Health Vulnerabilities of Migrants from Bangladesh

Baseline Assessment

IOM, Dhaka
August 2015

International Organization for Migration (IOM)
আন্তর্জাতিক অভিবাসন সংস্থা (আইওএম)

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour Change Communication
BDT	Bangladeshi Taka
BBS	Bangladesh Bureau of Statistics
BMET	Bureau of Manpower, Employment, and Training
CBS	Central Bureau of Statistics
CESLAM	Centre for the Study of Labour and Mobility
DIC	Drop-in-Centre
EU	European Union
FGD	Focus Group Discussion
FHI	Family Health International
GCC	Gulf Cooperation Council
GOB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
ICDDR,B	International Centre for Diarrheal Disease Research, Bangladesh
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
IHR	International Health Regulations
INGO	International Non-Government Organization
ILO	International Labour Organization
IOM	International Organization for Migration
IRC	Innovative Research & Consultancy, Ltd.
KII	Key Informant Interview
MDG	Millennium Development Goals
NGO	Non-Governmental Organization
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
ToT	Training of Trainers
UAE	United Arab Emirates
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNTDCD	United Nations Technical Department for Cooperation and Development
USAID	United States Agency for International Development
VDC	Village Development Committee
VCT	Voluntary Counselling and Testing
WHA	World Health Assembly
WHO	World Health Organization
WOREC	Women's Rehabilitation Centre

EXECUTIVE SUMMARY

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

Methodology: The study population consisted of departing and returnee migrants (those preparing to leave and those residing in the country of origin for no longer than 12 months following a period of migration aboard for work) and their spouses in Bangladesh. The study employed a mixed-methods approach that combines both quantitative and qualitative methodology. For quantitative data collection, interviews were conducted using a structured questionnaire, while qualitative data was collected through Key Informant Interviews (KII) with relevant government, international organizations and community-based organizations and Focus Group Discussions (FGD) with returnee migrants and their spouses. A multistage cluster sampling technique was used for the quantitative sampling. Qualitative participants were recruited through snowball and network recruitment. Research tools were pre-tested and translations of the tools into Bangla or Bengali languages were validated. Informed consent was sought from all the study respondents and participants before incorporating them under this study.

Results: This study interviewed 424 respondents for the quantitative survey, consisting of 206 departing and 218 returnee migrants; 357 male and 67 female respondents. More than 80 per cent of respondents were 35 years of age or younger, almost two thirds were married. More than 80 per cent of departing migrants and about 50 per cent of returnee migrants had no formal education or having completed primary education only. Relatives were the most prominent source of assistance during the migration process (82% and 77% respectively) for both departing and returnee migrants.

Using a condom for preventing pregnancy was a main concern for sex with regular partners such as spouses and girlfriends or boyfriends (60-84%). Preventing STI or HIV transmission was more important for casual or commercial partners (50%). While abroad, only six per cent (14 respondents) of 218 studied returnees indicated that they ever had sexual intercourse while they were staying abroad. Seven per cent of returnee migrants had experienced forced sexual intercourse while abroad, of which almost all were women.

The majority of Bangladeshi departing and returnee migrants (84%) indicated that health-care services were available in their home communities in Bangladesh, while 66 per cent reported that they could access public health services any time. The majority had access to services at an affordable rate within their communities while just over a quarter of departing and returnee migrants experienced financial difficulties accessing health-care in Bangladesh. Availability of the doctor was the most commonly cited barrier to health-care access among all migrants (56%), followed by unaffordable costs (39%) and long distances (29%). As for HIV and STI services, only twelve per cent were aware of HIV/STI testing and fourteen per cent were are aware of HIV care and treatment services in their communities. Departing migrants showed higher reliance on private facilities while most of returnee migrants relied on government centres at the community level.

Regarding accessing to health services in destination countries, half of the surveyed returnee migrants were aware of places where they could access care and treatment. Government facilities were most commonly mentioned (49%), followed by a private facility (31%). 28 per cent of migrants perceived health-care abroad to be easily affordable or affordable. Among those that sought health-care, the most common form of health-care financing was out-of-pocket payments, with 61 per cent of patients paying health-care services by themselves. Health insurance accounted for only one per cent of all health-care financing; however 12 per cent of returning migrants had insurance.

As respondents of the survey were documented migrants and sampling was coordinated through the Bureau of Manpower, Employment and Training (BMET), a high proportion (87%) of Bangladeshi migrants who participated in the survey underwent a medical examination which is mandatory prior to their departure.

The majority of Bangladeshi migrants who participated in this study perceived themselves not to be at risk of Tuberculosis (TB), HIV, STIs or Hepatitis C, and 85 per cent had no pre-departure health orientation, training or counselling. Because of perceived low risk and costs, migrants generally did not seek health-care upon their return. One third of the returnee migrants did not think or were not unaware that there are some diseases that can be transmitted to their partners or family. Of the 62 per cent of returnees that were aware of communicable diseases, 93 per cent mentioned HIV/AIDS and STIs.

Bangladeshi migrants received health related information mostly from television (87%) followed by health-care facilities or doctors (44%), newspaper and billboard/signboard/poster (both 30%). However, more than a third of them faced difficulties understanding the content. Television, friends/relatives, and newspapers were the main sources of HIV and health information when they were in destination countries. Returnee migrants were generally not exposed to any migrant-targeted health communication materials in the country of destination.

Results from the qualitative study found that there were no health services specifically targeting departing or returning migrants in Bangladesh. According to stakeholders, Government Organizations do not offer curative or palliative health-care services specifically targeting inbound or outbound migrants only. Pre-departure mandatory medical examinations are carried out as a component of bilateral agreements with countries of destination, such as Malaysia or countries of the Gulf Cooperation Council (GCC). Only health facilities located in Dhaka are licensed by GCC to provide medical certificates, which poses a financial and time burden for potential migrants that live in more remote areas. The pre-departure orientation was only provided to regular migrants going through regular recruiting agencies. The present migration policy does not include health issues, while the relatively new health policy of Bangladesh does not cover migrant issues. While the strategic plan for HIV mentions migrants as a vulnerable group, it fails to detail an implementing policy.

Recommendations: The major recommendations from the study include the need for Government of Bangladesh to improve migrant-friendly services for departing and returning migrants, such as tailored sexual and reproductive services and psychosocial counselling. Health-care quality and provider competency requires further development and training, including preventing discrimination towards patients with a migration background. More steps should be taken at the

national level to implement universal health coverage and prevent out-of-pocket expenditures of Bangladeshi migrants while abroad. Government of Bangladesh needs to develop a regulatory mechanism to effectively monitor the activities of private health providers, recruitment agencies, and medical testing centres. More pressure should be applied to employers and recruitment agencies to ensure migrants receive fair, equitable, comprehensive, and acceptable pre-departure health examination and orientations, and health-care in the country of destination. Employers should further ensure adherence to ethical and safe working conditions and comply with international standards of occupational health and safely. Radio and television, including 'Deshi' channels, should be harnessed for effective health communications that encourage health-care seeking. As a foundation for these suggestions, Government of Bangladesh should review the compliance of the ratified global migration related conventions and incorporate health as an essential and 'non-negotiable' component in bilateral agreements. Government of Bangladesh should implement migrant-friendly services through participatory and transparent planning inclusive of migrant and local health provider representatives, and harnesses the guidance and comparative advantages of relevant NGOs.

CHAPTER ONE

INTRODUCTION

1.1 Project background

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

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

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

Bangladesh is a predominantly migrant sending country. According to BMET records from 1976 to 2012, the total number of work permits issued was 8,307,749 (Siddiqui and Sultana, 2012). The health impacts and social consequences resulting from outbound migration flows are substantial and not well explored. Given the likelihood that migration trends will continue to increase in Bangladesh, improved knowledge of the migration and health related challenges that Bangladesh faces is needed in order for the key government ministries to understand the importance of supporting migrants, to reduce health and social disparities and ensure better health outcomes for all categories of migrants.

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

Since 2008, there have been a number of high-level regional meetings and commitments in South and South East Asia to operationalize and implement the WHA Resolution. In July 2010, the Regional Dialogue on the Health Challenges for Asian Labour Migrants was held in Bangkok, bringing together government representatives from thirteen Member States[1] from departments of Labour,

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

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

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

1.2 Purpose of study

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

1.2.1 Specific objectives

Specifically, the objectives of the study were to:

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

1.3 Research methodology

1.3.1 Study design

Based on the findings of the literature review, both qualitative and quantitative methods of data collection were developed to conduct this study. Quantitative data was collected from departing and returnee migrants through a semi-structured questionnaire. For the qualitative research information was collected using Key Informant Interviews (KII) and Focus Group Discussions (FGD) using a wider study population, including departing and returnee migrants, programme personnel, donors, management agencies, and service providers, to gain a more comprehensive understanding of migrant access to health services, process barriers, future direction, national responses, as well as lessons learnt from the existing programmes.

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

1.3.2 Study area

Six major areas with large migrant populations were selected for the study. As determined by the literature review, these sites included major metropolitan areas and rural areas with high levels of migration. Initially, five districts were chosen, namely Dhaka, Chittagong, B-Baria, Tangial, and Comilla. Due to the need to include more female migrants in the study, a sixth area, Manikganj was added.

1.3.3 Sampling scheme

A multistage, cluster sampling technique was used for the quantitative study. Several clusters were selected covering almost an equal number of clusters for departing and returnee migrants. Clusters of returnee migrants were selected using ward-level data on absentee households from the Bureau of Statistics of Government of Bangladesh. Aided by key informants, enumerators identified central points in each cluster with a high prevalence of returnee migrants. From the central point, a bottle was spun and the right hand rule applied to randomly determine household selection.

Health facilities performing pre-departure medical examinations and recruitment agencies were regarded as single clusters for departing migrants. They were selected using a list of health facilities doing medical exams for departing migrants, which was available from government sources. From the list, the required number of clusters were selected using the Probability Proportionate to Size (PPS) method, and respondents, primarily migrant workers, were randomly selected from the selected clusters. If departing migrants were not available in a certain cluster, snowball or chain referral sampling was used to draw more respondents from health centres.

For the qualitative study, departing and returnee migrants were randomly selected from the clusters selected for the quantitative survey to participate in FGDs. Participants for KII were selected at random to include relevant stakeholders, such as health service providers, migration and health officials, relevant government officials, manpower, employment and training officials, NGO officials working with migrants and relevant academic experts.

1.3.4 Participant selection and eligibility criteria

Quantitative research

In this study 424 respondents were interviewed for the quantitative data collection, consisting of 206 departing and 218 returnee migrants. Irrespective of age, gender, labour category and length of migration, the following eligibility criteria applied: departing migrants had to be in or have completed the process of signing a contract, applying for a visa, and/or undergoing a mandatory medical examination prior to departure. Those who planned to migrate but had not yet taken definitive steps to do so were excluded. Returnee migrants had to have returned to Bangladesh within the last 12 months.

Table 1: Distribution of quantitative survey respondents

Target groups	Method	Sample size	Comments/ distribution
Migrants (departing and returnee)	Questionnaire survey	424	30 departing female migrants 176 departing male migrants 37 returnee female migrants 181 returnee male migrants

Qualitative research

Seventeen KII were conducted with relevant key informants. This included health service providers, migration and health officials, government officials, employment and training officials, academic

experts, NGO officials working with migrants, departing, returnee, and cross border migrants, as well as spouses of migrants. In addition, FGDs were held with departing, returnee migrants and spouses of migrants:

Table 2: Distribution of qualitative research respondents

Target groups	Method	Sample size	Comments/ distribution
Migrants and Spouses	Focus Group Discussion	5 FGDs	2 FGDs, departing migrants 2 FGDs, returnee migrants 1 FGD, spouses of migrants
Stakeholders	Key Informants Interview	17 KIIs	2 IOM Health and Migration Officials 2 UN Health Officials (1 ILO and 1 UNHCR official) 2 Manpower, Employment and Training Officials 2 Officials from concerned ministries 2 Migrant's health service providers 2 NGOs or CBOs working with migrants 1 Relevant academician/other stakeholders 4 Inbound migrants (2 Males 2 Females)

1.3.5 Research tool development

Design, pre-testing and training

A semi-structured questionnaire was used for quantitative data collection. A FGD guideline and a checklist for KII were developed for purposes of qualitative data collection.

Research tools were developed by the lead researcher, based in Dhaka, Bangladesh, in consultation with the IOM teams in the Regional Office for Asia and the Pacific in Bangkok, and in the Country Office in Bangladesh. Field researchers were recruited in Bangladesh. The respective field researchers translated the tools into Bangla and Bengali languages. Pre-testing of the questionnaire was conducted to assess its validity and to determine the appropriateness of the translation and database design. Pre-testing was conducted in several households (of returnee migrants) and recruitment centres (for departing migrants) in selected sample area in the study countries.

All tools underwent a review process. A training session was held at IOM's Country Office in Dhaka from 1-3 July 2013 to finalize the sampling scheme and draft data collection tools. The quantitative survey was translated to Bangla and a pilot test was conducted among the target group, in order to check the validity of the questionnaire, difficulties in pitching the questions, difficulties in responding and respondents reaction towards queries.

The pilot test was administered in Dhaka between 10 and 13 July 2013 to twelve interviewees: six departing and six returnee migrants. Departing migrants were selected from health clinics in Dhaka while returnee migrants were selected via convenience sampling. Only minor revisions were required, such as recoding and rephrasing certain questions.

Recruited interviewers had at least two years of research experience, and were trained at the head office of the research consultancy, Innovative Research & Consultancy Ltd (IRC).

1.3.6 Data collection

Data was collected over a period of 20 days between September and October 2013. Eight field researcher teams were deployed overall; five teams for quantitative data collection and three for

qualitative data collection. Each quantitative team consisted of a supervisor and interviewer, who administered the questionnaire via face-to-face interviews with each respondent. A moderator and note-taker carried out the FGDs, making use of the FGD guideline and form. For the KII, an experienced interviewer spoke to each participant separately, guided by the KII checklist. Field-based supervisory visits were conducted, and daily monitoring was carried out by the monitoring desks via telephone by the field research team.

1.3.7 Data management and analysis

Quantitative data

Field supervisors coded the questionnaires, and at least five per cent of the coding was checked and validated by the data manager of the core research team. Open-ended responses were coded into numeric codes, code categories were made mutually exclusive and defined precisely. Coded data were entered into a data entry programme, which was designed to check for consistency and non-eligible or outlying data. Data was then transferred into SPSS, cleaned, labelled, and checked for internal consistency. Data analysis consisted of basic cross tabulations to create frequency tables and graphs. Differences between male and female, returnee and departing migrants, age groups, and professions were presented where appropriate. In some cases, statistical methods, including Chi-square tests and logistic regression, were used for bivariate and multivariate analysis.

Qualitative data

For qualitative data, recordings of FGDs were transcribed into the Bengali languages by the field researchers and then translated into English by experienced translators. The quality of the translation was checked thoroughly by the field research teams. Recordings of KIIs were transcribed and translated by the core research team members. The translated transcripts were then coded manually and using Atlas.ti software, which were then compiled into themes as per the guidelines developed by the lead researcher and IOM.

1.3.8 Ethical considerations

The following steps were undertaken during the study to ensure ethical conduct during the research.

Informed consent, through a generic form incorporated at the beginning of all study tools, was sought from all study participants before participating in data collection; efforts were continuously made to ensure the comfort of participants, including privacy during interviews. The study team followed UNAIDS guidelines for generating data on HIV/AIDS and other infectious diseases (UNAIDS, 1997).

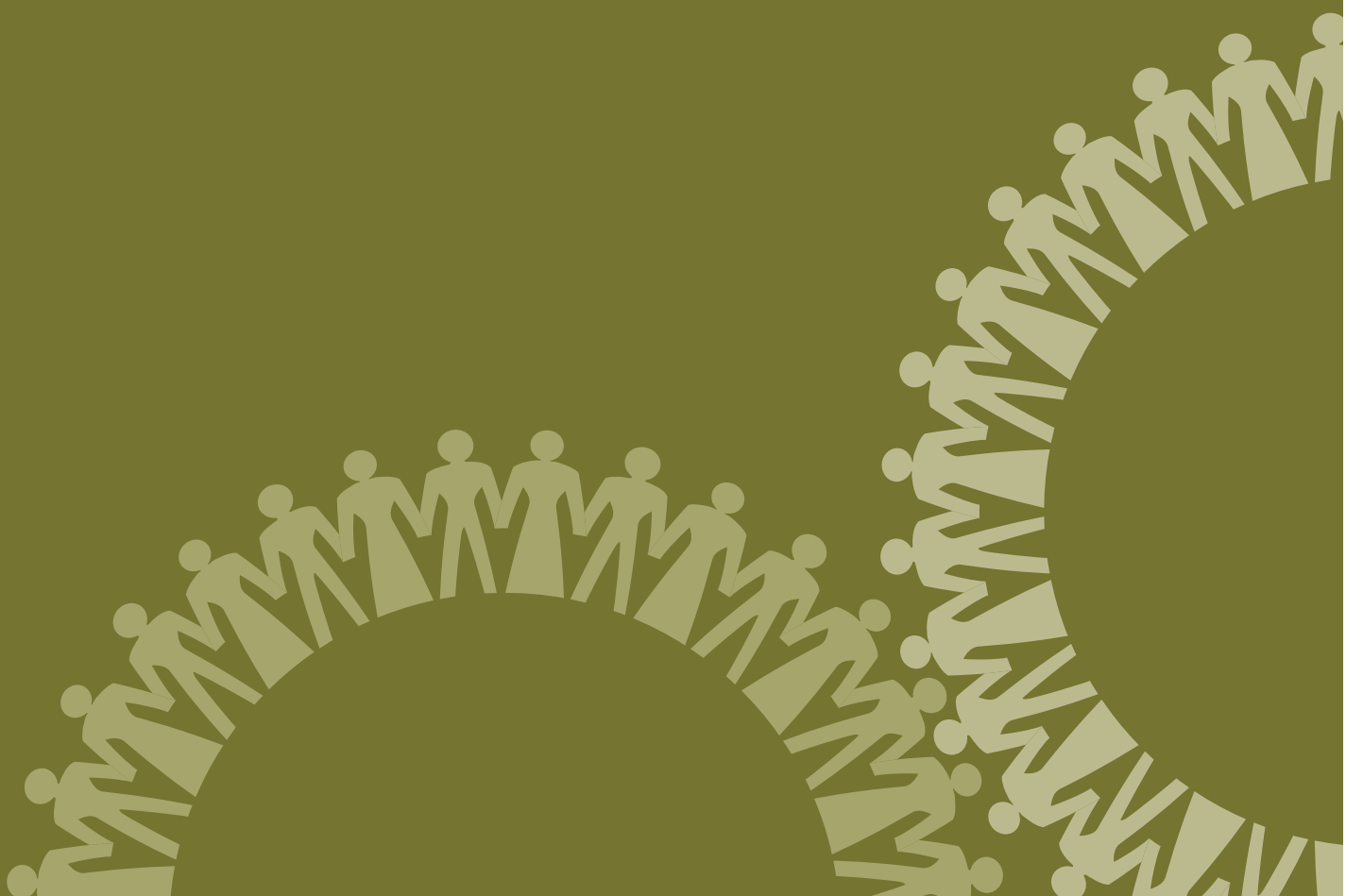
1.3.9 Study limitations

Data collection took place over two weeks in September and October 2013. There were various obstacles that made it difficult to access departing migrants, which limited the recruitment of the desired number of respondents due to coincidence with harvest season and the religious occasions. Especially the sample size of female migrants was quite low which was consistent with the latest statistics in Bangladesh, and therefore the findings need to be interpreted with some caution. Furthermore, as sampling frame was based on BMET list, this study does not capture the experiences of cross-border migrants, undocumented migrants from Bangladesh while living abroad, and those intend to go abroad for the purpose other than employment.

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

CHAPTER TWO

LITERATURE REVIEW



2.1 Labour migration in Bangladesh

Migration out of Bangladesh was first documented in 1976. As a developing country with a 156.6 million population, a growing labour force[3] of approximately 101.8 million people and 4.3 per cent unemployment rate (World Bank, 2013), outbound labour migration continues to provide an important economic option for many people in Bangladesh. While rates of migration were initially low (6,078 registered migrants in 1976), according to BMET records from 1976 to 2012, the total number of work permits issued was 8,307,749 (Siddiqui and Sultana, 2012).

Presently, migrants from Bangladesh are engaged in overseas employment in more than 100 countries. In 2011, it was estimated that about 3 per cent of the total population of Bangladesh (or 4.7 million) was abroad (ADB, 2011). The major receiving countries are: United Arab Emirates, Saudi Arabia, Kuwait, Qatar, Bahrain, Oman, Malaysia, Republic of Korea and Singapore (Islam, 2007). Currently, there is not much information available on situation of Bangladeshi returnee migrants. According to the Socio Economic and Demographic Report (SEDR) from the Bangladesh Bureau of Statistics (BBS) the total number of returnees in 2011 was 99,130. Among them, the highest number of migrants returned from Saudi Arabia (36.3%) followed by United Arab Emirates (26.1%) and Malaysia (6.4%) (Bangladesh Bureau of Statistics, 2011).

About 49 per cent of the total Bangladeshi workforce can be classified as unskilled or less skilled. Among migrants 8.3 per cent have no schooling, 48 per cent have education up to junior secondary, 38 per cent has secondary schooling and only five per cent have post-secondary higher education (BBS, 2011). Bangladeshi male migrant workers mainly work in construction, cleaning, agriculture and service sectors. In 2003, the proportion of female migrants was estimated to be around 1 per cent. Over the last decade, however, this number has increased to approximately 14 per cent. Most female workers migrate as domestic workers but they also work in garment or other manufacturing companies and as cleaners; there is also an undetermined number of irregular female migrants that migrate to India (Jahan, 2014).

Costs to send remittances have been declining, making it more feasible for migrants sending monies back to their country of origin. Remittances sent home by Bangladeshi migrants have emerged as a dominant source of income for over 20 million people in over 4 million households (Buchenau, 2008). Between 2010 and 2014, remittances accounted for 9.2 per cent of GDP or nearly 14 billion USD (World Bank, 2014a).

2.2 Health system in Bangladesh

Bangladesh has a multi-tiered, decentralized health system with three levels of primary care covering all communities, as well as secondary and tertiary health services offered in more urban areas. Following independence in 1971, the health system made the provision of health services to rural populations a strong priority and the country has made great strides in reducing mortality, increasing life expectancy, increasing overall health expenditure and implementing sound health-care infrastructure. The world has been witness to Bangladesh's successes, especially in over-achieving the Millennium Development Goals 4 (maternal mortality) and 5 (under-5 child mortality), however, there exist many structural challenges that prevent the health system from providing comprehensive, free services to all residents (Islam and Biswas, 2014).

[3] *Based on the data from World Bank, approximately 65 per cent of the estimated total populations of Bangladesh in 2013 were between ages 15 to 64 representing the age group of people who could potentially be economically active.*

Among the challenges that Bangladesh's health system faces are current trends of greater health-care privatization, and shortcomings including alleged corruption in government health programming. Over 70 per cent of the population of Bangladesh resides in poor, rural areas. This coupled with high private and public health-care costs make access to health services difficult for the rural population; 60 per cent of health-care expenditures are out-of-pocket (Islam and Biswas, 2014).

A further challenge is the limited number of public facilities. The population of Bangladesh is expected to reach 218 million by 2030 presenting an ever present need for the increase in health-care facilities to address the needs of the fast growing population. The country also faces lack of essential medical supplies and medication, sparse medical workforce, inadequate financial resources and political instability, among others (Islam and Biswas, 2014).

Regarding health services targeting pre-departure migrants in Bangladesh, these services are provided for particularly by private providers. INGOs and NGOs are not widely available. However, IOM Dhaka has a separate Migration Health Unit through which it conducts health assessments primarily for migrants applying for visas to the UK, US, Australia and Canada. IOM Dhaka has significant experience in Tuberculosis (TB) management and has been designated a TB Direct Observed Treatment (DOT) centre by the National TB Control Programme in Bangladesh (IOM, 2013).

2.3 Health vulnerabilities of Bangladeshi migrant populations

In an ICDDR,B and IOM study, findings indicated that migrants had a worse physical and mental health status compared to potential migrants (ICDDR,B, 2008). Approximately 60 per cent of the migrants experienced injuries in the workplaces while they were abroad; 34 per cent experienced physical disability. Employers bore treatment cost of only 10 per cent and only 6 per cent were covered by health insurance or provided medical allowances (Saifi and Mels, 2007).

Migrant workers account for a significant number of HIV cases. It has been estimated that 51 per cent of the 219 confirmed HIV cases in 2002 were returning migrant workers. In 2004, 57 of the 102 newly reported HIV cases were returning migrants (UNDP, CARAM Asia, CLMC, 2009).

A study conducted by UNDP in Bangladesh clearly revealed that only nine per cent of migrants interviewed had attended pre-departure orientation organized by BMET (UNDP, 2008). Of the Bangladeshi domestic workers interviewed in destination countries, 96 per cent claimed they did not receive training on HIV before leaving Bangladesh. Half had heard of HIV through the media or from co-workers, but none had in-depth knowledge of HIV prevention or safe sex practices.

In the destination countries, women face numerous hardships, including irregular payment of salaries, long working hours and physical and sexual abuse. Even for some of the more common illnesses, they seldom have the time, knowledge or resources to visit a physician, and so tend to treat themselves for maladies such as back pains, colds, headache, fever, gastric pain and menstrual cramp. All research participants in the three destination countries said that they had no knowledge of support services provided either by their nearest Bangladesh embassy or by other agencies (UNDP, 2009).

In some destination countries such as the United Arab Emirates and Bahrain, it is a crime for unmarried women to be pregnant, which is of concern, especially in circumstances where migrant women are subjected to sexual abuse. Since abortion is officially prohibited in many Arab States, some migrant women will take the risk of unsafe, clandestine abortions. In a study conducted by

UNDP regarding HIV vulnerabilities faced by women migrants from Bangladesh to Arab states all research participants included in the study said that they had no knowledge of support services provided either by their nearest Bangladesh embassy or by other agencies. Very few domestic workers approached the embassy for support, even when they needed it (UNDP, 2009).

2.4 Policy on migration health in Bangladesh and regional initiative

Rapid population growth and development, in addition to current migration dynamics and trends, such as increasing female participation in migration present particular challenges for policy development in the areas of migration and the health of migrants. However, the national policies to address health of migrants and protect their rights to health have not yet been developed in Bangladesh.

In 2011, the Government of Bangladesh hosted the Fourth Ministerial Consultations of the Regional Consultative Process on Overseas Employment and Contractual Labour for Countries of Origin in Asia (the Colombo Process) in Dhaka. The agenda was "Migration with Dignity". In the declaration they recommended promoting rights welfare and dignity, services and capacity building, emergency response and emerging issues and enhance dialogue and cooperation (IOM, 2011).

CHAPTER THREE

STUDY FINDINGS

3.1 Quantitative results

3.1.1 Characteristics of study population

Demographic profile. A total of 424 respondents were interviewed for the quantitative survey, consisting of 206 departing and 218 returnee migrants who have returned from work abroad. Of the respondents, 357 were men and 67 were women. As shown in Table 3 below, more than 80 per cent of respondents were 35 years of age or younger. Departing migrants were younger compared to the returnees, with more than a quarter aged under 25 (p=0.000) (Appendix 1.1). Almost two thirds of the respondents were married.

Table 3: Study population demographics

	Total		Departing		Returnees	
	%	n	%	n	%	n
Gender						
Men	84.2%	357	85.4%	176	83.0%	181
Women	15.8%	67	14.6%	30	17.0%	37
Age						
Less than 25	18.0%	76	28.2%	58	8.3%	18
25 to 35	64.1%	272	63.5%	131	64.6%	141
36 to 50	17.2%	73	8.3%	17	25.7%	56
Above 51	0.7%	3	0.0%	0	1.4%	3
Marital status						
Never married	35.1%	149	40.8%	84	29.8%	65
Married	64.1%	272	58.2%	120	69.7%	152
Widowed/ Divorced/ Separated	0.7%	3	1.0%	2	0.5%	1
Highest level of education						
No formal education	14.4%	61	14.1%	29	14.7%	32
Below primary	16.8%	71	26.2%	54	7.8%	17
Primary	22.0%	140	40.8%	84	25.7%	56
Secondary	32.5%	138	16.5%	34	47.7%	104
College/university	3.3%	14	2.4%	5	4.1%	9
Ease of writing among those had below primary or primary education						
Easily	48.2%	131	52.1%	87	41.9%	44
With difficulty	22.4%	61	23.4%	39	21.0%	22
Not at all	24.3%	66	18.0%	30	34.3%	36
Number of people in family						
1 to 3	90.1%	385	94.2%	194	87.6%	191
4 to 6	8.3%	35	5.8%	12	10.6%	23
Above 6	1.0%	4	0.0%	0	1.8%	4
Family Average Monthly Income (in BDT with USD based on Forex Rates of June 2013)						
5,001-10,000 BDT (65 – 130 USD)	48.8%	207	63.1%	130	35.3%	77
10,001-20,000 BDT (130 – 258 USD)	33.5%	142	30.6%	63	36.2%	79
20,001-30,000 BDT (258 – 388 USD)	11.1%	47	4.9%	10	17.0%	37
30,001+ BDT (388+ USD)	6.6%	28	1.5%	3	11.5%	25
Total		424		206		218

Regarding education and literacy, 42 per cent of the departing migrants had limited education, ranging from having completed primary education to no formal education at all. More returnees were found to have a higher level of education (22%). In total, just under half of these individuals said they could read or write a simple letter easily, and a remaining quarter could not read or write

at all. Most of the Bangladeshi migrants went abroad as labourers followed by domestic workers and construction workers (Figure 1).

Departing migrants were mostly from a lower income group. 63 per cent of the departing migrants claimed to have had an average family monthly income of BDT 10,000 or less. In comparison, 18 per cent of departing and 28.5 per cent of the returnee migrants received a monthly family income of more than BDT 20,000 (Table 1) showing that returnee migrants have relatively higher family income. (Appendix 1.1).

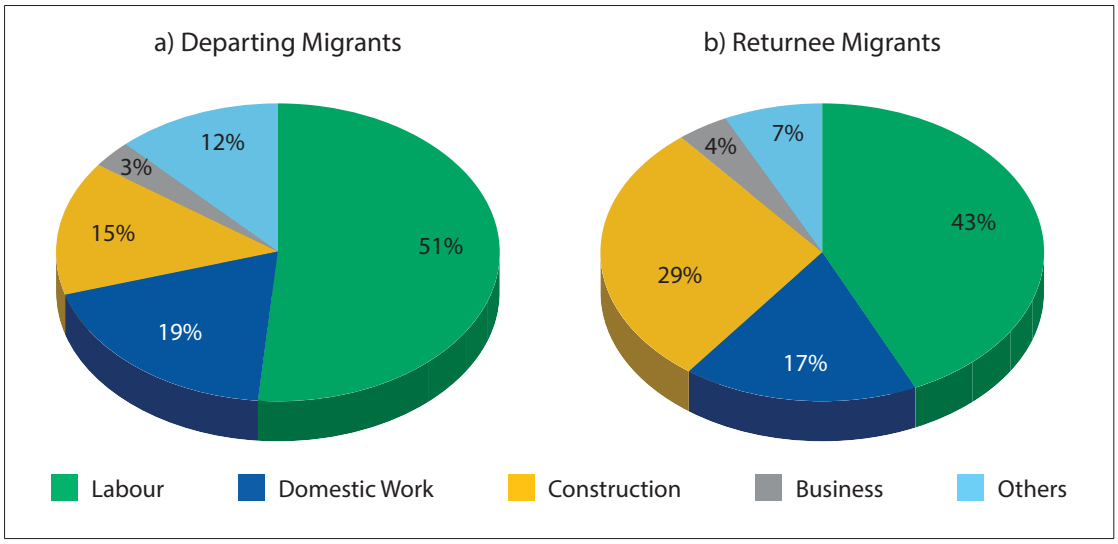


Figure 1: Types of employment by departing and returnee migrants

Migration profile. The Middle East was the primary destination region for 99 per cent of departing migrants, and the most recent region of work for 79 per cent of returnee migrants (Figure 2). Among the countries in the region, Oman was the most popular country for departing migrants (64%), followed by Bahrain (16%) and Dubai 10%); while Saudi Arabia was the most popular for returnee migrants (24.3%), followed by the United Arab Emirates (25%) and Singapore (12%). The full list of countries with the corresponding distribution of respondents is shown in Appendix 1.2 of this report.

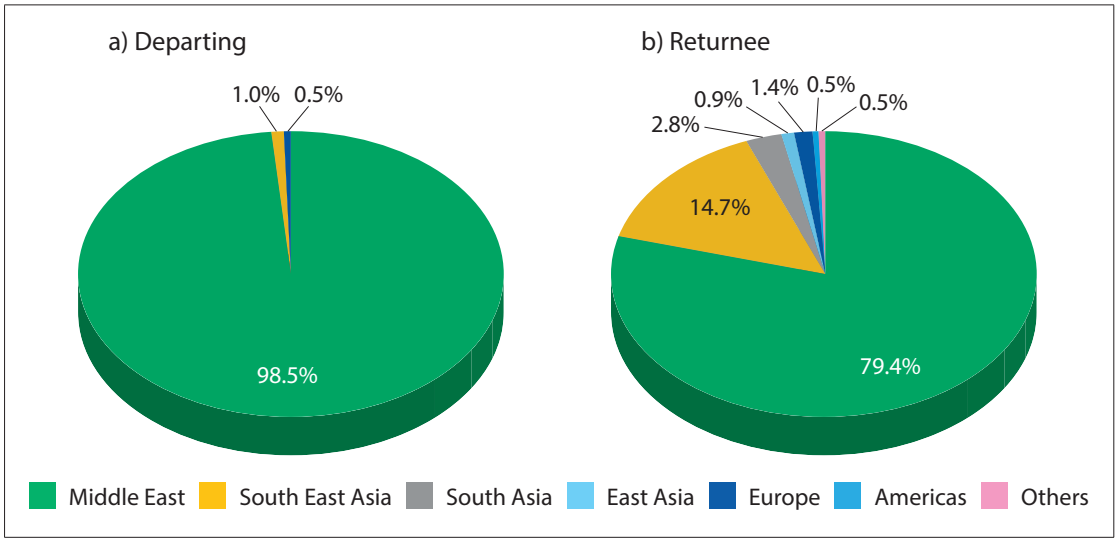


Figure 2: Intended or past country of work for a) Departing migrants and b) Returnee migrants

Frequently, departing migrants planned to stay in the country of destination between one to two years (47%). This preference was particularly strong among female departing migrants (80%) compared to male departing migrants (42%) who want to stay longer. The majority of returnee spent more than 2 years (38%) with 12 % of migrants staying less than 12 months. Women tend to spend less time abroad (28% under 12 months compared to 8% of men), while men were more likely to spend more than 2 years (43% compared to 14% of women). See Table 4 for full details.

Table 4: Planned and time spent abroad for work by departing and returnee migrants

	All		Male		Female	
	%	n	%	n	%	n
Departing migrants: Expected length of stay in most recent destination country						
12 months	1.0%	2	1.1%	2		0
12 - 24 months	47.1%	97	41.5%	73	80.0%	24
24 - 48 months	29.6%	61	32.4%	57	13.3%	4
More than 48 months	22.3%	46	25.0%	44	6.7%	2
Total		206		176		30
Returnee migrants: Length of stay in most recent destination country						
12 months	11.9%	26	8.3%	15	29.7%	11
12 - 24 months	23.9%	52	19.3%	35	45.9%	17
24 - 48 months	26.1%	57	29.3%	53	10.8%	4
More than 48 months	38.1%	83	43.1%	78	13.5%	5
Total		218		181		37

For both departing and returnee migrants, relatives were the most prominent source of assistance during the migration process (82% and 77% respectively; see Figures 3 and 4). This is followed by self-reliance for both departing and returnee migrants, but the group differed between local brokers or friends as their third common source of assistance. Local brokers were more common for returnee migrants (22%) compared to departing migrants (8%), particularly among returnee female migrants (60%). The vast majority of departing female migrants (93%) claimed to have had assistance from relatives, unlike their female? returnee counterparts (43%).

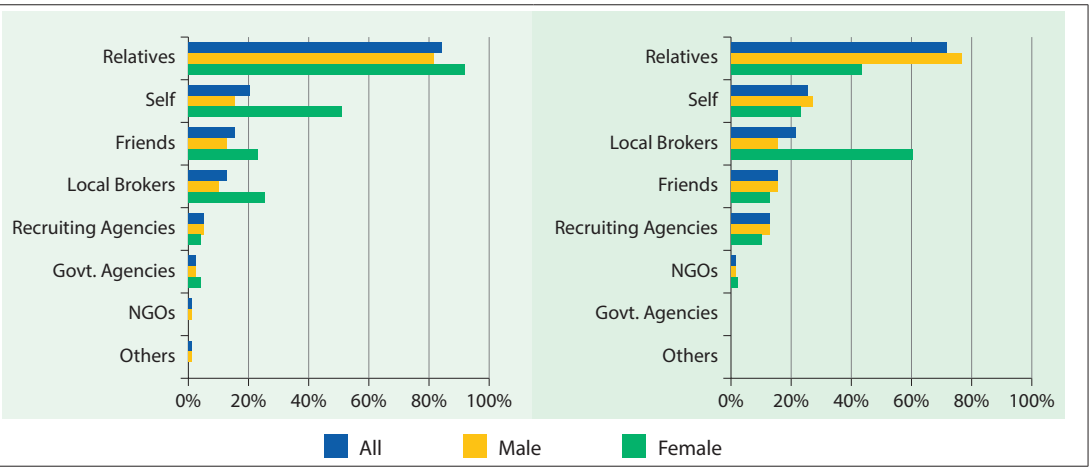


Figure 3: Sources of assistance for departing migrants during the pre-departure migration process

Figure 4: Sources of assistance for returnee migrants during the pre-departure migration process

The majority of departing migrants (67%) stated that they had not experienced any particular burdens. Of those departing migrants that indicated having experienced burdens, "financial arrangements" was the most prominent response (25%) (Figure 5). Other barriers mentioned were health examination (12%), bribes to authorities (9%), as well as abuses (5%) and discrimination (2%). Men appeared to have better experiences, with more men reporting no burdens (70% compared to 47% of women), and more women reporting all other barriers.

17% of returnee migrants stated that they had not experienced and particular burdens throughout the process of migration. Like departing migrants financial difficulties was the predominant burden (73%), followed by "bribes to the authorities" (18%) and "health examination" (13%) (Figure 6). Furthermore, fewer returnee male migrants reported no burden (9.9%) compared to 51.4 per cent of females.

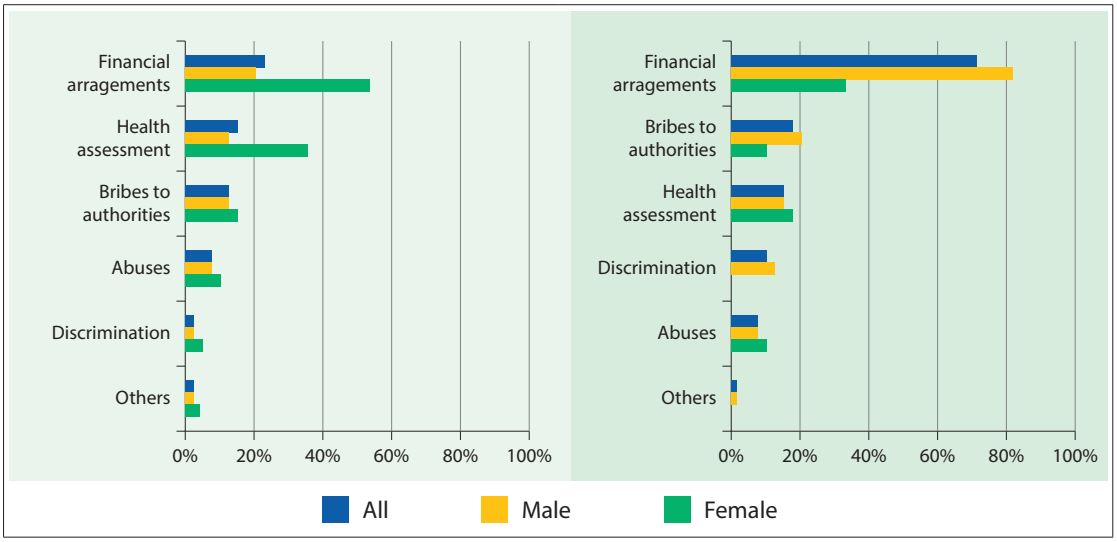


Figure 5: Burdens reported by departing migrants during the pre-departure migration process

Figure 6: Burden reported by returnee migrants during the pre-departure migration process

Among the returnee migrants, 33 per cent had returned because their contract had ended, while 24 per cent were on leave and 22 per cent returned for personal reasons. Nine per cent were deported and seven per cent returned earlier than planned due to early termination of contract. 3 of 4 (75%) respondents indicated that they were planning to travel abroad for work in the future. This percentage was higher for male returnee migrants (79%) than female returnee migrants (49%). See Table 5 for full details.

Table 5: Reasons for return and mobility patterns of returnee migrants

	All		Male		Female	
	%	n	%	n	%	n
Reasons for return to Bangladesh *						
End of contract	32.6%	71	34.3%	62	24.3%	9
Coming for leave	23.9%	52	24.9%	45	18.9%	7
Personal reasons	21.6%	47	20.4%	37	27.0%	10
Deported	9.2%	20	10.5%	19	2.7%	1
Early termination of contract	7.3%	16	8.8%	16	0.0%	0
Political unrest	0.5%	1	0.6%	1	0.0%	0
Others	7.3%	16	3.3%	6	27.0%	10

	All		Male		Female	
	%	n	%	n	%	n
Number of previous travels abroad for work						
Once	57.3%	125	53.0%	96	78.4%	29
2 – 3 times	34.4%	75	38.1%	69	16.2%	6
4 – 5 times	5.5%	12	5.5%	10	5.4%	2
More than 5 times	2.8%	6	3.3%	6	0.0%	0
Intention to travel abroad again						
Yes	73.4%	160	78.5%	142	48.6%	18
No	26.6%	58	21.5%	39	51.4%	19

** Multiple choice, does not add to 100%*

3.1.2 Health risks and vulnerabilities

Health profile and health-care seeking behaviour. About 30 per cent of the interviewed migrants had fallen ill in the past 6 months (23% departing; 34% returnee migrants). As shown in Figure 7, among the returnees who had presented at a health-care centre when they most recently felt ill in their destination countries, half of the respondents indicated minor health problems as the cause, followed by occupational hazards (21%), and mental illness (14%).

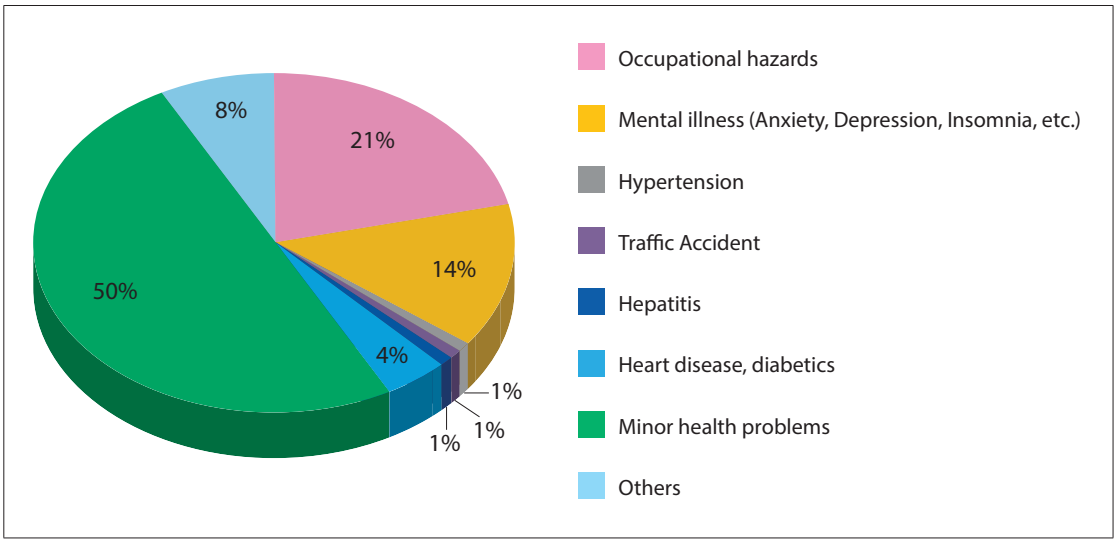


Figure 7: Illnesses experienced abroad, as % of returnee migrants who fell ill in the destination country

When asked about specific conditions, occupational hazards, non-communicable diseases, sexually transmitted infections (STI), and mental health problems were reported by 21 per cent, 8 per cent, 7 per cent, and 6 per cent of migrants respectively. Occupational hazards were experienced by more men than women, however as shown in Appendix 1.3 this difference was much more prominent among departing migrants (19% female versus 25% male among returnee, and 3% female versus 19% male departing). Returnee migrants appeared to have a more frequent history of each disease or condition than departing migrants. For example, 16 per cent of returnee and 0.5 per cent of departing migrants reported experiencing a non-communicable disease (Figure 8; Appendix 1.5).

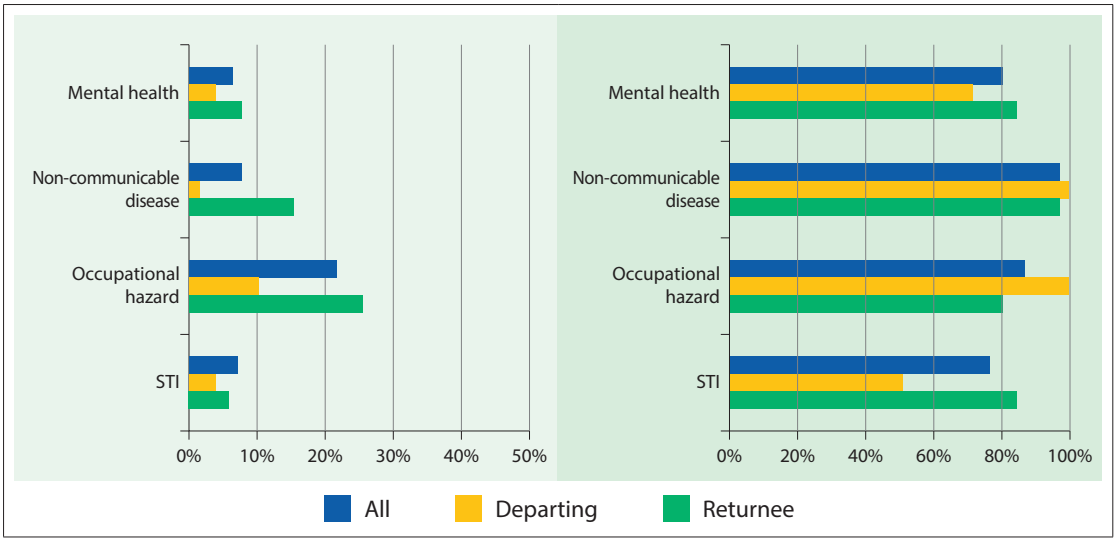


Figure 8: Migrants who reported history of non-communicable disease, mental health problem, occupational hazard, or STI

Figure 9: Migrants who sought healthcare due to a non-communicable disease, mental health problem, occupational hazard, or STI

Among the 29 per cent of migrants who reported to have had medical conditions in the last six months, health-care seeking was 79 per cent for those who had STIs, 87 per cent for occupational hazards, 80 per cent for mental health problems, and 97 per cent for non-communicable diseases (Figure 9; Appendices 3.3-3.5). Doctors, clinics and or hospitals were the most commonly visited facilities for all of these conditions; however local alternatives such as shops or pharmacies or village quacks were also mentioned (Appendices 3.3-3.5).

Sexual behaviour and condom use. Of those migrants who reported being sexually active (Figure 10), 88 per cent had one partner within the past 6 months (Figure 11). As shown in Table 6, these partners mostly consisted of spouses and girlfriends or boyfriends; 5 per cent indicated they had solicited sex from commercial sex workers. Commercial sex workers were only reported by men and it was more common among departing than returnee in the past 6 months.

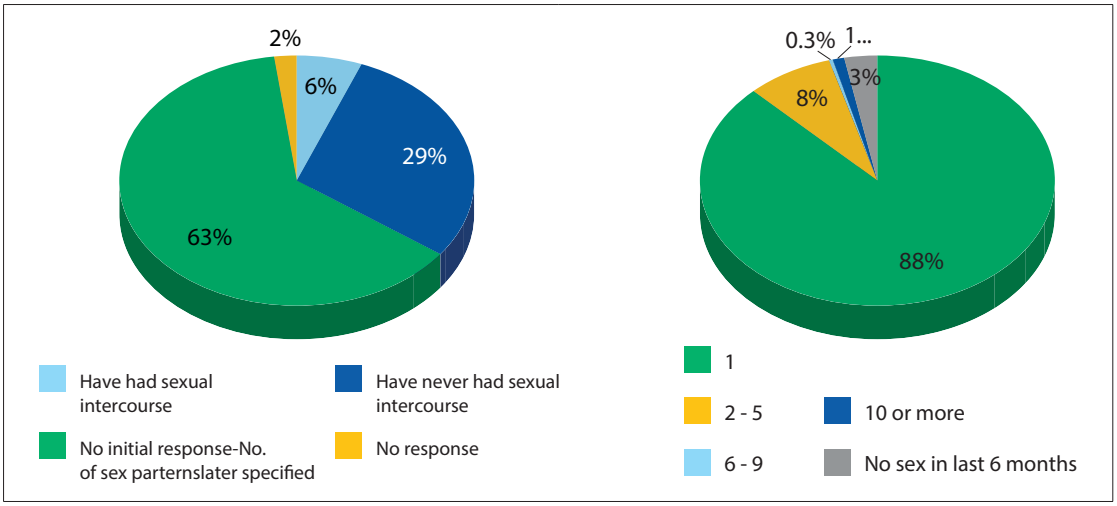


Figure 10: Migrants who have had sexual intercourse (n=424)

Figure 11: Number of sexual partners in the last 6 months (n=293)

Table 6: Sex partners reported for all departing and returnee migrants who had sex in the past 6 months (multiple answers possible) (n=293)

	All		Departing migrants						Returnee migrants					
			All		Male		Female		All		Male		Female	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Spouse	88.4%	267	85.2%	121	81.7%	94	100.0%	27	91.3%	146	92.2%	119	87.1%	27
Girlfriend/boyfriend	6.6%	20	8.5%	12	10.4%	12	0.0%	0	5.0%	8	5.4%	7	3.2%	1
Commercial sex worker	5.3%	16	8.5%	12	10.4%	12	0.0%	0	2.5%	4	3.1%	4	0.0%	0
Friend	2.0%	6	3.5%	5	4.3%	5	0.0%	0	0.6%	1	0.8%	1	0.0%	0
Relative	1.0%	3	2.1%	3	2.6%	3	0.0%	0	0.0%	0	0.0%	0	0.0%	0
Casual Acquaintance	0.3%	1	0.7%	1	0.9%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0
Other	1.0%	3	0.0%	0	0.0%	0	0.0%	0	1.9%	3	0.0%	0	9.7%	3
Total		302		142		115		27		160		129		31

Condom use among migrants. Unsurprisingly, condom is reported to be highest during sex with commercial sex workers, with 100 per cent of those who had sex with commercial sex workers in the past 6 months among both departing and returnee migrants indicating they had used a condom at last sex (Figure 12); and 94 per cent reported "always" using a condom with a commercial sex worker (Figure 13). Condom use with friends was second highest, followed by condom use with "other partners" and spouses. It appears that condom use was slightly higher among returnee migrants, although this difference is minimal.

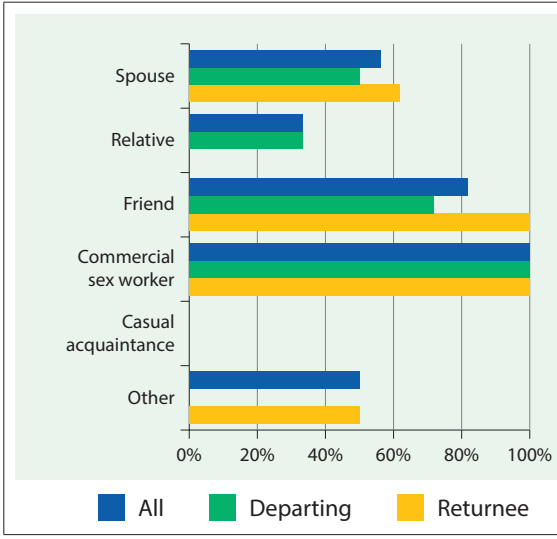


Figure 12: Respondents that used a condom at last sex by partner type, among migrants that had sex in the past 6 months (n=293)

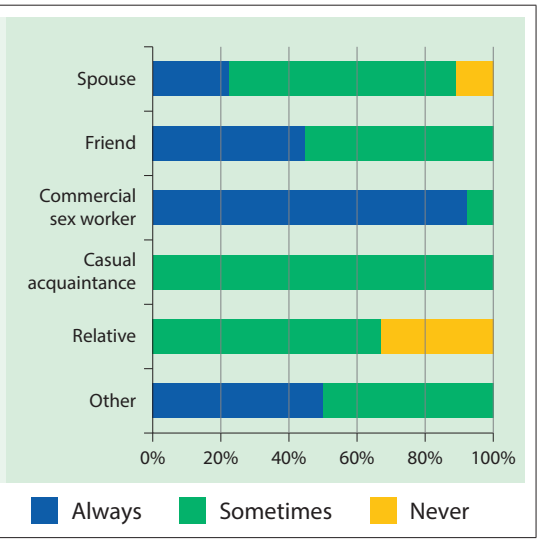


Figure 13: Frequency of condom use by partner type, among all migrants that had sex in the past 6 months (n=293)

There are no strong patterns regarding reasons for condom use with different partners. As demonstrated in Table 7, preventing pregnancy was a stronger concern for sex with regular partners such as spouses and girlfriends or boyfriends compared to sex with sex workers or casual acquaintances. Preventing STI or HIV transmission was also conversely more important for casual or commercial partners. However, the low denominator size makes comparison difficult.

Table 7: Reasons for using a condom by partner type, among those who had sex in the past 6 months (multiple answers possible) (n=293)

	Spouse		Girlfriend or boyfriend		Friend		Sex worker		Casual acquaintance		Relative	
Prevent pregnancy	84.3%	225	65.0%	13	60.0%	4	37.5%	6	0.0%	0	66.7%	2
Prevent STI/STD	11.2%	30	20.0%	4	0.0%	0	18.8%	3	100.0%	1	0.0%	0
Prevent HIV	12.0%	32	25.0%	5	16.7%	1	31.3%	5	0.0%	0	0.0%	0
Other	0.4%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0
Total		267		20		6		16		1		3

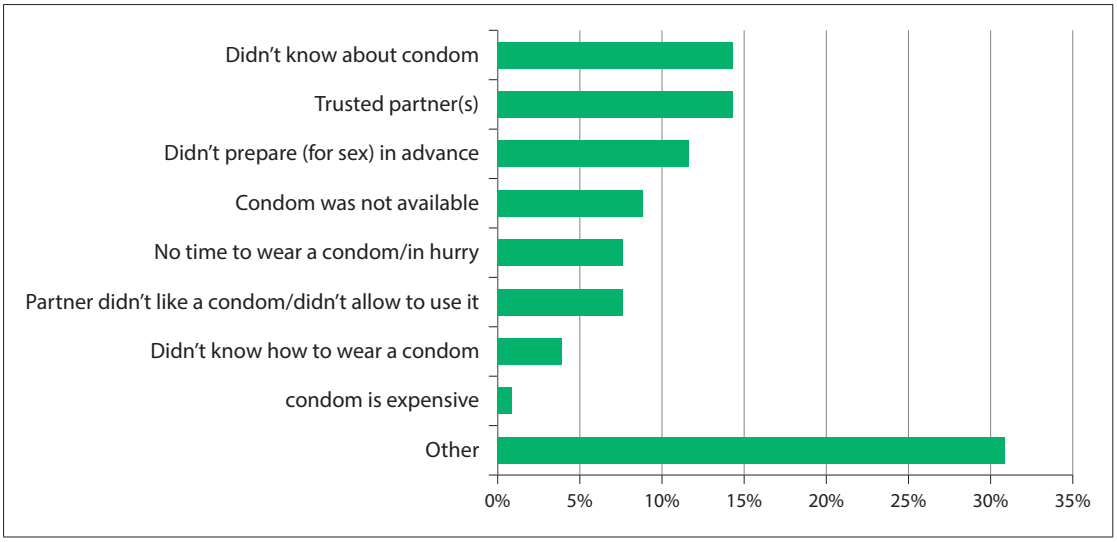


Figure 14: Reasons for not using condoms at last sex

Not knowing about condoms and trust in one's partner were the most common reasons reported for not using a condom, reported by 14 per cent of those who had not used a condom at last intercourse respectively (Figure 14). Poor preparation, including lack of condom availability, was also cited. More than 30 per cent of respondents cited "other" reasons, which were not further investigated.

Sexual behaviour and condom use in country of destination. Only 6 per cent (14 people) of returnees included in the study indicated that they had had sexual intercourse while abroad (Figure 15). Of those who had sexual intercourse abroad, 54 per cent (8 people) had one partner; and 39 per cent reported having had between 2 and 5 partners (Figure 16). These respondents who reported sexual intercourse with different partners, reported that their partner were spouses, friends, commercial sex workers, and girlfriends or boyfriends.

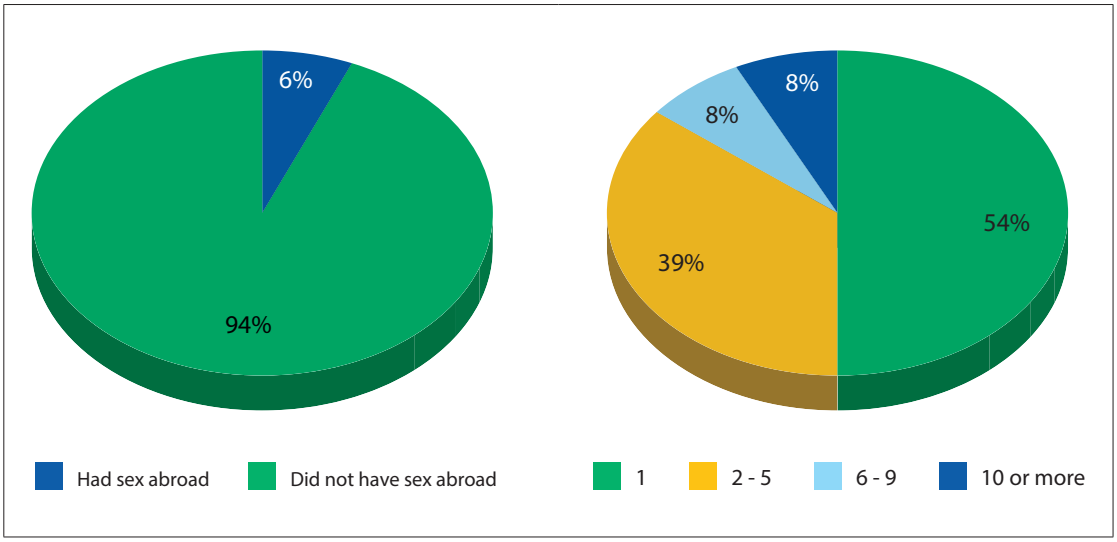


Figure 15: Percent of returnee migrants who had sexual intercourse in the country of destination

Figure 16: Number of sexual partners in country of destination among those had sexual intercourse while abroad (n=14)

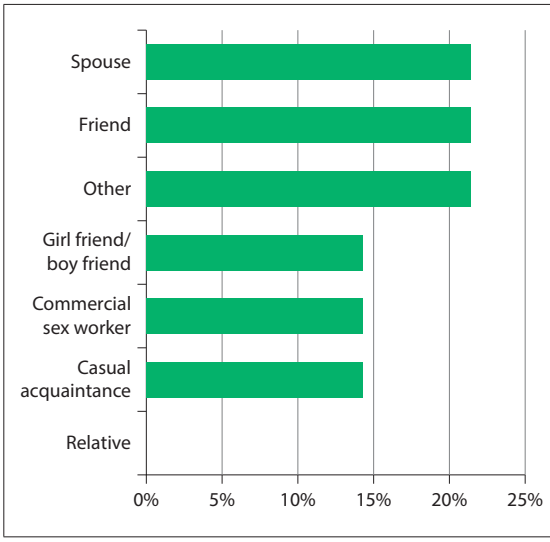


Figure 17: Returnee migrants who used a condom at last sex by partner type (in country of destination)

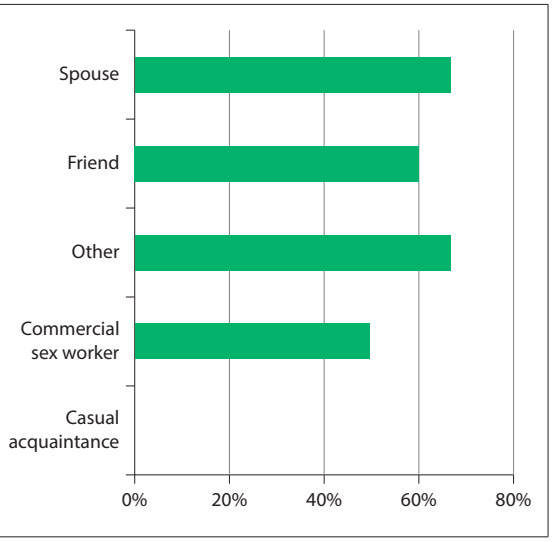


Figure 18: Sexual partners, among returnee migrants who had sex in the country of destination (n=14)

Sexual violence in country of destination. Seven per cent of returnee migrants experienced forced sex while abroad, of which almost all were women (38% of female returnee migrants). The same percentage knew of someone else who had experienced sexual violence or were abuse while abroad. Of these individuals, colleagues were the most common perpetrators, followed by employers and friends. See Table 8 for full details.

Table 8: Sexual abuse and violence experienced by male and female returnee migrants

	Returnee migrants					
	All		Male		Female	
	%	n	%	n	%	n
% of migrants who experienced sexual violence abroad (n=218)						
Have experienced sexual violence	7.3%	16	1.1%	2	37.8%	14
Have not experienced sexual violence	91.7%	200	98.3%	178	59.5%	22
Don't remember	0.9%	2	0.6%	1	2.7%	1
% of migrants who know of someone who has experienced sexual violence or abuse abroad (n=218)						
Know of someone	7.3%	16	2.2%	4	37.8%	14
Do not know of someone	83.5%	182	87.8%	159	59.5%	22
Don't remember/know	9.2%	20	9.9%	18	2.7%	1
Reported perpetrators of sexual violence while abroad (n=16)						
Colleague	62.5%	10	50.0%	2	66.7%	8
Friend	18.8%	3	75.0%	3	0.0%	0
Employer	25.0%	4	0.0%	0	33.3%	4
Other	12.5%	2	25.0%	1	8.3%	1

Substance abuse. A minority (3%) of respondents or 11 migrants had used drugs in the past 12 months, and marijuana (*ganja)* was the main drug reported. "Other" unspecified drugs were also popular. Only 1 person had injected drugs in the past year (Appendix 1.6).

3.1.3 Knowledge of health risks and prevention including HIV/AIDS

General health knowledge. Among returnee migrants, 37.6 per cent did not believe or were not unaware that there are diseases that can be transmitted to their partners or family. Of those that were aware (62.4%), 93.4 per cent mentioned HIV/AIDS and STIs followed by Tuberculosis (11%), and malaria (11%) (Table 9).

Table 9: General health knowledge among returnee migrants

	All		Male		Female	
	%	n	%	n	%	n
Returnee migrants that believe diseases can be transmitted from them to their partners and family (n=218)						
Yes	62.4%	136	69.6%	126	27.0%	10
No	19.7%	43	16.0%	29	37.8%	14
Don't know	17.9%	39	14.4%	26	35.1%	13
Communicable diseases identified among those disease can be transmitted from them to their partners and family*						
HIV/AIDS	93.4%	127	95.2%	120	70%	7
STIs	4.4%	6	4.0%	5	10.0%	1
TB	11.0%	15	10.3%	13	20.0%	2
Malaria	24.3%	33	23.8%	30	30.0%	3
Other	1.50%	2	0.8%	1	10.0%	1

* Total does not add to 100% due to multiple choices allowed

HIV/AIDS knowledge. When asked specifically, 86 per cent indicated that they had heard of HIV and 96 per cent had heard of AIDS. Awareness of HIV/AIDS was slightly higher among returnee migrants.

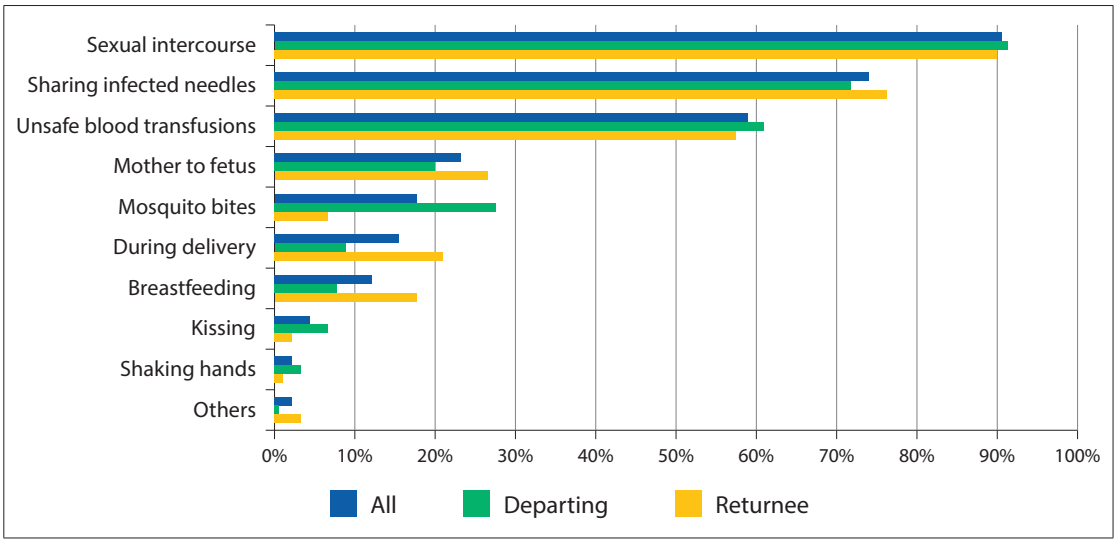


Figure 19: Known or believed causes of HIV transmission, as % of migrants familiar with AIDS

When asked about what they believed caused HIV infection, sexual intercourse was the most often mentioned means of transmission for all respondents, followed by sharing infected needles and unsafe blood transfusions (Figure 19). There was poor knowledge of mother-to-child transmission, with only 23 per cent recognizing the risk of transmission during pregnancy, and 15 per cent aware of risk during delivery. Misconceptions prevailed, namely the idea that mosquitoes can transmit HIV, which was mentioned by 17 per cent of all respondents, (28% departing; 7% returnee).

Perceived risk of contracting infectious disease. The majority of migrants perceived themselves not at risk for Tuberculosis, HIV, STIs or Hepatitis C. However, approximately a third of migrants reported not knowing their risk, which suggests poor understanding of these diseases (Figure 20). Returnee migrants were less likely to say they did not know, and more likely to say they were not at risk.

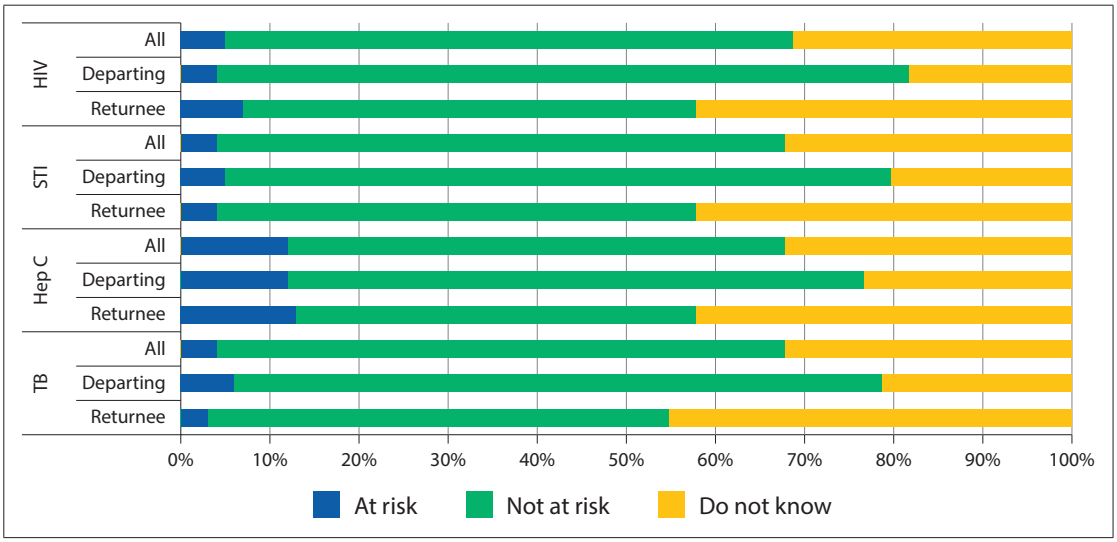


Figure 20: Perceived risk of Tuberculosis, STIs, HIV, and Hepatitis C among migrants

Past history of testing for Tuberculosis, STIs, HIV, and Hepatitis C ranged from 26 per cent of all migrants for TB, to 47 per cent of all migrants for Hepatitis C (Figure 21). Departing migrants appeared to have better testing history than returnee migrants.

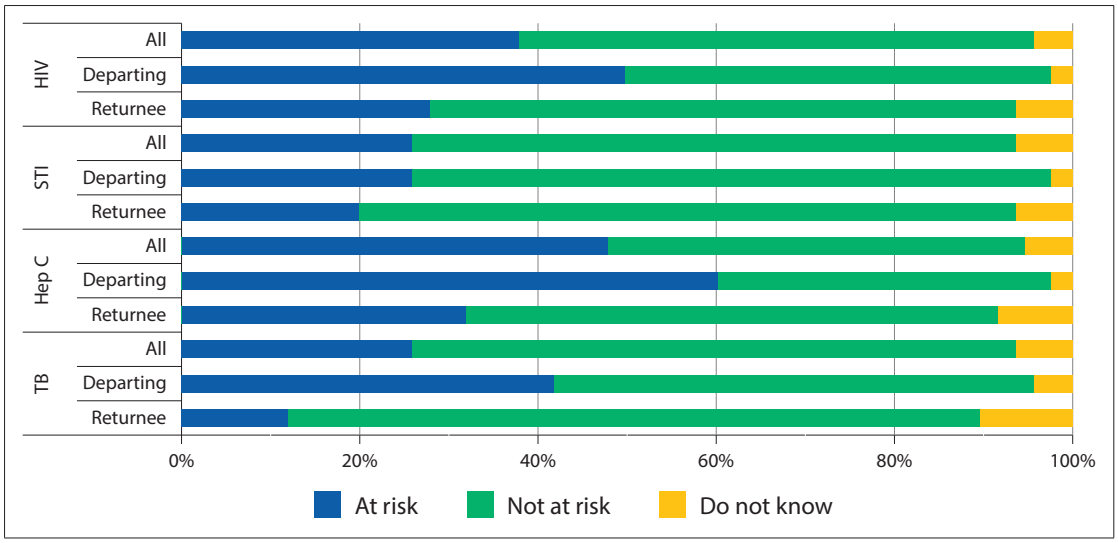


Figure 21: Past history of testing for Tuberculosis, STIs, HIV, and Hepatitis C among all migrants

Knowledge of health facilities followed similar patterns of test history, with lower knowledge of STI and TB test facilities reflecting lower test rates (Figure 22).

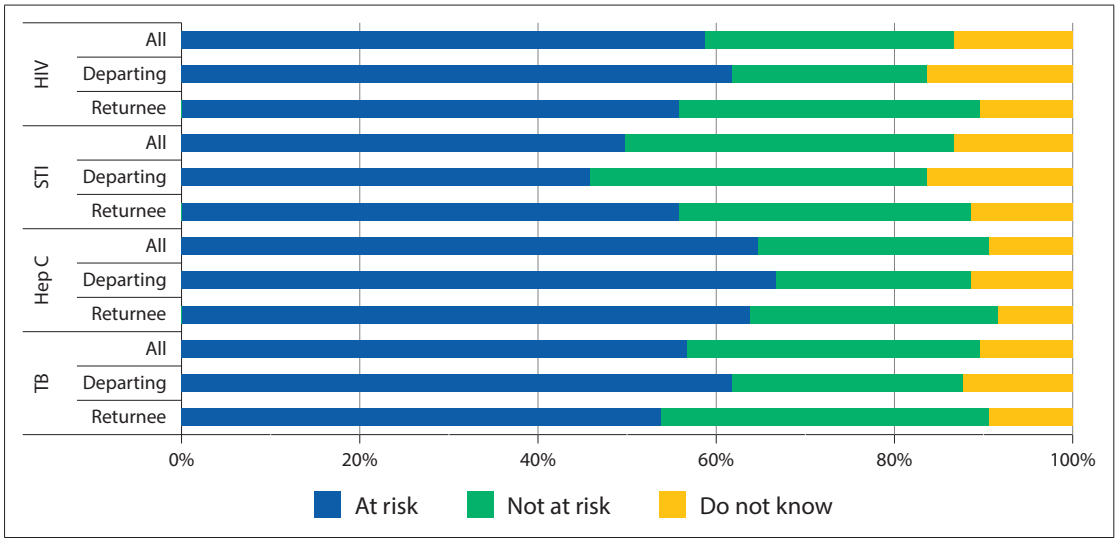


Figure 22: Knowledge of testing facilities for Tuberculosis, STIs, HIV, and Hepatitis C among all, departing, and returnee migrants

Pre-departure health orientation. Although pre-departure orientation is mandatary for labour migrants, only 15 per cent of migrants had received a health orientation or training prior to their departure from Bangladesh for destination countries for work, as observed by 23 per cent of returnee migrants and 7 per cent of departing migrants.

Orientations most frequently covered general health, and were mentioned by 76 per cent of migrants who attended an orientation, followed by mental health (51%), sexual harassment (37%), and HIV/AIDS (27%). Occupational hazards were only mentioned by 13 per cent of migrants who had had a health orientation. Employers or agencies were the primary providers of health orientations (52%), although the government and NGOs were also mentioned. See Table 10 for full details.

Table 10: Health orientations among migrants

	All		Departing migrants						Returnee migrants					
			All		Male		Female		All		Male		Female	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Migrants who went through a health orientation during the process of migration														
Yes	14.9%	63	6.8%	14	2.3%	4	33.3%	10	22.5%	49	19.3%	35	37.8%	14
No	85.1%	361	93.2%	192	97.7%	172	66.7%	20	77.5%	169	80.7%	146	62.2%	23
Total		424		206		176		30		218		181		37
Organizer of health orientation														
Employer/Agency	79.4%	50	85.7%	12	75.0%	3	90.0%	9	77.6%	38	77.1%	27	78.6%	11
GO	11.1%	7	0.0%	0	0.0%	0	0.0%	0	14.3%	7	14.3%	5	14.3%	2
NGO	7.9%	5	14.3%	2	25.0%	1	10.0%	1	6.1%	3	5.7%	2	7.1%	1
Other	1.6%	1	0.0%	0	0.0%		0.0%	0	2.0%	1	2.9%	1	0.0%	0
Topics discussed during health orientation*														
General Health	76.2%	48		14	100.0%	4	100.0%	10	69.4%	34	65.7%	23	78.6%	11
Mental health	50.8%	32		9	50.0%	2	70.0%	7	46.9%	23	48.6%	17	42.9%	6
Sexual Harassment	36.5%	23		1	0.0%	0	10.0%	1	44.9%	22	60.0%	21	7.1%	1
HIV/AIDS	27.0%	17		6	75.0%	3	30.0%	3	22.4%	11	25.7%	9	14.3%	2
Tuberculosis	22.2%	14		2	0.0%	0	20.0%	2	24.5%	12	34.3%	12	0.0%	0
Occupational hazards	12.7%	8		1	0.0%	0	10.0%	1	14.3%	7	14.3%	5	14.3%	2
Rights of Migrants	9.5%	6		2	50.0%	2	0.0%	0	8.2%	4	11.4%	4	0.0%	0
Physical abuse and exploitation	9.5%	6		1	25.0%	1	0.0%	0	10.2%	5	14.3%	5	0.0%	0
STIs	6.3%	4		3	25.0%	1	20.0%	2	2.0%	1	2.9%	1	0.0%	0

**Total does not add to 100% due to multiple choices allowed*

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

Health-care seeking behaviour in Bangladesh. Of all migrants who had a history of illness in Bangladesh, 44 per cent had sought health-care during their last bout of illness in Bangladesh. As demonstrated in Figure 23, the majority (53%) of those who sought health-care had attended pharmacies or village quacks (traditional practitioners), followed by public and private health-care service providers (36.7% and 26.6% respectively). This pattern differed according to migration status; 73 per cent of departing migrants went to pharmacies or village quacks, 41 per cent went to public medical services, while only 9 per cent went to private facilities. Among returnees, 25 per cent presented at a pharmacy or village quack in Bangladesh, while private providers or clinics were the most popular venue for medical care, attended by 52 per cent of respondents.

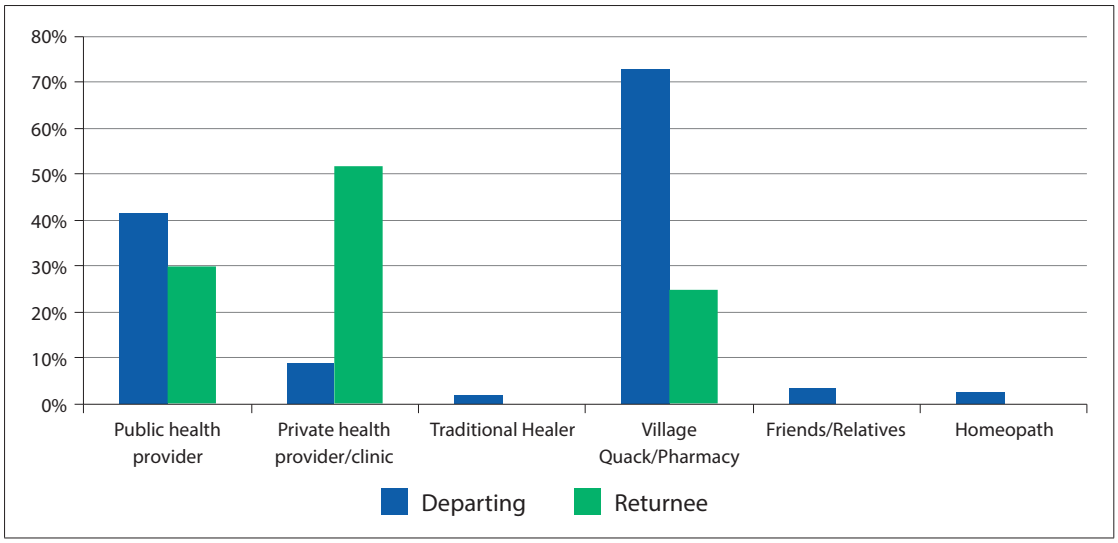


Figure 23: Facilities visited for health-care at last illness in country of origin, as % of departing and returnee migrants

Post-arrival medical check-up. Just over half of returnee migrants reported it was necessary to undergo a medical check-up following a period abroad; 17 per cent of returnees actually had one (Figure 24). Of those who had not, 92 per cent indicated perceived insusceptibility as the primary reason (Table 9). Unaffordable costs were an important reason for not seeking a post-arrival medical check-up among women (32%), but were less important for men (4%).

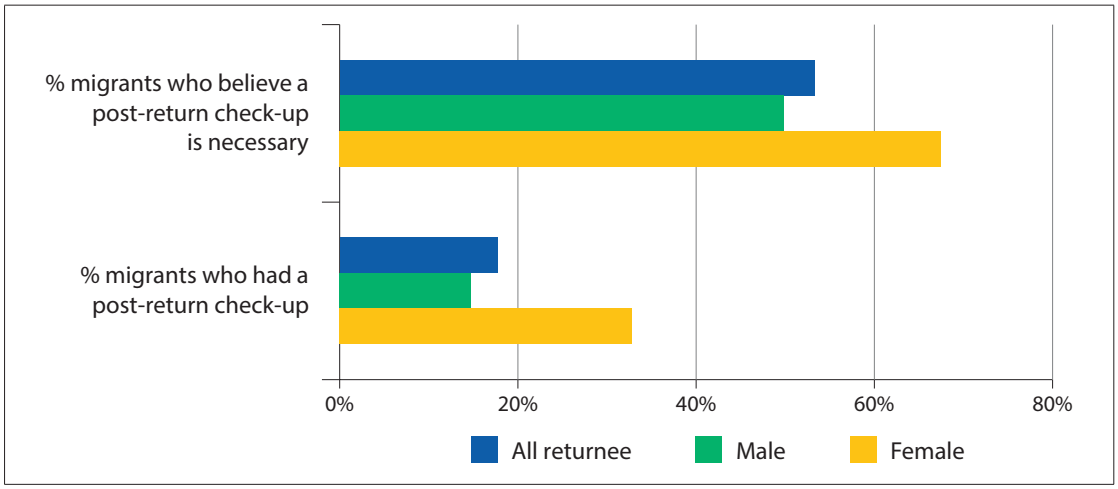


Figure 24: Returnee migrants who believe a post-arrival medical check-up is necessary and % who underwent a post-arrival medical check-up

As displayed in Table 11, those who underwent a medical check-up after returning to Bangladesh seemed reluctant to do so; 13 per cent went for a medical check-up within a week of arrival, while over a third of respondents went for check-up after 3 months. Men showed more reluctance than women; the majority chose to test after 3 months and 42 per cent chose to go for medical check-up less than a week after return. In terms of tests provided during the post-arrival medical check-ups, 42 per cent, 32 per cent, and 11 per cent of returnee migrants underwent HIV, TB, and STI tests respectively. Government centres in the capital were the most often mentioned locations for the check-ups (69%), followed by government centres at the district level.

Table 11: Experiences of post-arrival medical check-ups among returnee migrants

	Total		Male		Female	
	%	n	%	n	%	n
Reason for not having a post-return medical check-up among those who did not have one						
Perceived insusceptibility	92.2%	166	96.1%	149	68.0%	17
Unaffordable costs	7.8%	14	3.9%	6	32.0%	8
No medical centres nearby	0.6%	1	0.6%	1	0.0%	0
Travelling difficulty	0.6%	1	0.6%	1	0.0%	0
Stigma/discrimination as migrant	0.0%	0	0.0%	0	0.0%	0
Inconvenient time	0.0%	0	0.0%	0	0.0%	0
Others	0.0%	0	0.0%	0	0.0%	0
Total		**180**		**155**		**25**
Length of time between return to Bangladesh and post-return medical check-up						
Less than a week	13.2%	5	0.0%	0	41.7%	5
1 week to 1 month	31.6%	12	30.8%	8	33.3%	4
1 to 3 months	21.1%	8	23.1%	6	16.7%	2
After 3 months	34.2%	13	46.2%	12	8.3%	1
Total		**38**		**26**		**12**
Location of post-return medical check-up						
Govt. centres in the capital	68.4%	26	76.9%	20	50.0%	6
Govt. centres at district level	10.5%	4	7.7%	2	16.7%	2
NGO	7.9%	3	7.7%	2	8.3%	1
Employer/Agency	7.9%	3	3.8%	1	16.7%	2
Govt. centres at provincial level	0.0%	0	0.0%	0	0.0%	0
Others	5.3%	2	3.8%	1	8.3%	1
Total		**38**		**26**		**12**
Type of medical test sought during post-return medical check-up						
General health check-up	0.0%	0	0.0%	0	0.0%	0
HIV test	42.1%	16	53.8%	14	16.7%	2
STI test	10.5%	4	3.8%	1	25.0%	3
TB test	31.6%	12	42.3%	11	8.3%	1
Others	36.8%	14	30.8%	8	50.0%	6
Total		**38**		**26**		**12**

Health-care accessibility in Bangladesh

Availability and accessibility of health services. In terms of the types of health-care facilities available in the local community, general medical treatment was most often mentioned as available by 84 per cent of all migrants interviewed. This is followed by maternity care and or antenatal check-up (52%), medical check-up (38%), dental care (35%) and optical care (33%). As shown in Table 10, differences were not very pronounced between groups, however returnee migrants tended to have lower knowledge of or access to health-care services in the community compared to departing migrants. Regarding accessibility of services, approximately 66 per cent of respondents indicated that they can access public health-care facilities at any time. This was similar for departing and returnee migrants, however men appeared to have improved access compared to women (Table 12).

Table 12: Health-care service availability in the local community in Bangladesh for departing and returnee migrants

	All migrants		Departing migrants						Returnee migrants					
			All		Male		Female		All		Male		Female	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Available health-care facility or services in the community*														
Medical treatment	84.4%	358	84.0%	173	84.1%	148	83.3%	25	84.9%	185	83.4%	151	91.9%	34
Maternity care/ ante-natal checks	51.7%	219	67.5%	139	67.0%	118	70.0%	21	36.7%	80	31.5%	57	62.2%	23
Medical check-up	37.7%	160	40.8%	84	35.8%	63	70.0%	21	34.9%	76	31.5%	57	51.4%	19
Glasses, contact lenses (optical care)	33.3%	141	38.8%	80	34.7%	61	63.3%	19	28.0%	61	30.4%	55	16.2%	6
Dental care	34.9%	148	43.2%	89	44.3%	78	36.7%	11	27.1%	59	28.7%	52	18.9%	7
X-Ray	28.1%	119	29.6%	61	33.0%	58	10.0%	3	26.6%	58	27.6%	50	21.6%	8
Laboratory tests, blood tests	25.7%	109	29.6%	61	31.3%	55	20.0%	6	22.0%	48	22.7%	41	18.9%	7
Physiotherapy	8.3%	35	8.7%	18	8.0%	14	13.3%	4	7.8%	17	7.7%	14	8.1%	3
Mental health or psychological treatment	3.8%	16	0.5%	1	0.6%	1	0.0%	0	6.9%	15	7.7%	14	2.7%	1
MRI	3.5%	15	1.5%	3	1.7%	3	0.0%	0	5.5%	12	6.6%	12	0.0%	0
Other treatment or unknown	14.2%	60	14.1%	29	8.0%	14	50.0%	15	14.2%	31	10.5%	19	32.4%	12

**Percentages do not add to 100% due to multiple choices*

Table 13: Perception of access and utilization of public health facilities in the country of destination

	All migrants		Departing migrants						Returnee migrants					
			All		Male		Female		All		Male		Female	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Can use any time	65.8%	279	68.0%	140	69.9%	123	56.7%	17	68.8%	139	65.2%	118	56.8%	21
Cannot use any time	34.2%	145	32.0%	66	30.1%	53	43.4%	13	36.2%	79	34.8%	63	43.2%	16
Total		**424**		**206**		**176**		**30**		**218**		**181**		**37**

Only 12 per cent of respondents indicated that an HIV/STI testing facility was available at the community level. More departing migrants mentioned that they have access to family planning services when compared to returnees. Regarding curative health-care services, the most available form was provision of medicines (available to 80.2% of all studied migrants), followed by diagnosis (65.8%) and surgery (24.5%). See Table 14 for full details.

Table 14: Preventive and curative health-care service availability in the community, as % of all, male, and female departing and returnee migrants

	All Migrants		Departing migrants						Returnee migrants					
			All		Male		Female		All		Male		Female	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Available health-care in the community*														
Primary health care	73.6%	312	73.8%	152	75.0%	132	66.7%	20	73.4%	160	77.9%	141	51.4%	19
Family planning	66.5%	282	82.5%	170	83.0%	146	80.0%	24	51.4%	112	55.2%	100	32.4%	12
Health Education	61.8%	262	62.6%	129	62.5%	110	63.3%	19	61.0%	133	62.4%	113	54.1%	20
Maternal and Child health	42.7%	181	55.8%	115	55.1%	97	60.0%	18	30.3%	66	30.4%	55	29.7%	11
HIV/ STI testing	12.0%	51	9.2%	19	9.7%	17	6.7%	2	14.7%	32	16.6%	30	5.4%	2
Others	2.4%	10	2.9%	6	3.4%	6	0.0%	0	1.8%	4	2.2%	4	0.0%	0
Available curative health-care in the community*														
Medicine	71.7%	304	75.7%	156	72.7%	128	93.3%	28	84.4%	184	82.9%	150	91.9%	34
Diagnosis	65.8%	279	69.4%	143	72.7%	128	50.0%	15	62.4%	136	68.0%	123	35.1%	13
Surgery	24.5%	104	18.4%	38	20.5%	36	6.7%	2	30.3%	66	33.1%	60	16.2%	6
HIV	13.7%	58	16.0%	33	18.2%	32	3.3%	1	11.5%	25	13.8%	25	0.0%	0
STI Management	11.6%	49	6.8%	14	6.8%	12	6.7%	2	16.1%	35	18.8%	34	2.7%	1
Maternal health	6.4%	27	6.8%	14	6.3%	11	10.0%	3	6.0%	13	6.1%	11	5.4%	2
Others	0.2%	1	0.0%	0	0.0%	0	0.0%	0	0.5%	1	0.6%	1	0.0%	0
Total		**424**		**206**		**176**		**30**		**218**		**181**		**37**

**Percentages do not add to 100% due to multiple choices*

Government facilities at community level were the most often mentioned providers for both preventive and curative services, followed by private health-care providers (Figure 25).

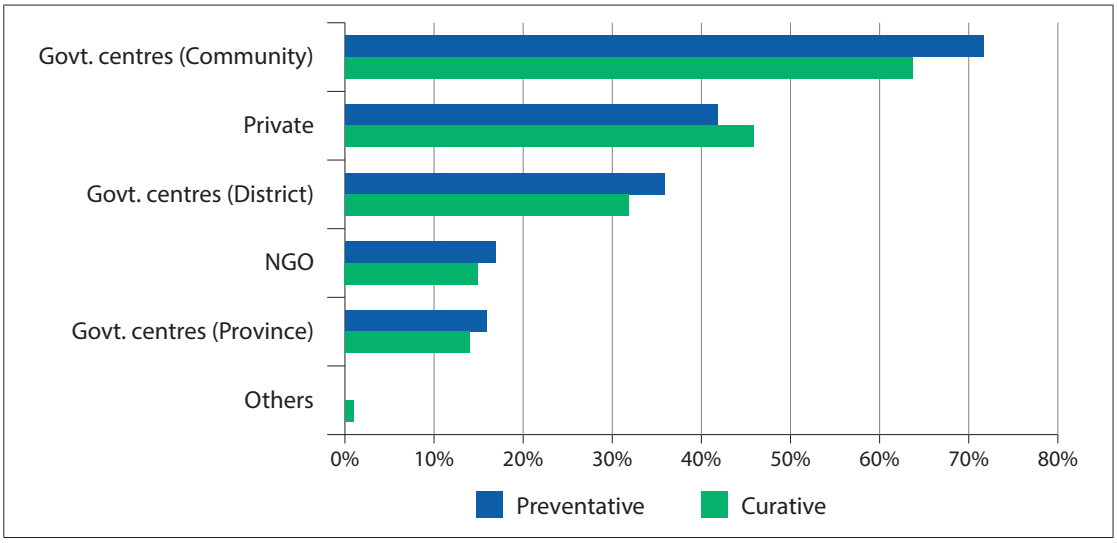


Figure 25: Providers of identified preventive and curative health-care services available in the community, as % migrants who identified each provider

Affordability and health-care financing. As shown in Figure 26, the majority of respondents found health-care to be affordable or easily affordable in Bangladesh; just over a quarter of migrants experienced financial difficulties accessing health-care, including the 11 per cent who found costs to be entirely unaffordable. There was a slight skew towards increased affordability among returnee migrants.

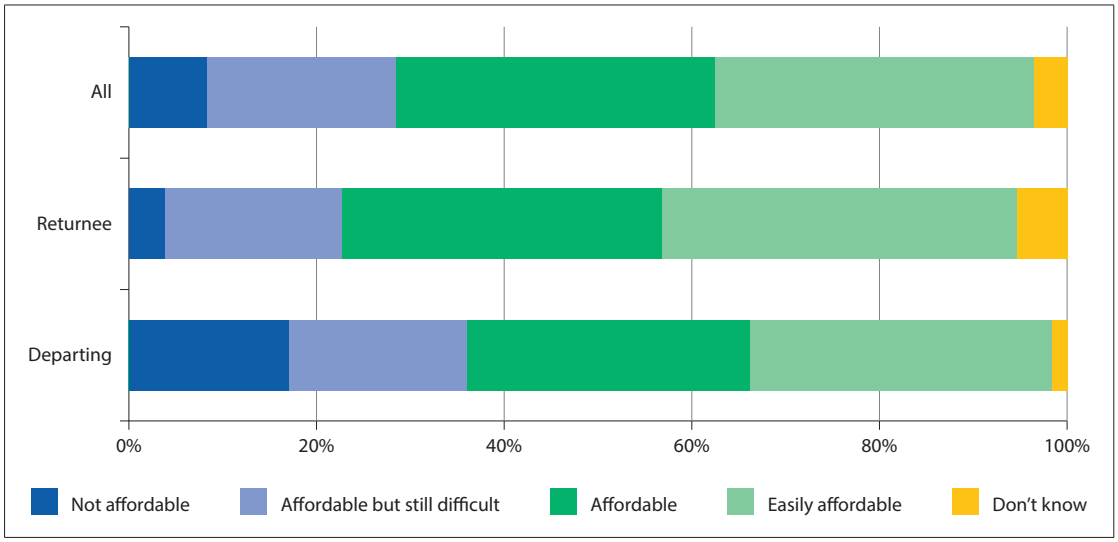


Figure 26: Perceived affordability of health-care in the community among all migrants

According to the health-care structure of Bangladesh, government health-care services are free to all. However, when respondents were asked whether they received any free services from government facilities, results indicated that most facilities did not offer free services. As shown in Figures 27 and 28, government centres were most often identified as those facilities to offer free services, (50% departing; 36% returnees; 43% in total). More returnees than departing migrants reported facilities that offered free health services.

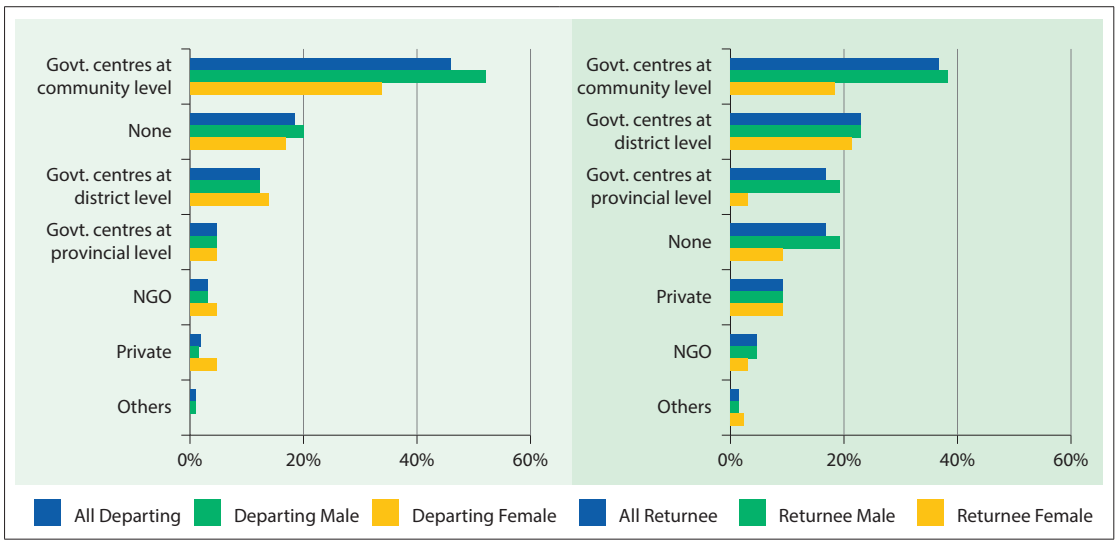


Figure 27: Reported health facilities that offer free health services, as % of total, male, and female departing migrants

Figure 28: Reported health facilities that offer free health services, as % of total, male, and female returnee migrants

Experience accessing health-care. Among all respondents, 26 per cent claimed they have had faced difficulties accessing health-care services in Bangladesh. The percentage was similar among departing and returnee migrants; male migrants in both groups reported more difficulties than women (Figure 29).

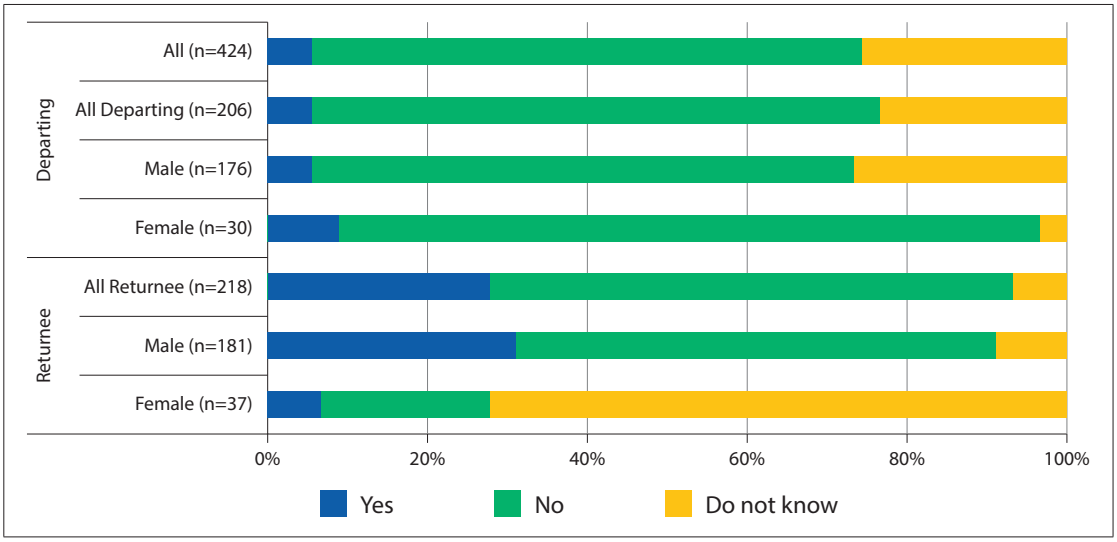


Figure 29: Migrants who had faced difficulties accessing health-care in Bangladesh, as % of male and female departing and returnee migrants

Limited doctor availability was the most often cited barrier to health-care access (56%) among respondents, followed by unaffordable costs (39%) and long distances to facilities (29%). Lack of information, discrimination due to migration status, and inconvenient operating times were also important factors. Discrimination due to migration status was a particular problem among returnee migrants (38% of returnees compared to 20% of departing migrants (Table 15).

Table 15: Barriers accessing health-care in Bangladesh, as % of all, departing, and returnee male and female migrants that identified each barrier

	All Migrants		Departing migrants						Returnee migrants					
			All		Male		Female		All		Male		Female	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Doctors are not available	55.5%	66	74.5%	41	75.0%	41	66.7%	2	39.1%	25	43.9%	25	0.0%	0
Unaffordable cost	38.7%	46	50.9%	28	50.0%	28	66.7%	2	28.1%	18	31.6%	18	0.0%	0
Long distance	29.4%	35	52.7%	29	51.9%	29	66.7%	2	9.4%	6	10.5%	6	0.0%	0
Lack of information	21.0%	25	34.5%	19	32.7%	18	66.7%	2	9.4%	6	10.5%	6	0.0%	0
Discrimination due to Migration status	20.2%	24	0.0%	0	0.0%	0	0.0%	0	37.5%	24	36.8%	21	42.9%	3
Inconvenient operating time	17.6%	21	21.8%	12	21.2%	12	33.3%	1	14.1%	9	14.0%	8	14.3%	1
Discrimination due to socioeconomic status	2.5%	3	3.6%	2	3.8%	2	0.0%	0	1.6%	1	1.8%	1	0.0%	0
Others	4.2%	5	0.0%	0	0.0%	0	0.0%	0	7.8%	5	3.5%	2	42.9%	3
Total (frequency)		**119**		**55**		**52**		**3**		**64**		**57**		**7**

Health-care accessibility in the country of destination

Availability and access to health services. Half of returnee migrants surveyed were aware of places in the country of destination where they could access care and treatment. As shown in Table 16, of those who could identify a health care facility, government facilities were most often mentioned (49%), followed by private facilities (31%) and NGOs (7%). Medical examination was the health service most available in the destination country according to the 44 per cent of those who knew where to seek health-care, followed by laboratory tests such as blood tests and X-rays, and dental care.

Table 16: Health-care service availability in destination countries

	All returnee migrants		Male returnee migrants		Female returnee migrants	
	%	n	%	n	%	n
Migrants who feel they can access public health services in destination country						
Yes	32.6%	71	34.8%	63	21.6%	8
No	67.4%	147	65.2%	118	78.4%	29
Total		218		181		37
Returnee migrants who have heard of any places where migrants can access care and treatment in their destination country						
Have heard	49.5%	108	45.9%	83	67.6%	25
Have not heard	50.5%	110	54.1%	98	32.4%	12
Total		218		181		37
Places where migrants reported to receive care and treatment services						
Government organization	49.1%	53	56.6%	47	24.0%	6
Private	30.6%	33	33.7%	28	20.0%	5
NGO	7.4%	8	7.2%	6	8.0%	2
Other	13.0%	14	2.4%	2	48.0%	12
Total (frequency)		108		83		25
Types of health services that migrants reported to be available in destination country (multiple answers)*						
Dental care	25.0%	27	28.9%	24	12.0%	3
Optical care	20.4%	22	21.7%	18	16.0%	4
Physiotherapy	15.7%	17	15.7%	13	16.0%	4
Medical check-up	43.5%	47	51.8%	43	16.0%	4
Maternity care/ ante-natal checks	7.4%	8	4.8%	4	16.0%	4
Laboratory tests, blood tests, MRI or X-Ray	39.8%	43	47.0%	39	16.0%	4
Mental health or psychological treatment	24.1%	26	27.7%	23	12.0%	3
Other treatment or unknown	19.4%	21	18.1%	15	24.0%	6
Never sought any health services	12.0%	13	13.3%	11	8.0%	2
Other	2.8%	3	1.2%	1	8.0%	2
Total (frequency)		**108**		**83**		**25**

*Percentages do not add to 100% due to multiple answers

When asked about specific health-care services available for migrants in destination countries where they have been, returnee migrants reported primary health care was most accessible, followed by health education. Government centres most frequently provided these services, followed by private providers (Table 17). Provision of medicines was the most common curative health service, followed by diagnostics. HIV/AIDS-specific services were mentioned by 1 in 10 respondents and surgery by a quarter of respondents. (Figure 30).

Table 17: Health-care accessibility in destination country among those familiar with health facilities

	Returnee Migrants					
	All		Male		Female	
	%	n	%	n	%	n
Migrants who report having access to specific preventive health-care services in the destination country?*(n=218)						
Health Education	59.2%	129	62.4%	113	43.2%	16
Primary health care	60.1%	131	66.3%	120	29.7%	11
HIV/ STI testing	13.3%	29	16.0%	29	0.0%	0
Family planning	11.0%	24	12.2%	22	5.4%	2
Maternal and Child health	4.1%	9	3.9%	7	5.4%	2
Others	1.4%	3	1.7%	3	0.0%	0
Migrant perception of accessibility of specific curative health-care services in their destination country?*(n=218)						
Medicine	73.9%	161	75.1%	136	67.0%	25
Diagnosis	59.2%	129	63.0%	114	40.5%	15
Surgery	26.6%	58	29.8%	54	10.8%	4
HIV/AIDS	11.0%	24	12.2%	22	5.4%	2
Maternal health	6.4%	14	6.1%	11	8.1%	3
STI Management	3.2%	7	3.9%	7	0.0%	0
Others	0.9%	2	1.1%	2	0.0%	0

**Percentages do not add to 100% due to multiple answers*

Table 18: Satisfaction with health facilities in destination country

	Returnee Migrants					
	All		Male		Female	
	%	n	%	n	%	n
Satisfied	61.0%	64	59.6%	56	72.7%	8
Slightly satisfied	30.5%	32	34.0%	32	0.0%	0
Unsatisfied	3.8%	4	2.1%	2	18.2%	2
Don't know	4.8%	5	4.3%	4	9.1%	1
Total		**105**		**94**		**11**

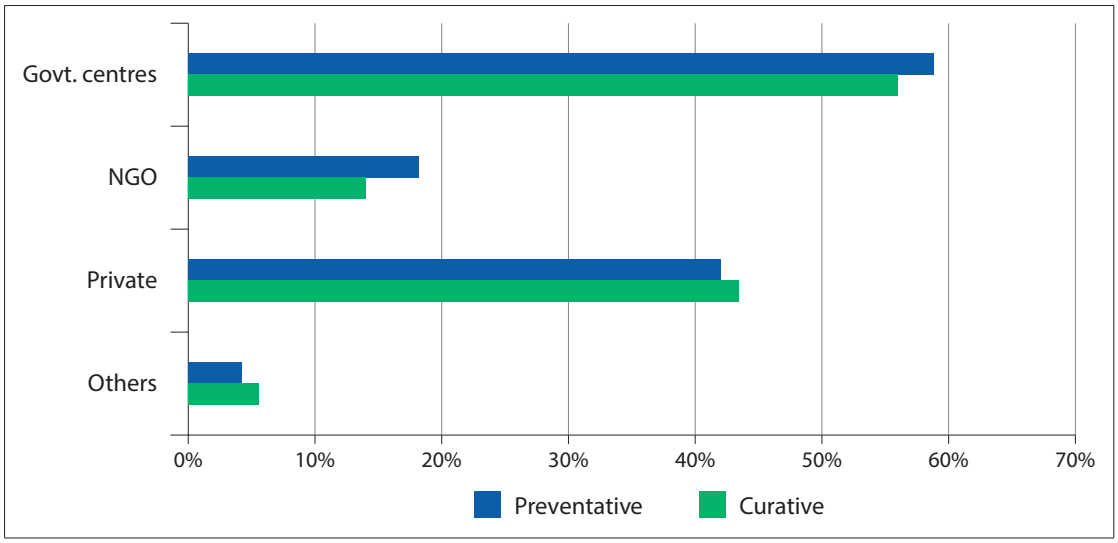


Figure 30: Health facilities reported by returnee migrants to to offer preventive or curative services abroad

Affordability and health-care financing. Approximately 28 per cent of migrants perceived health-care abroad to be easily affordable or affordable, while 49 per cent found it to be unaffordable or difficult to afford. A further 19 per cent said they did not know (Figure 31).

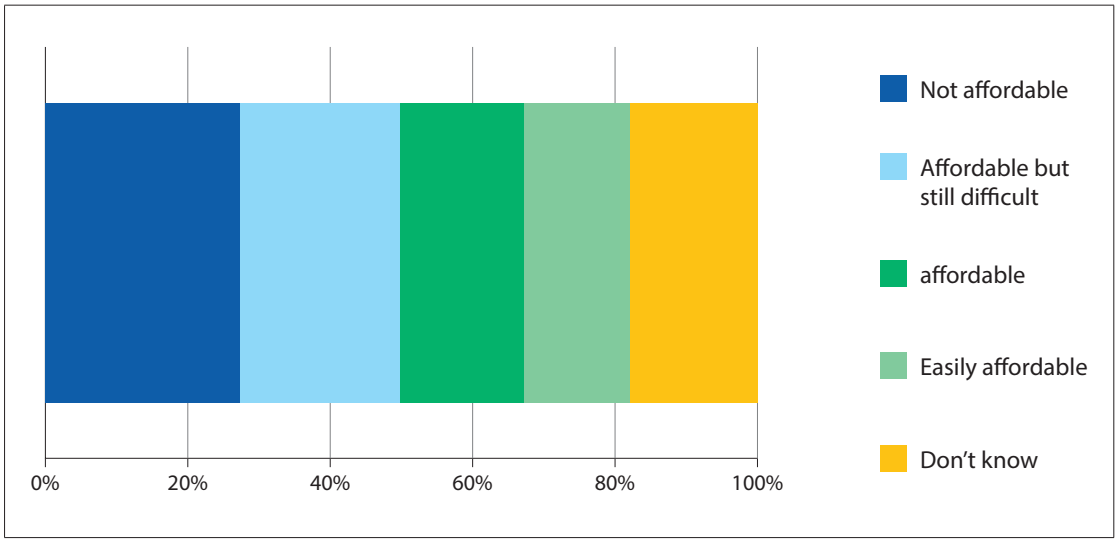


Figure 31: Perceived affordability of health-care services in country of destination

Among those that sought health-care, the most common form of health-care financing was out-of-pocket payment, with 61 per cent of returnee migrants reporting that they paid themselves for health-care services (Figure 32). Among returnee migrants, 22 per cent of those with a history of seeking health-care services indicated that their employer partially contributed to paying for their care. Only 16 per cent of returnee migrants reported that their employers fully paid for their health care. Health insurance was reported only by 1 per cent of migrants-, although 12 per cent of returnee migrants had insurance (Figure 33).

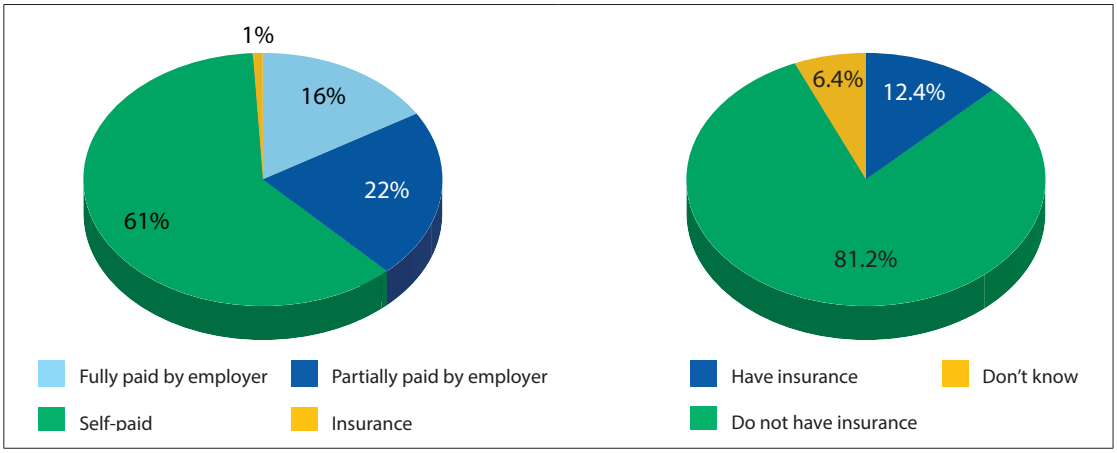


Figure 32: Health-care financing among respondents who sought healthcare

Figure 33: Respondents who had insurance in destination country

Experiences accessing health-care. Migrants who had accessed preventive or curative services abroad were generally satisfied with their experience; only 4 per cent claimed that they were unsatisfied. The data indicates that 35 per cent of returnee migrants in the sample faced any difficulty in accessing health-care services in the country of destination (Table 19). The main obstacles to access health-care services were non-availability of doctors (61%) and complex system (42%).

Table 19: Barriers faced accessing health-care in the country of destination

	Returnee migrants					
	All		Male		Female	
	%	n	%	n	%	n
% of migrants that faced difficulties accessing health-care services						
Yes – have faced difficulties	34.9%	76	35.9%	65	29.7%	11
No – have not faced difficulties	56.0%	122	58.6%	106	43.2%	16
Don't Know	9.2%	20	5.5%	10	27.0%	10
Total		**218**		**181**		**37**
Primary obstacles to obtaining health-care in destination country (multiple choices) (n=76)						
Doctors are not available	60.5%	46	64.6%	42	36.4%	4
System is complex (unaware about rights/ does not know where to go)	42.1%	32	43.1%	28	36.4%	4
Unaffordable cost	39.5%	30	46.2%	30	0.0%	0
Was denied access to health-care	21.1%	16	23.1%	15	9.1%	1
Does not like going to the doctor	15.8%	12	18.5%	12	0.0%	0
Inconvenient operating Time	10.5%	8	12.3%	8	0.0%	0
Administrative problems	7.9%	6	9.2%	6	0.0%	0
No perceived obstacle	7.9%	6	7.7%	5	9.1%	1
Fear of discrimination, of being unwelcome or denied treatment	6.6%	5	7.7%	5	0.0%	0
Fear of being reported or being arrested	5.3%	4	4.6%	3	9.1%	1
Others	3.9%	3	0.0%	0	27.3%	3

Mandatory medical examinations prior to departure. The majority (87%) of all migrants underwent a mandatory medical examination prior to departure with 79 per cent of departing migrants and 95 per cent of returnee migrants.

The migrants reported that the medical examination typically consisted of a general medical check-up and or an HIV test. Tuberculosis (TB) screening was the second most common disease-specific test reported. Tests for STIs were reported by 20 per cent of migrants. A larger proportion of men recalled having each specific test compared to women (69% of men reported having had an HIV test compared to 21% of women). See Table 20 for full details.

Table 20: Reported locations and procedures of mandatory medical examinations prior to departure,

	All		Departing migrants						Returnee migrants					
			All		Male		Female		All		Male		Female	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Migrants that underwent a mandatory medical examination														
Yes	86.8%	368	94.7%	195	94.3%	166	96.7%	29	79.4%	173	73.0%	27	73.0%	27
No	13.2%	56	5.3%	11	5.7%	10	3.3%	1	20.6%	45	27.0%	10	27.0%	10
Total		**424**		**206**		**176**		**30**		**218**		**37**		**37**
Source/location of mandatory health assessment(multiple answers)* (n=368)														
Govt. centre in the capital	44.6%	164	34.6%	71	34.7%	61	34.5%	10	53.8%	93	54.1%	79	51.9%	14
Employer/ agency	45.4%	167	52.2%	107	52.8%	93	48.3%	14	34.7%	60	34.2%	50	37.0%	10
Govt. centres at district level	10.1%	37	12.2%	25	11.4%	20	17.2%	5	6.9%	12	7.5%	11	3.7%	1
NGO	1.9%	7	1.0%	2	1.1%	2	0.0%	0	2.9%	5	2.1%	3	7.4%	2
Others	0.8%	3	0.0%	0	0.0%	0	0.0%	0	1.7%	3	2.1%	3	0.0%	0
Procedures during mandatory health assessment (multiple answers)* (n=368)														
General health check up	85.6%	315	85.6%	167	79.5%	140	93.1%	27	85.5%	148	85.6%	125	85.2%	23
HIV test	61.7%	227	70.7%	145	76.7%	135	34.5%	10	47.4%	82	54.8%	80	7.4%	2
STI test	20.1%	74	25.9%	53	27.3%	48	17.2%	5	12.1%	21	13.0%	19	7.4%	2
TB test	32.9%	121	43.9%	90	47.7%	84	20.7%	6	17.9%	31	19.9%	29	7.4%	2
Others	20.7%	76	18.0%	37	21.0%	21	0.0%	0	22.5%	39	23.3%	34	18.5%	5

*Percentages do not add to 100% due to multiple answers

Only 3 per cent of all migrants that underwent a medical examination didn't have to pay (Figure 34). About 95 per cent of migrants reported that they paid for examination themselves, and a very small minority had the costs covered by their employer or recruitment agencies (Appendix 1.8).

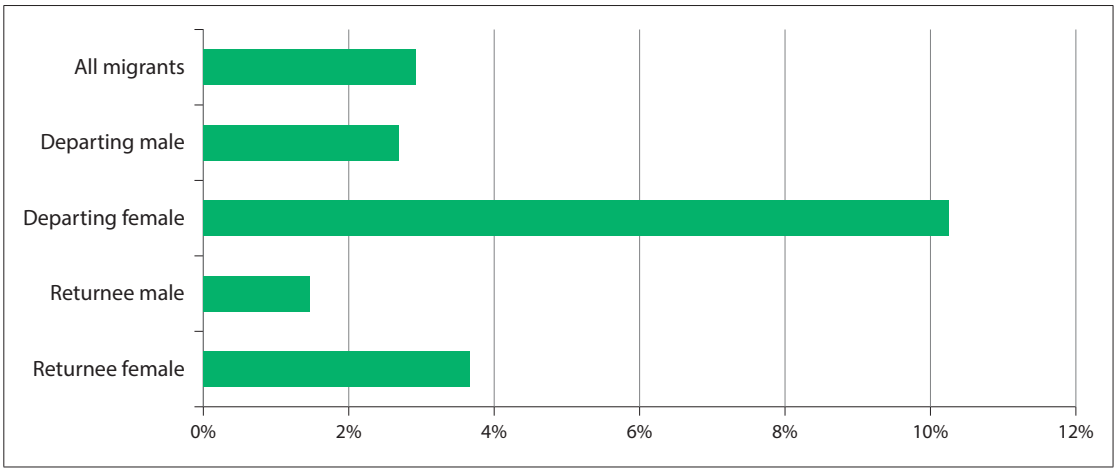


Figure 34: Respondents who didn't have to pay for the medical examination prior to departure,

Access to health information and communication

Source of health information in Bangladesh. Television was the most common form of media accessed by departing migrants (91%), followed by 45 per cent reporting reading the newspaper and 23 per cent listening to radio (Appendix 1.9). Access to media in Bangladesh was slightly lower among returnee migrants, but with similar patterns; television viewing was highest at 89 per cent and both use of newspaper and radio was lower at 42 per cent and 28 per cent respectively (Appendix 1.9). Frequency of use also followed the same patterns; of those who watched television, 69 per cent viewed every day. This dropped to 47 per cent for newspaper and 38 per cent for radio (Appendix 1.10). Internet was rarely used; only 1 of 10 respondents (Appendix 1.9).

As demonstrated in Figure 35, 87 per cent of all departing and returnee migrants indicated they received health related information via television. The next most popular source was treatment centres or from doctors (42.9%) followed by newspaper and billboard/ signboard/ poster (both 30.4%). Just over one third of migrants had received health information materials from health providers in Bangladesh, however more than a third faced difficulties understanding contents (Table 21). When asked about preferred channels for health information, television and other mass media was the most popular, and information from health workers was less popular (Figure 36).

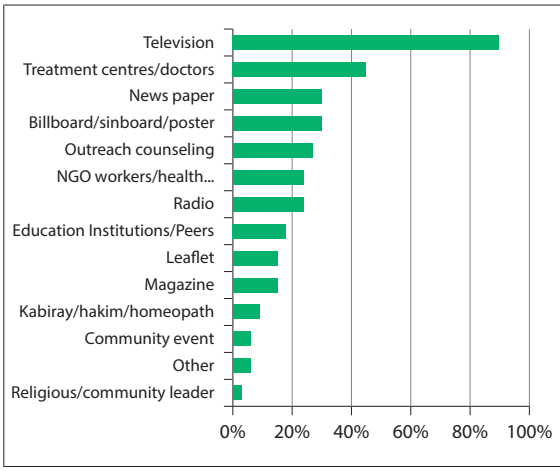


Figure 35: Main sources of health information among all migrants (n=424)

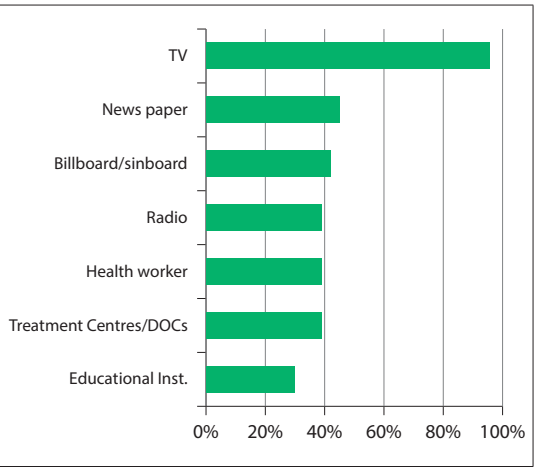


Figure 36: Preferred channels for health information dissemination (n=424)

Table 21: Health communication materials received from health providers in Bangladesh

	All		Departing migrants						Returnee migrants					
			All		Male		Female		All		Male		Female	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Migrants who received health-related communication materials from health providers/ facilities in Bangladesh														
Yes	37.3%	158	53.4%	110	53.4%	94	53.3%	16	22.0%	48	23.2%	42	16.2%	6
No	51.2%	217	44.2%	91	46.0%	81	33.3%	10	57.8%	126	59.7%	108	48.6%	18
Don't Know	11.6%	49	2.4%	5	0.6%	1	13.3%	4	20.2%	44	17.1%	31	35.1%	13
Total		**424**		**206**		**176**		**30**		**218**		**181**		**37**
Ease of understanding health communication materials among migrants having received health communication (n =158)														
Easily Understandable	27.2%	43	32.7%	36	34.0%	32	25.0%	4	14.6%	7	16.7%	7	0.0%	0
Understandable	36.7%	58	39.1%	43	43.6%	41	12.5%	2	31.3%	15	35.7%	15	0.0%	0
With some difficulties	28.5%	45	26.4%	29	21.3%	20	56.3%	9	33.3%	16	33.3%	14	33.3%	2
Don't understand	7.6%	12	1.8%	2	1.1%	1	6.3%	1	20.8%	10	14.3%	6	66.7%	4
Total		**158**		**110**		**94**		**16**		**48**		**42**		**6**

Departing migrants reported they would like to obtain more information about HIV/AIDS (62%), health services and health providers (46%), Tuberculosis (43%), malaria (40%) and STIs (23%) (Figure 37). Female migrants expressed particular interest in health services/providers (87%, versus 39% of men), but expressed slightly less interest for other subjects. The topics of interest was the same for returnee migrants, however they expressed slightly less interest overall (Figure 38).

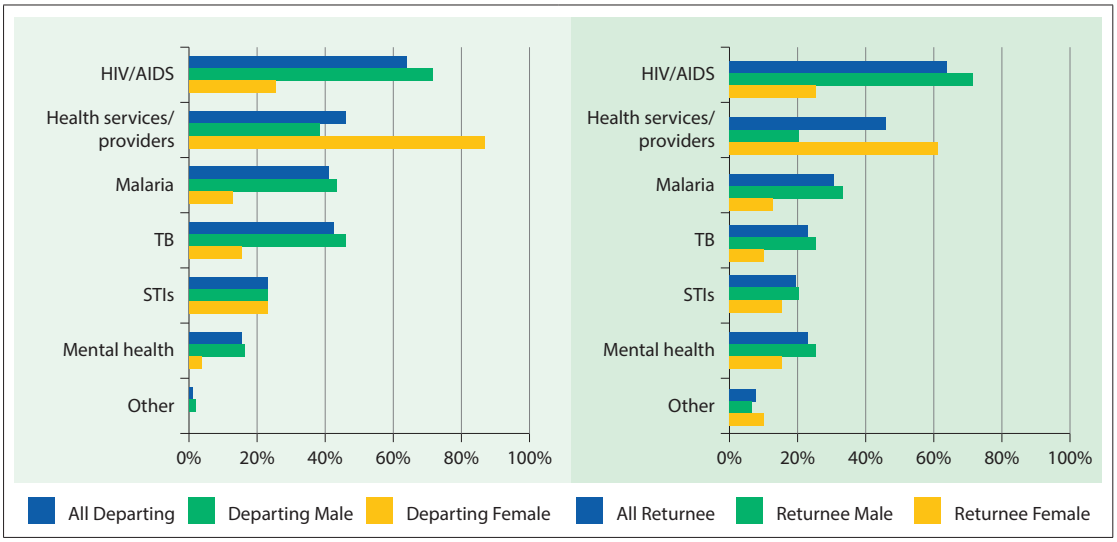


Figure 37: Health topics that departing migrants would like to receive more information on

Figure 38: Health topics returnee migrants would like to receive more information on

Source of health information in the country of destination. In the country of destination, television was the most useful communication media for health, identified by 78 per cent of returnees. This was followed by newspapers (24.3%) and health service providers (22.5%). Approximately 46.3 per cent returnee migrants indicated that they got health related information from friends or relatives (Figure 39).

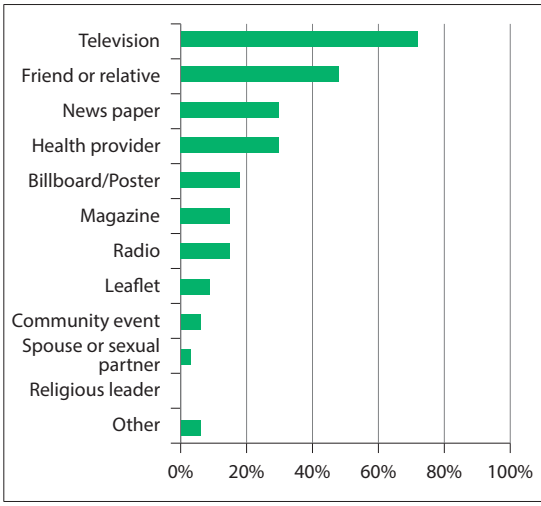


Figure 39: Main sources of health information among returnee migrants in Bangladesh

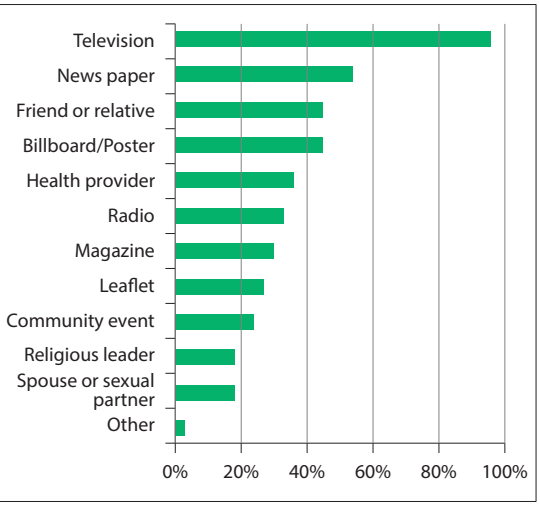


Figure 40: Ideal channels for health information identified by returnee migrants in destination country

Once again, television was the most preferred channel for getting information on health related services, indicated by 96 per cent of returnee migrants (Figure 40). Other preferred channels are the newspaper (54%), billboard/poster (42%) and radio (34%). However, 43 per cent of the returnee migrants indicated friends or relatives as a preferred channel for receiving health related information.

Only 15 per cent of the returnee migrants indicated that health-care related communication materials were available at their destination countries (Table 22). The communication materials were not produced in the native language, and 97 per cent of returnee migrants found it difficult or were completely unable to understand the materials.

Table 22: Reported provision of health communication materials in destination countries

	All		Male		Female	
	%	n	%	n	%	n
Returnee migrants who have received health materials in destination country						
Receive health com. materials	15.1%	33	15.5%	28	13.5%	5
Did not receive health com. materials	78.0%	170	79.6%	144	70.3%	26
Don't know	6.9%	15	5.0%	9	16.2%	6
Total		**218**		**181**		**37**
Returnee migrants who received health materials in their own language in destination country (n= 33)						
In their own language	3.0%	1	3.6%	1	0.0%	0
Not in their own language	87.9%	29	96.4%	27	40.0%	2
Don't know	9.1%	3	0.0%	0	60.0%	3
Ease of understanding health communication materials (n=33)						
Easily Understandable	3.0%	1	3.6%	1	0.0%	0
Understandable	0.0%	0	0.0%	0	0.0%	0
With Some Difficulties	78.8%	26	85.7%	24	40.0%	2
Don't Understand	18.2%	6	10.7%	3	60.0%	3

Source of HIV/AIDS information. The majority of migrants mentioned television as their source of information on HIV/AIDS; followed by friends and relatives, newspaper, and health workers (Figure 41). Departing migrants also appeared to particularly rely on magazines for HIV information.

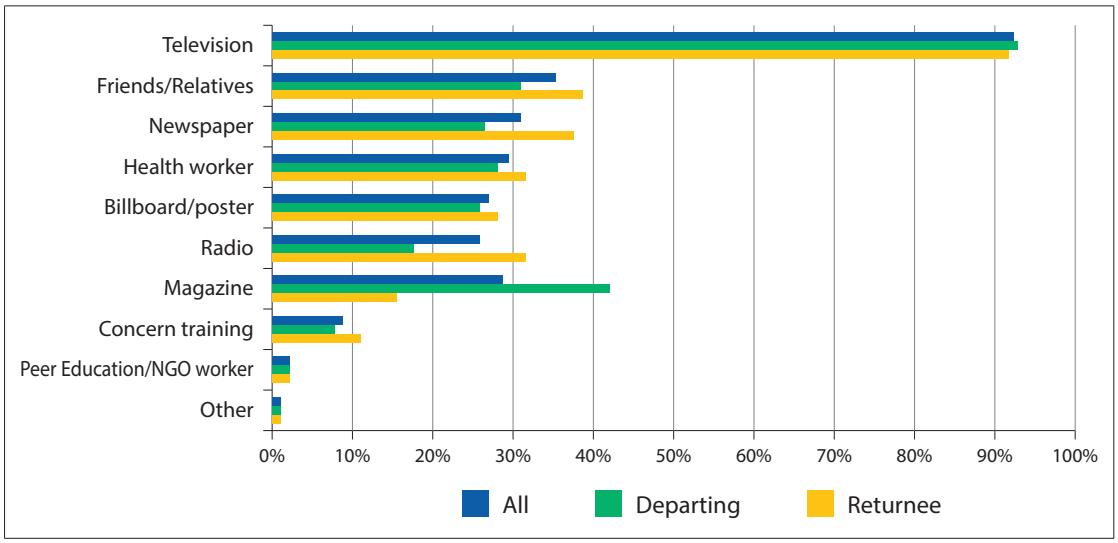


Figure 41: Sources of HIV information among migrants

3.2 Qualitative results (Focus Group Discussions and Key Informant Interviews)

3.2.1 Health risks faced by migrants and their dependents

During FGDs returnee migrants discussed the risks of occupational hazards, experienced particularly by men. Overseas male migrants are considered at increased occupational health and safety risk due to working outdoor jobs such as driving, construction or electrical work. Females, on the other hand, are often hired as domestic helpers, and returnees noted that their employers tend to take better care of their employees. Despite the risks, participants had mostly experienced minor health problems such as an upset stomach and headaches while abroad, with only one experiencing an occupational hazard in the form of a hand fracture.

Sexually transmitted infections and concerns related to sexuality were alluded to by respondents. Spouses of migrants discussed a lack of sexual satisfaction and difficulties conceiving children due to the absence of their husbands. They furthermore mentioned experiencing problems such as urinary tract infections, allergies, excessive periods, and white discharge after having sexual intercourse with their husbands.

Returnee migrants made many references to experiencing anxiety while abroad grounded in concerns about finances and the wellbeing of family members staying behind in Bangladesh. When explaining the roots of their anxiety, they said:

> "My son used to study in school. After my going abroad, he left school and started working…"
>
> *FGD participant, Returnee migrant*
>
> "My husband can't cook by himself. That is why my daughter could not go to her father-in-law's house after her marriage…"
>
> *FGD participant, Returnee migrant*

> "I went abroad by taking loan. So I had always a tension to repay the loan…My parents have become happy as their daughter came back."
>
> *FGD participant, Returnee migrant*

The health impact of migration on family members is multi-dimensional. As explained by stakeholders, spouses and children of migrants are often staying behind in Bangladesh, and commonly suffer from anxiety or social difficulties, due to the disintegration of the close family structure, irregularity in receiving remittances, and concerns about safety of themselves and their family members abroad. They may additionally become exposed to infectious diseases upon their partner's return. On the other hand, if the migrating family member experiences financial success, families may experience improvements to their socio-economic status, and improved access to health services.

Returnee migrants stated that counselling, both on arrival and during their stay in their destination country, would help improve their lives. They also reiterated the importance of a pre-departure health training and/or orientation.

3.2.2 Health-care seeking behaviour

Departing and returnee migrants explained that they rarely visit the doctor or a health facility both in the country of origin or destination unless they feel severely ill, which they defined as exhibiting symptoms of TB, cardiac problems or serious infections, or requiring a blood test. They found doctors and health facilities to be "troublesome", time consuming or expensive. On the other hand, inbound migrants[4] explained that they usually visited local health facilities for health issues, and were satisfied with the services and level of accessibility. Spouses of migrants depend on remittances sent from their partners abroad to pay for health services. Spouses typically seek homeopathic or *Ayurvedic* treatment,[5] unless the problem is serious, in which case they seek "better treatment" usually in urban areas.

3.2.3 Knowledge of health risks and prevention

Participants among all FGD groups were found to be aware of AIDS, however they were less familiar with the term *HIV,* or the connection between the two. Departing and returnee migrants acknowledged that HIV/AIDS is a communicable disease, but did not have detailed knowledge about it. All respondents identified the following means of transmission: using syringes or needles and engaging in sexual intercourse without a condom. Departing and returnee migrants also identified transmission through blood transfusion, while spouses of migrants suggested that breastfeeding was a possible route. Departing migrants had a number of misconceptions about HIV/AIDS transmission, including through physical contact with a person living with AIDS (such as shaking hands), by mosquitoes, and by wearing the clothes of infected people. Suggested means of preventing HIV/AIDS included: following the doctor's advice, using condoms during sexual intercourse, not using syringes or needles, increasing awareness, and having a blood test to know HIV status upon arrival in a new place. Spouses of migrants also suggested that a partner should undergo urine, blood and full-body exams, and a condom should be used on the first night after the arrival/ return of their partner.

[4] *Inbound migrant is defined as the person migrates into a country and includes categories such as migrant workers.*

[5]

Participants lacked detailed knowledge about other STIs. Spouses of migrants had no information, while departing and returnee migrants were collectively aware of the terms *syphilis, gonorrhoea* and *white vaginal discharge* or leucorrhoea. All participants were aware of TB, although returnee migrants were more familiar with the local language term, "*jokkha*". Spouses of migrants perceived TB to be a cough with bleeding. There were generally misconceptions among all groups in the transmission of TB, including the confusion of risk factors with actual means of transmission: spread genetically, from coldness, by eating from the same plate or drinking from the same glass as someone with TB, smoking, and inhaling polluted air.

Departing migrants were the only group to discuss mental health. They noted that mental health problems can arise through stress, hypertension, insomnia and loss of appetite.

3.2.4 Pre-departure orientation

The pre-departure orientation organized by the Bureau of Manpower, Employment and Training (BMET) appeared to be a minor component of the pre-departure migration phase. Most key informants mentioned this orientation, and described it to last for one to one and a half hours with a brief focus on health issues and no in depth information. Returnee migrants indicated the insufficiency of this orientation, and acknowledged the need for a comprehensive pre-departure health orientation to allow improved awareness of risks abroad.

The pre-departure orientation is only provided to regular migrants going through regular recruitment agencies. Those who migrate through informal and or illegal channels do not receive this service.

3.2.5 Migrant focused services in Bangladesh

Migrant-focused health services were not prominent in Bangladesh. According to stakeholders, Government Organizations do not offer curative or palliative health-care services targeting inbound or outbound migrants, and the only preventative health-care service takes the form of the mandatory pre-departure medical examination.

Other key informants shared that a few international Organizations such as WHO, and FAO offer services related to health promotion and education. Other Non-Governmental Agencies (NGOs) such as OKUP, WARBE, BOMSA, Oxfam, Action Aid, and Wake-up, partner with hospitals to deliver health services. Given their reliance on donors, these efforts are not always continuously implemented, and many of the projects are community-based and small-scale. These services were not identified by migrants during the FGDs.

Despite this, key informants pointed out that preventative, palliative, curative and health-information services are already integrated into the health system, particularly at primary level. These are intended to be free to all, including outbound and inbound migrants. Indeed a departing migrant from Dhaka pointed out that their migration status can even prompt improved health-care services:

> "If we say that we will go abroad, they treat us quickly and with importance"
>
> *FGD participant, Departing migrant*

These public health services however exclude counselling and psychological services.

3.2.6 Accessibility and perceived quality of health-care in country of origin and destination

FGD participants were aware of health facilities in Bangladesh, and noted that government facilities are located within 2 to 3 km, or 10 to 15 minutes' drive, from their home.

The perceptions of government facilities were mixed among the participants of FGDs. Returnee migrants participating in FGDs had negative feedback, and pointed to poor quality services and logistical difficulties in Bangladesh. They explained that smaller government facilities within closer distances usually do not provide any services. On the other hand larger facilities (hospitals) have the capability to provide all services, but demand extra money. Consequentially, participants do not seek health care at either type of facility.

Spouses of migrants provided more favourable feedback, and were particularly aware of health providers in the area such as the Marie Stopes Clinic that provides satisfactory family planning and reproductive health services. Stakeholders also pointed out specialized hospitals such as the TB Hospital, Diarrhoea Hospital, and Sohrawardi and Pongu Hospital. These hospitals focus on their area of specialization, but also provide general health-care. Key Informants expressed that overall government facilities are in a good shape in Dhaka, but outside Dhaka public facilities are inadequate, due to a lack of physicians and necessary equipment. According to an IOM official:

> "the health system in Bangladesh is comparatively better than many other countries. Maybe it is lacking behind in terms of quality. the government is providing free treatment from the very top level to the grass root level. I am not aware of any other country providing such service.."
>
> *Key informant, IOM*

Private facilities were preferred by many FGD participants, due to improved accessibility and better quality of services, in part due to better remuneration of staff. Participants reported that larger government facilities forced them to pay extra money as well. Services available at private facilities include treatment of fever, Tuberculosis, abdominal pain, and injury, as well as blood or urine tests, minor surgery, and antenatal care.

> "Private health facilities are good…"
>
> *FGD participant, Migrant*
>
> "In Government health centres diagnosis is very problematic issue…In private, all kinds of tests including blood test is done."
>
> *FGD participant, Migrant*
>
> "Doctors give time in the private chamber and do not come in the Hospital…They are taking salary but instead of giving time in the hospital, they are giving time to private clinic or chamber because they are getting much money there…Staffs or nurses also do not provide services unless they are paid money…"
>
> *FGD participant, Migrant*

Health services in destination countries were described as modern. In certain places, discounted access to health care was obtained through medical cards, however these services were limited to certain hospitals or clinics. Returnee migrants participating in FGDs described several barriers to health-care access including, high costs and poor access. Health insurance exists, but the plans

cover almost nothing. Employers are supposed to pay for health services but in the majority of cases they do not. Compounding this, governments in destination countries fail to look into the matter.

Cultural and language barriers were also reported. Factors such as difficulties with language and sensitive issues, for instance regarding sexual health, sometimes discourage the migrants from seeking health services. Female migrants in particular face cultural barriers, especially in the Middle East. Sometimes they live in separate compounds which they are only permitted to leave at the end of the contract.

3.2.7 Mandatory medical examinations prior to departure

Key informants explained that mandatory medical examinations are carried out as part of immigration regulations of destination countries, such as Malaysia or countries within the Gulf Cooperation Council (GCC). The GCC Approved Medical Centres Association (GAMCA) is particularly important in that it governs the medical exams of foreign workers headed to GCC states and accredits health providers in countries of origin to carry them out[6]. All returnee migrants from Chittagong and Manikganj participating in the FGDs had undergone a pre-departure mandatory medical examination, and one recounted undergoing an additional check-up upon arrival in the destination country. These tests are mandatory, as a certificate of medical fitness is required to be eligible for work abroad. Despite this, migrants reported that they, and not their employers or recruitment agencies, paid for the tests.

Collectively, migrants reported the following tests in their pre-departure health assessments: "Full-body check-ups" or complete physical examination, "blood tests", "jaundice" or liver function tests, "blood grouping", TB tests, X-ray, Electrocardiogram (ECG), and diabetes tests. Migrants interviewed noted that other tests were also applied, the medical staff at the health centres did not inform them of the nature of the test so they were unaware of their name or purpose.

FGD participants expressed general satisfaction with the pre-departure mandatory medical exams, despite expressing a number of complaints. Corruption was commonly reported, in the form of health centres refusing to provide deserved certificates of medical fitness, and instead requesting a follow-up appointment that required an additional fee.

Key informants also explained that only facilities located in the capital are licensed to provide medical certificates, which poses a financial and time burden for potential migrants that live in more remote areas. Addressing these challenges, a government officer disclosed that the Ministry of Expatriate Welfare and Overseas Employment recently requested all civil surgeons to arrange or give priority to screening departing migrants in their areas. He also added that they are trying to generate a policy which will bring all the medical service providers under one umbrella so that they can be monitored and controlled. (Enable other facilities to provide medical certificates).

[6] *There are total 26 health facilities accredited by GAMCA in Bangladesh as of June 2015 to provide pre-departure health examination. All are located in capital city, Dhaka in Bangladesh. The required tests includes; physical examination, Chest X-ray, HIV test, HBs Ag, anti-HCV, VDRL, Urine test, stool examination, Malaria test, and micro-filariasis test.*

3.2.8 Source of health information

Participants from all FGD groups noted media sources as a key source of health information. Some also had access to information, education and communication (IEC) materials, and health-care providers for health information. Departing and returnee migrants had not received IEC materials in destination countries. However, departing migrants said that they were aware of such information and had seen health-related posters and billboards in Bangla [7] or Bengali language, which they could understand (this was considered positive). Returnee migrants said that they had received some IEC materials from their home countries. Spouses of migrants could not recall seeing any health communication material specifically targeting migrants.

FGD group	Primary source(s) of health information	Additional source(s) of health information
Departing migrants	Television, radio	Health-related posters and billboards; mobile SMS sent from telecommunications provider (could not recall the information source)
Returnee migrants	TV, health service providers, IEC materials from home country	Friends
Spouses of migrants	Health service providers	Media: TV, mobile SMS, newspapers, posters

In terms of usage patterns, TV was popular among all FGD groups. Departing and returnee migrants watched TV almost daily, usually in the evening or late at night, with males preferring to watch the news, talk shows, sports and drama, and females preferring drama and news shows, particularly Indian Bangla channels. However, the scheduling of programmes was the primary determinant of what they watched. Returnee migrants reported that they watch TV more regularly while abroad, particularly "*Desi*" channels, to keep updated on events in Bangladesh, as a leisure activity, and to combat homesickness. Spouses of migrants shared similar programme preferences, in addition to cooking programmes, movies and music. Their most watched channels are Channel I, NTV, RTV and Indian channels.

Radio listenership was generally low among all FGD groups. Departing migrants were the most likely to listen, with two thirds of participants stating that they listen regularly, with a preference for BBC news, as well as music, drama and sports updates. However, they acknowledged that listening occurred on an *ad hoc* basis, usually in order to follow popular sporting events such as cricket matches.

Reading the newspaper was found to be uncommon among all FGD groups except returnee migrants, who read the newspaper regularly at home. They noted that this was not possible abroad, due to difficulty accessing Bangla newspapers outside of their home country.

The majority of participants do not use the internet. As most migrants are illiterate and unfamiliar with computer technology, the internet is not seen as a strong dissemination channel for health information.

[7] *Bangla or Bengali language is the national language of Bangladesh. It is also one of the national languages officially recognized by the constitution of India.. Encyclopaedia Britannica. 2014. http://global.britannica.com (accessed on 17 February 2015)*

Migrants noted that it was important to have communication materials in Bangla language, so that it is understandable. They suggested the following channels would be most desirable for delivering health communication materials:

- Leaflets, posters ("more effective at conveying messages"; departing migrants prefer posters to leaflets)
- Counselling services prior to departure/at airport
- Pre-departure seminars on health topics
- Mobile SMS; TV and newspaper features
- Health-care centres
- Doctors

Spouses of migrants also noted they would prefer to receive migrant-specific information from doctors, whom they consider to provide authentic information. Key health information topics that were requested were: HIV/AIDS, TB, diabetes, nutrition, 'how to lead life', health service provider information, and cancer. One of the key informants suggested creating a toll-free calling service. This would involve distributing a toll-free phone number to migrants at departure or arrival, which can be called at any time to receive assistance or health information. It was also suggested that a mobile text messaging scheme already used by the government could be harnessed to deliver health messages.

3.2.9 Policy environment on migrants' health in Bangladesh

Generally key informants had incomplete knowledge of the International Health Regulations (IHR), or the Dhaka Declaration, and were not aware of any government initiatives. Key informants reported that the Bangladeshi Government is reluctant to take real action on the issue of migrants' health, and prefer to attend seminars and sign declarations, but failing to implement real actions on the ground. Various limitations also hinder their capacity in this regard, with existing policies requiring revision, particularly to incorporate migration and health issues. The present migration policy does not include health issues, while the relatively new health policy of Bangladesh does not cover migrant issues. While the strategic plan for HIV mentions migrants as a vulnerable group, it fails to detail an implementing policy. Perceptions are a further limitation, with government officials concerned that in acknowledging health issues they will discourage individuals from migrating. However, as a result, migrants' rights, including their right to health are neglected.

Currently, migrants in Bangladesh are exceedingly vulnerable and are "forgotten" from policies and health programmes. Key informants agreed that government support is required to promote equity in health for migrants, with capacity building needed in sending and receiving countries. The involvement of the Ministry of Expatriates Welfare and Overseas Employment is requested, to facilitate the provision of education, information, access to health services, and legal protection of departing and returnee migrants. Special steps to monitor the employee-employer contract will also be required, particularly with regard to health and safety risks, migrant entitlements, and the payment of damages and health costs. It will also be important to ensure that both parties understand the terms of agreement.

A government official acknowledged the limitations in knowledge and practice by the government, but noted that progress is starting to be made, and policymakers are increasingly aware of the need to address migrant health issues. There are plans to increase the duration of the pre-departure health briefing session from one hour to three days, and revise and update the content. Additionally, all district-level civil surgeons have been instructed to arrange and prioritize medical check-ups for departing migrants, while collaboration between the Ministry of Health and Ministry of Expatriates will facilitate the development of relevant policies, although a timeframe was not provided.

Given that the policies in destination countries are difficult to influence, it will be important for the Government of Bangladesh takes action for the protection and well-being of Bangladeshi migrants.

CHAPTER FOUR

DISCUSSION OF FINDINGS

Bangladesh is a low income country and one of the most densely populated developing countries in the Asia and the Pacific region. The country has a rapidly growing population and labour force with hardly any investment for new economic opportunities. In addition to its shrinking economy, Bangladesh have been facing several natural disasters, such as cyclones, droughts, floods and river erosions brought about by climate change affecting the livelihood of the people. Under these circumstances, outbound labour migration has become a regular and significant feature of Bangladesh's social and economic profile for several decades.

Bangladesh is one of the largest migrant sending countries in South Asia after India. Majority of the Bangladeshi migrant workers are in the Gulf Cooperation Countries, particularly Saudi Arabia and the United Arab Emirates followed by Malaysia in Southeast Asia. Almost half of the migrant workforce is engaged in unskilled and less-skilled jobs, considering that almost ten per cent were reported as uneducated and half achieving only a junior level education. Female migrants, mostly domestic and factory workers have increased in the past years along with an undetermined number of irregular migrants working in India (UN WOMEN, 2012).

Boosted by the remittances of migrants working abroad, the national economy of Bangladesh has steadily improved. Remittances now constitute approximately 9.2 per cent of the country's Gross Domestic Product (World Bank, 2014a). Ranked by World Bank as 8th among countries deriving highest income from foreign remittances in 2013 (World Bank, 2014b), the country's migrant workers has not only kept the economy afloat but are also investing on its future through the earnings they send back for the livelihood, income, education and well-being of their families left behind. Labour migration also benefits the country of destination through the cheap labour migrant workers provide that spurs the social and economic development of the countries hosting them.

Health is a critical asset for migrant workers and their families. Any negative health outcomes do not only affect individual migrants, but also impacts the social and economic conditions of the migrants and their host communities. It also has a repercussion on the families left behind, including the wider community in the country of origin (IOM, 2009). Thus, for Bangladeshi migrant workers it is essential to ensure their protection and well-being through sound policies and programmes that are guided and at pace with the growing challenges and dynamics of modern migration.

Studies on the health status and vulnerabilities of inbound and outbound migrants in or from Bangladesh have been very limited. So far, there has been very little quantitative or qualitative data to support policy and programme development.

Although the results of this study may not have captured all the nuances of migration in or out of Bangladesh, it provides an evidence-base for the government and other stakeholders to develop and strengthen national strategy and programmes to address the health needs of migrants.

4.1 Migration Profile

The majority of respondents were 35 years of age or younger. Departing migrants were younger compared to returnees, with more than a quarter aged under 25. Almost two thirds of respondents were married. Just over one third of respondents had a secondary or higher education. Departing migrants reported a poorer economic status than returnees. The majority of migrants spent between 1 and 3 years abroad. There appears to be an inconsistency between the intended and actual time

spent abroad, with women typically spending less time and men spending slightly more time than anticipated. While it is difficult to directly compare the expectations of departing migrants with the experiences of returnee migrants as they are a different group of people, data indicate that migrants experience circumstances leading to alterations to their original migration plans. Termination of contract and personal reasons, for instance, were more likely to lead to truncated trips abroad.

The data from this study suggest that migrants faced increased difficulties while abroad, particularly financial problems, but also difficulties related to discriminatory treatment. The appeal of work abroad, however, appears to trump these problems, as most intend to travel abroad again. To prevent exploitation and limit the difficulties faced by these workers, more support is required from official sources throughout the migration process. While NGOs already appear to offer assistance to returnee migrants, increased assistance efforts from those already mentioned as well as employing companies could improve the living circumstances of migrants. Financial assistance such as health insurance would be particularly valuable;

4.2 Health risks and vulnerabilities

Only 1 in 4 migrants had fallen ill in the past 6 months, mostly due to minor illnesses and respondents tended not perceive themselves to be at risk of diseases such as Tuberculosis, HIV/AIDS, STI or Hepatitis C. They did, however, report the occurrence of occupational hazards and mental health problems brought on by physical and psychosocial risks within their living and working environments. Indeed these conditions were especially highlighted by returnee migrants. Health-care providers should be able to adequately address these concerns through adequate training in migrant health needs and services, such as counselling. This particularly applies to public health-care providers, as these are the providers most commonly visited in Bangladesh. Employers also need to address migrants' health concerns through the provision of health-care support or health financing schemes, as well as secure working environments. Capped working hours, adequate safety equipment, and no-tolerance policies towards sexual abuse and violence in the workplace are a few examples of conditions that migrants should have guaranteed to them, all of which the Government of Bangladesh should be working to ensure.

The migrants interviewed in this study did not report strong tendencies towards risk behaviour that could increase the possibility of HIV infection, including injecting drug use or unprotected sex. While one sexual partner, typically a spouse, was the norm at home in Bangladesh, and having more than one partner was more often reported among those who live abroad, the low numbers of those who stated that they had sex abroad makes it difficult to characterize the types of sexual partners. Regardless, the inconsistent condom usage, including with sex workers while abroad, as well as STI symptoms reported by the spouses of migrants is a cause for concern for their sexual health. More studies need to be undertaken to understand these behaviours and how they change during the different phases of migration.

Although the number of female respondents may not be representative of the general female migrant population, it is important to highlight the considerably high number of respondents who reported sexual violence and abuse. These responses are consistent with data from other studies of migrants in South Asia (UNDP, 2009) and should be investigated further.

4.3 Health-care seeking behaviour

Migrants have a tendency to seek health-care only when ill rather than seeking preventive medical check-ups. This was reflected in the low percentage of returnee migrants who elected for a medical check-up upon return from destination countries and the comparatively high rate of health-care seeking among those who identified themselves as symptomatic due to, for instance, an STI or occupational hazard. This low level of preventive health-care seeking is due largely to the fact that migrants don't perceive themselves vulnerable to disease or accidents. While this is understandable as the sample was of a young and typically healthy demographic, it is clear that there is also sub-optimal understanding of possible risks associated with poor working and living conditions. A third of migrants, for instance, did not know their risk of Tuberculosis. The low health-care seeking is also a result of inconvenient or sub-optimal quality services in both the country of origin and destination. Health facilities, therefore, need to be made more user-friendly in order to encourage positive health seeking behaviour.

4.4 Health-care accessibility in the country of origin and destination

Comprehensive health-care is lacking in respondents' communities in Bangladesh. While the majority of respondents acknowledged that general medical treatment is available, specific health-care services were not frequently identified. Indeed a third of respondents felt that public health facilities were not available to them. Long distances to health facilities constituted the third most important barrier to accessing health-care. The data does not differentiate between actual poor availability and poor knowledge of availability, however the fact that availability was lower according to returnee migrants may suggest that familiarity with the community plays an important role. As a result, the findings suggest room for improvement in terms of both infrastructure and health service awareness among the population.

One in four migrants faced difficulties seeking health-care including unavailable doctors, long distances to health facilities, the lack of information and discrimination towards migrants.

Finally, the fact that approximately 1 in 3 migrants faced difficulties financing health-care and the predominant method of health-care financing was out-of-pocket payment reveals sub-optimal adoption of the universal health coverage implemented in Bangladesh.

In destination countries, health-care accessibility was limited with only a third of returnee migrants feeling like they could access public health services there, and just under a half of them know where migrants could access care and treatment. Among the latter group, the most frequently identified services were primary health care (60%) and medicines (75%). However as medicines are also accessible at pharmacies, this higher figure does not necessarily represent access to health-care providers and pharmacies.

Barriers accessing health-care were more pronounced abroad compared to in Bangladesh, cited by 35 per cent of migrants. Health infrastructure in the countries of destination appears to be lacking, as unavailable doctors was a common complaint among respondents. However, lack of information was a more important barrier, and discrimination was surprisingly less important.

Poor affordability of health-care in the country of destination was reported as a serious problem for migrants, with almost 50 per cent experiencing difficulties affording health services. This is rooted in the lack of health-care coverage schemes; only 16 per cent of employers fully paid for health-care services, and only 1 per cent of migrants utilized health insurance while 12 per cent actually had health insurance. There is a general lack of understanding of how health systems function in the country of destination; 42 per cent cited the 'complex system' as a major barrier. Migrants therefore need to be equipped with information regarding their right to health-care financing, as well as the various options and financing schemes available, including the responsibility of employers to cover health expenses and the terms of conditions of health insurance plans, which often appear to not be usable when migrants fall ill. Also the need for information is not appropriately addressed through general health communications or through pre-departure health orientations. This is discussed in more detail later.

4.5 Mandatory medical examinations prior to departure

Mandatory medical examinations prior to departure were undertaken by almost all migrants according to the rules and regulations. The individual tests undertaken, varied across participants, for example, men reported higher numbers of HIV tests compared to women. While this may indicate risk profiling or unstandardized components of the medical examinations across providers, it is more likely pointing to a general lack of understanding among migrants of the tests as it is a fact that all migrants needing a work permit for most destination countries need to undergo a standard number of tests and are screened for a standard list of diseases and health conditions.

Additionally, migrants reported experiences of corruption and falsifying medical certificates which indicates that ethical standards in health facilities are not in place or enforced. Furthermore, migrants pay for these medical examinations which is unethical as the examination is a mandatory requirement of destination countries part of obtaining the work permit.

4.6 Health knowledge and sources of health information

Limited health knowledge presents a health risk for migrants as well as their families, as more than a third of migrants were unaware of diseases that could be transmitted to relatives and other members of the home communities upon return in the country of origin.

Distribution of IEC materials was also inconsistent, with migrants reporting that some received IEC materials at pre-departure orientations and others from foreign missions. This is further reflected in the feedback from the FGDs, where participants reported varying access to IEC materials. In many cases, migrants did not receive or were not aware of IEC materials.

Television, however, has wide coverage and local or 'Deshi' channels could potentially be utilized as an effective channel for dissemination of health information both in Bangladesh and abroad. The use of other mass media such as billboards/signboards and radio should also be further optimized; these sources appear to be preferred, but are not actually used as such. Informal networks appear to be particularly important for spreading information among returnee migrants particularly while in destination countries. This is especially true for hard-to-reach groups. This method of information dissemination could be harnessed by holding more community events or through the use of social

media as the internet becomes increasingly popular, although data from this study indicates that internet use is not high.

Community doctors and health worker or centres can play an additional effective role in distributing health information, however care must be taken to ensure that their methods or materials are appropriate for a migrant audience in both language and content. This is particularly the case in destination countries, where almost no respondents could understand the health materials they were provided.

Heath orientations could provide an excellent opportunity for the provision of important health information prior to departure. They are, however, not often available to migrants in Bangladesh, not accessible to undocumented migrants, and furthermore if they are offered they provide limited, unstandardized information. Therefore, contents of pre-departure health orientations should be expanded Migrants should be provided information on a range of health risks, as well as where and how to access health services in destination countries. Health information should also challenge health misconceptions, such as the reported notions that mosquitos or sharing clothes can transmit HIV, or the belief that TB can be transmitted through the cold or acquired via smoking.

CHAPTER FIVE

RECOMMENDATIONS

Improvements to the health of Bangladeshi migrants can be achieved through both strengthening migrant sensitive health systems in Bangladesh, as well as improved working conditions abroad, including adherence to occupational health and safety standards, access to health insurance and pro-active health promotion programmes by employers and other stakeholders.

One of the ways in which such improvements can be attained is through bilateral agreements between Bangladesh and destination countries and increased multi-sectoral cooperation and coordination in Bangladesh.

The following recommendations have been made in accordance with the *World Health Assembly Resolution 61.17 on the Health of Migrants Global Operational Framework*. The framework consists of four primary action points, namely monitoring migrant health; policy-legal frameworks; migrant sensitive health systems; and partnerships, networks and multi-country frameworks.

5.1 Monitoring Migrant Health

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

a. More research is needed to understand the female experience of migration;

b. More comprehensive research on the sexual behaviours of migrants throughout the migration process would be useful to understanding their risks of STIs/HIV;

c. Research should be undertaken to consider destination country-specific migrant experiences to enable custom interventions for Bangladeshi migrants;

d. More research should examine the health status of cross-border and irregular Bangladeshi migrants, who are not frequently covered in current literature;

e. Regional research should be undertaken to identify key indicators that are acceptable and useable across the region; and to identify the techniques of promoting the inclusion of migration variables in existing censuses, national statistics, targeted health surveys and routine health information systems, as well as in statistics from sectors such as housing, education, labour and migration.

5.2 Policy and Legal Frameworks

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

a. The government of Bangladesh should sign and ratify the major migration related conventions such as UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, and review the compliance;

b. Bangladesh should develop migration policy that explicitly takes into account the health of migrants;

c. Government of Bangladesh should take steps to make the migration process more 'migrant-friendly' rather than 'state-friendly' by monitoring and regulating the activities of recruiting agencies and health assessments centres;

d. Interactions should take place in the form of discussions, meetings and conferences with representations from government, private agencies, NGOs/INGOs and migrants to come up with a comprehensive policy and implementation mechanism enabling migrants to access prejudice-free health-care abroad. In particular, specific steps should be taken to limit discrimination in the health-care environment, such as implementing no-tolerance policies;

e. Through a progressive empowerment model, migrants should be engaged in the planning, implementation and oversight of health services, and health systems should facilitate an ongoing dialogue with migrant communities and their representatives. Migrants can be involved in bridging the gap between their communities and health-care systems by participating as interpreters, intercultural mediators and educators in outreach programmes, and those with health professional credentials from other countries can be supported to re-qualify and enter practice.

5.3 Migrant Sensitive Health Systems

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

a. Agencies and employers should take on increased responsibility for the well-being of migrants, particularly concerning health-care financing providing pre-departure orientations, and promoting safe and secure working environments. This should include:

   i. Issuing a medical health-care card in countries where such cards exist;

   ii. Drafting a clear and transparent binding contract that details the provision of health-care by the employing party;

   iii. Integrating capped working hours, safety measures, and no-tolerance policies towards sexual abuse and violence in the workplace.

b. A system involving a third-party overseeing authority should be developed, or stricter regulations should be applied to ensure agencies or employers adhere to their commitments.

c. Bangladesh should continue to invest in improved health infrastructure and health provider capacity. Activities should include:

   i. Provision of training and disseminating guidelines to ensure implementation of SOPs such as informed consent, test result sharing, and post-test counselling, particularly where sensitive tests such as HIV tests are concerned;

   ii. Training on ethics and preventing corruption;

   iii. Increasing health-care accessibility in rural areas;

   iv. Implementing universal health coverage.

d. Popular media, particularly popular television channels, should be used to spread health messages targeting migrants both in both the country of origin and destination. Strategically located posters and other visual media should also be made easily accessible; however they must be understandable by the target audience.

e. Health providers should be harnessed for improved health education. Improved health materials should be developed, using effective content and language tailored for migrant populations.

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

   i. Specific health issues, including relevant communicable diseases such as HIV, TB, and hepatitis, occupational hazards, mental health problems, including those related to sexual violence, as well as the validity of seeking health-care for these conditions;

   ii. Availability of health-care and health insurance, as well as the related terms and conditions;

   iii. The importance of condoms and receive empowerment training to demand use;

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

5.4 Partnerships, Networks and Multi-country Frameworks

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

a. Any bilateral labour agreements between Bangladesh and any labour receiving country should include the health of migrants as an essential and 'non-negotiable' component.

b. Effective health related foreign policies, especially at the diplomatic level must be established in order for diplomatic intervention if Bangladeshi citizens encounter problems that jeopardize their health while in the country of destination.

c. Government of Bangladesh should initiate inter-ministerial coordination between stakeholder agencies, especially Ministry of Foreign Affairs, Ministry of Labour and Employment and Ministry of Health to facilitate the foreign employment process.

d. The Government of Bangladesh should consider the problems faced by undocumented migrants and form comprehensive policies to include them in efforts of protection and promotion. This can be done by including migration issues on the agenda for South Asian Association for Regional Cooperation (SAARC) processes.

e. Initiative should be taken to form functional multi-stakeholder working groups to further refine and implement the operational framework on migrant health and to develop a resource mobilization plan and establish an inventory of reference of good practices in migrant health monitoring, policy development and service delivery.

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ANNEXES

Annex 1: Bivariate and multivariate tables

Appendix 1.1: Univariate and multivariate logistic regression analysis of demographic differences between departing and returnee migrants (Where departing = 1 and returnee = 0)

	Univariate analysis			Multivariate analysis		
	Odds ratio	Confidence interval	P-value	Odds ratio	Confidence interval	P-value
Gender (Female = 0, Male = 1)	1.20	0.71-2.02	0.497			
Age	0.88	0.85-0.92	0.000*	0.88	0.83 - 0.92	0.000
Marital status (0=Married, 1=Not Married)	0.61	0.41-0.90	0.014*	1.01	0.91 - 1.12	0.864
Highest level education (0 = None, 1 = below primary, 2 = primary, 3 = secondary, 4 = college/university)	0.64	0.53-0.77	0.000*	0.52	0.39 - 0.69	0.000
Family income (tk)	0.42	0.32-0.54	0.000*	250	53.08 - 1183.30	0.000
Number of people in family	1.08	0.82-1.41	0.585			

Multivariate logistic regression model based on variables with P<0.05 in univariate analysis (marked with *)
Interpretation: Odds ratio >1 means higher value/category has association with returnee migrants

Appendix 1.2: Intended and most recent countries among departing and returnee migrants

	All		Male		Female	
	%	N	%	n	%	n
Departing migrants: Intended countries of destination						
Oman	63.6	131	67.1	118	43.3	13
Bahrain	16.0	33	18.2	32	3.3	1
Dubai	9.7	20	4.6	8	40.0	12
Saudi Arabia	4.9	10	5.1	9	3.3	1
Qatar	2.4	5	2.8	5	0.0	0
Lebanon	1.5	3	0.0	0	10.0	3
Malaysia	0.5	1	0.6	1	0.0	0
Europe	0.5	1	0.6	1	0.0	0
Kuwait	0.5	1	0.6	1	0.0	0
Singapore	0.5	1	0.6	1	0.0	0
Total		**206**		**176**		**30**

	All		Male		Female	
	%	N	%	n	%	n
Returnee migrants: Countries of destination at last migration						
United Arab Emirates	27.1	59	28.2	51	26.7	8
Saudi Arabia	24.3	53	28.2	51	5.4	2
Singapore	11.5	25	13.8	25	0.0	0
Lebanon	8.3	18	2.2	4	37.8	1
Oman	7.8	17	6.1	11	16.2	6
Kuwait	5.5	12	2.2	4	37.8	14
Qatar	3.2	7	3.9	7	0.0	0
Malaysia	3.2	7	3.3	6	2.7	0
Bahrain	2.8	6	2.2	4	5.4	2
Maldives	2.8	6	3.3	6	0.0	0
United Kingdom	0.9	2	1.1	2	0.0	0
China	0.5	1	0.6	1	0.0	0
Italy	0.5	1	0.6	1	0.0	0
Jordan	0.5	1	0.6	1	0.0	0
Total		**218**		**181**		**37**

Appendix 1.3: Incidence of occupational hazards and associated health-care seeking behaviour among departing and returnee migrants

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Have you ever been suffered from any occupational hazard?							
Yes	19.3% (34)	3.3% (1)	17.0% (35)	24.9% (45)	18.9% (7)	23.9% (52)	20.5% (87)
No	80.7% (142)	96.7% (29)	83.0% (171)	75.1% (136)	81.1% (30)	76.1% (166)	79.5% (337)
Don't Know	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**176**	**30**	**206**	**181**	**37**	**218**	**424**
Did you seek any kind of advice or treatment?							
Yes	100.0% (34)	100.0% (1)	100.0% (35)	84.4% (38)	42.9% (3)	78.8% (41)	87.4% (76)
No	0.0% (0)	0.0% (0)	0.0% (0)	15.6% (7)	57.1% (4)	21.2% (11)	12.6% 11)
Don't Know	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**34**	**1**	**35**	**45**	**7**	**52**	**87**

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
To whom did you seek advice or treatment?							
Doctor/ clinic/ hospital	23.5% (8)	100.0% (1)	25.7% (9)	92.1% (35)	100.0% (3)	92.7% (38)	61.8% (47)
Traditional healer	2.9% (1)	0.0% (0)	2.9% (1)	0.0% (0)	0.0% (0)	0.0% (0)	1.3% (1)
Village quack/ shop/ pharmacy	88.2% (30)	100.0% (1)	88.6% (31)	7.9% (3)	0.0% (0)	7.3% (3)	44.7% (34)
Friends/ relatives	8.8% (3)	0.0% (0)	8.6% (3)	0.0% (0)	0.0% (0)	0.0% (0)	3.9% (3)
Homeopathic	5.9% (2)	0.0% (0)	5.7% (2)	0.0% (0)	0.0% (0)	0.0% (0)	2.6% (2)
Others	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**34**	**1**	**35**	**38**	**3**	**41**	**76**

Appendix 1.4: Incidence of mental health problems and associated health-care seeking behaviour among departing and returnee migrants

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Have you ever been suffered from a Mental Health problem?							
Yes	3.4% (6)	3.3% (1)	3.4% (7)	8.8% (16)	5.4% (2)	8.3% (18)	5.9% (25)
No	96.6% (170)	96.7% (29)	96.6% (199)	91.2% (165)	94.6% (35)	91.7% (200)	94.1% (399)
Don't Know	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**176**	**30**	**206**	**181**	**37**	**218**	**424**
Did you seek any kind of advice or treatment?							
Yes	66.7% (4)	100.0% (1)	71.4% (5)	87.5% (14)	50.0% (1)	83.3% (15)	80.0% (20)
No	33.3% (2)	0.0% (0)	28.6% (2)	12.5% (2)	50.0% (1)	16.7% (3)	20.0% (5)
Don't Know	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**6**	**1**	**7**	**16**	**2**	**18**	**25**
To whom did you seek advice or treatment?							
Doctor/ clinic/ hospital	75.0% (3)	100.0% (1)	80.0% (4)	92.9% (13)	100.0% (1)	93.3% (14)	90.0% (18)
Traditional healer	50.0% (2)	100.0% (1)	60.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)	15.0% (3)
Village quack/ shop/ pharmacy	75.0% (3)	100.0% (1)	80.0% (4)	7.1% (1)	0.0% (0)	6.7% (1)	25.0% (5)
Friends/ relatives	25.0% (1)	0.0% (0)	20.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	5.0% (10
Homeopathic	50.0% (2)	100.0% (1)	60.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)	15.0% (3)
Others	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**34**	**1**	**35**	**38**	**3**	**41**	**76**

Appendix 1.5: Incidence of non-communicable diseases and associated health-care seeking behaviour among departing and returnee migrants

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Have you ever been suffered from a non-communicable disease?							
Yes	0.0% (0)	3.3% (1)	0.5% (1)	15.5% (28)	18.9% (7)	16.1% (35)	8.5% (36)
No	100.0% (176)	96.7% (29)	99.5% (205)	84.5% (153)	81.1% (30)	83.9% (183)	91.5% (388)
Don't Know	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**176**	**30**	**206**	**181**	**37**	**218**	**424**
Did you seek any kind of advice or treatment?							
Yes	-	100.0% (1)	100.0% (1)	96.4% (27)	100.0% (7)	97.1% (34)	97.2% (35)
No	-	0.0% (0)	0.0% (0)	3.6% (1)	0.0% (0)	2.9% (1)	2.8% (1)
Don't Know	-	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**0**	**1**	**1**	**28**	**7**	**35**	**36**
To whom did you seek advice or treatment?							
Doctor/ clinic/ hospital	-	100.0% (1)	100.0% (1)	92.6% (25)	100.0% (7)	94.1% (32)	94.3% (33)
Traditional healer	-	100.0% (1)	100.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	2.9% (1)
Village quack/ shop/ pharmacy	-	100.0% (1)	100.0% (1)	11.1% (3)	0.0% (0)	8.8% (3)	11.4% (4)
Friends/ relatives	-	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Homeopathic	-	100.0% (1)	100.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	2.9% (1)
Others	-	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
Total	**0**	**1**	**1**	**27**	**7**	**34**	**35**

Appendix 1.6: Drug use among male and female departing and returnee migrants

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
In the past 12 months, have you ever used any drug to make you feel high?							
Yes	5.1% (9)	0.0% (0)	4.4% (9)	1.1% (2)	0.0% (0)	0.9% (2)	2.6% (11)
No	94.9% (167)	100.0% (30)	95.6% (197)	96.1% (174)	100.0% (37)	96.8% (211)	96.2% (408)
Don't Know	0.0% (0)	0.0% (0)	0.0% (0)	2.8% (5)	0.0% (0)	2.3% (5)	1.2% (5)
Total	**176**	**30**	**206**	**181**	**37**	**218**	**424**

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Types of drugs used (multiple answers):							
Alcohol	33.3% (3)	-	33.3% (3)	0.0% (0)	-	0.0% (0)	27.3% (3)
Ganja	66.7% (6)	-	66.7% (6)	50.0% (1)	-	50.0% (1)	63.6% (7)
Phensydyl	11.1% (1)	-	11.1% (1)	100.0% (2)	-	100.0% (2)	27.3% (3)
Others	55.6% (5)	-	55.6% (5)	100.0% (2)	-	100.0% (2)	63.6% (7)
Total	**9**	**0**	**9**	**2**	**0**	**2**	**11**
Have you injected any drug in past 12 months?							
Yes	11.1% (1)	-	11.1% (1)	0.0% (0)	-	0.0% (0)	9.1% (1)
No	88.9% (8)	-	88.9% (8)	100.0% (2)	-	100.0% (2)	90.9% (10)
Total	**9**	**0**	**9**	**2**	**0**	**2**	**11**

Appendix 1.7: Blood transfusions among male and female departing and returnee migrants

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Have you ever had a blood transfusion?							
Yes	0.6% (1)	0.0% (0)	0.5% (1)	10.5% (19)	5.4% (2)	9.6% (21)	5.2% (22)
No	99.4% (175)	100.0% (30)	99.5% (205)	88.4% (160)	94.6% (35)	89.4% (195)	94.3% (400)
Don't Know	0.0% (0)	0.0% (0)	0.0% (0)	1.1% (2)	0.0% (0)	0.9% (2)	0.5% (2)
Total	**176**	**30**	**206**	**181**	**37**	**218**	**424**
Was that blood screened?							
Yes	100.0% (1)	-	100.0% (1)	89.5% (17)	100.0% (2)	90.5% (19)	90.9% (20)
No	0.0% (0)	-	0.0% (0)	10.5% (2)	0.0% (0)	9.5% (2)	9.1% (2)
Total	**1**	**0**	**1**	**19**	**2**	**21**	**22**

Appendix 1.8: Financing of mandatory health assessments among male and female departing and returnee migrants

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Was your health assessment free of charge?							
Yes	2.8% (5)	10.3% (3)	3.9% (8)	1.4% (2)	3.7% (1)	1.7% (3)	2.9% (11)
No	97.2% (171)	89.7% (26)	96.1% (197)	98.6% (144)	96.3% (26)	98.3% (170)	97.1% (367)
Total	**166**	**29**	**195**	**146**	**27**	**173**	**378**
If no, who paid for treatment?							
Employer/ Agency	1.8% (3)	3.8 (1)	2.0% (4)	6.3% (9)	11.5% (3)	7.1% (12)	43.6% (16)
Self	97.7% (167)	92.3% (24)	97.0% (191)	93.8% (135)	88.5% (23)	92.9% (158)	94.5% (349)
Other	0.6% (1)	3.8% (1)	1.0% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.5% (2)
Total	**171**	**26**	**197**	**144**	**26**	**170**	**367**

Appendix 1.9: Distribution of respondents according to use of media materials, presented by male and female departing and returnee migrants

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Do you watch/read…							
Newspaper	51.1% (90)	16.7% (5)	46.1% (95)	44.8% (81)	5.4% (2)	38.1% (83)	42.0% (178)
Radio	36.9% (65)	16.7% (5)	34.9% (70)	22.7% (41)	16.2% (6)	21.6% (47)	27.6% (117)
Television	94.9% (167)	80.0% (24)	92.3% (191)	91.2% (165)	59.5% (22)	85.8% (187)	89.2% (378)
Internet	6.8% (12)	3.3% (1)	6.3% (13)	14.4% (26)	2.7% (1)	12.4% (27)	9.4% (40)
Total	**176**	**30**	**206**	**181**	**37**	**218**	**424**

Appendix 1.10: Frequency of watching/reading the newspaper, radio, television, and internet, as % of male and female departing and returnee migrants

	Departing Male	Departing Female	All Departing	Returnee Male	Returnee Female	All Returnee	All
	%(n)	%(n)	%(n)	%(n)	%(n)	%(n)	%(n)
How often do you read the newspaper?							
Everyday	44.4% (40)	20.0% (1)	43.2% (41)	50.6% (41)	50.0% (1)	50.6% (42)	46.6% (83)
At least once a week	51.1% (46)	40.0% (2)	50.5% (48)	40.7% (33)	0.0% (0)	39.8% (33)	45.5 (81)
Less than once a week	4.4% (4)	40.0% (2)	6.3% (6)	8.6% (7)	50.0% (1)	9.6% (8)	7.8% (14)
Total	**90**	**5**	**95**	**81**	**2**	**83**	**178**
How often do you listen to the radio?							
Everyday	49.2% (32)	20.0% (1)	47.1% (33)	22.0% (9)	33.3% (2)	23.4% (11)	37.6% (44)
At least once a week	41.5% (27)	80.0% (4)	44.3% (31)	56.1% (23)	50.0% (3)	55.3% (26)	48.7% (57)
Less than once a week	9.2% (5)	0.0% (0)	8.6% (6)	22.0% (9)	16.7% (1)	21.3% (10)	13.7% (16)
Total	**65**	**5**	**70**	**41**	**6**	**47**	**117**
How often do you watch television?							
Everyday	67.1% (112)	66.7% (16)	67.0% (128)	71.5% (118)	63.6% (14)	70.6% (132)	68.8% (260)
At least once a week	28.7% (48)	25.0% (6)	28.3% (54)	26.7% (44)	36.4% (8)	27.8% (52)	28.0% (106)
Less than once a week	4.2% (7)	8.3% (2)	4.7% (9)	1.8% (3)	0.0% (0)	1.6% (3)	3.2% (12)
Total	**167**	**24**	**191**	**165**	**22**	**187**	**378**

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