific sanctions for PDOS providers who fail to comply.

• Implementing rules and regulations of these laws need to be operationalized by the specific Government agencies tasked for its specific provisions. For example, the DOH’s Bureau of Health Facilities and Standards need to develop clear guidelines for monitoring the conduct of pre- and post-test counseling by medical clinics. This should be done in coordination with the POEA in order to make sure that the recruitment agencies also adhere to the rules imposed on the medical clinics where they send their migrant workers.
• Bilateral Agreements with receiving countries on labor standards for Filipino migrant workers need to be strengthened and/or revived, and provisions on health services need to be included.

**On Capacity Building of Stakeholders**

• The capacities of migrant workers who can no longer work abroad because of HIV infection, but who want to be involved in the advocacy efforts, need to be built and enhanced. This will enable them to participate more effectively in initiatives being developed to improve the situation of Filipino migrant workers, particularly on the issue of health and HIV and AIDS.

• Capacity building efforts for relevant Government Personnel, like Foreign Service Officers and Personnel, need to be strengthened, institutionalized and sustained so that they become more capable in delivering the services of Government to Filipino migrant workers on-site.

• Providers of orientation seminars need to be equipped with adequate knowledge and skills and the right attitude to deliver the messages across to migrants and their families.
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**Action for Health Initiatives (ACHIEVE), Inc.**

Action for Health Initiatives (ACHIEVE), Inc. is a Philippines-based organization engaged in the development and implementation of an action-research program on mobility and health, specifically addressing sexual and reproductive health and HIV and AIDS vulnerability of migrant workers and their families. Formed in 2000, ACHIEVE is the focal point of the Coordination of Action Research on AIDS and Mobility in Asia (CARAM-Asia), a regional network of NGOs and community-based organizations in 13 Asian countries.

Currently, ACHIEVE has the following programs: 1) National Campaigns on Migration and HIV and AIDS; 2) Regional Campaigns on Migration and HIV and AIDS; 3) Women and HIV and AIDS; 4) Institutional Advocacy on Migration and HIV and AIDS; and, 5) Empowering Migrant Workers and Spouses Living with HIV. ACHIEVE undertakes proactive campaigns on the following issues: reproductive health and rights of migrant domestic workers; access to treatment for migrants; and, campaigns against mandatory HIV testing for migrants, among others.

In partnership with other stakeholders, ACHIEVE has successfully implemented various activities and projects. It has conducted trainings and seminars on migration, gender, sexuality, and HIV and AIDS issues for government such as the Department of Foreign Affairs, the Foreign Service Institute, Overseas Workers Welfare Administration, Department of Social Welfare and Development, Philippine Overseas Employment Administration, Bureau of Quarantine; NGOs; diagnostic clinics; migrant workers; families of migrant workers; and, people living with HIV.

**Coordination of Action Research on AIDS and Mobility in Asia (CARAM-Asia)**

Coordination of Action Research on Aids and Mobility in Asia (CARAM-Asia) is a regional network of organizations working on migration and health issues. Formed in 1997, it has developed a network of 12 partner organizations in 11 countries. Technical support for the network is provided by the Vrije University Medical Center based in The Netherlands.

CARAM-Asia has collected and produced substantial information on conditions in migration and on factors that increase HIV and AIDS vulnerability of migrant and their families. Through the process of action research, CARAM-Asia has been able to develop responses at the national, regional and international levels to create awareness on the issue of migration and HIV and AIDS as an important area of concern and action.