



MIGRANT FORUM IN ASIA INPUT FOR UN SR VIOLENCE AGAINST WOMEN: MISTREATMENT AND VIOLENCE AGAINST WOMEN DURING REPRODUCTIVE HEALTH CARE WITH A FOCUS ON CHILDBIRTH - MAY 2019

INTRODUCTION

Migrant Forum in Asia is a network of grassroots organisations in Asia that work for the protection and promotion of migrant and human rights. Migrant Forum in Asia (MFA) welcomes the decision of the Special Rapporteur on Violence Against Women to produce a joint general comment on mistreatment and violence against women during reproductive health care. MFA looks forward to providing a contribution to the issue relating to the topic in the context of international migration and particularly regarding domestic workers. In this paper, we have compiled inputs of our members and partners on ground realities of reproductive healthcare practices in several countries in Asia including Lebanon, India, Bangladesh, Nepal, Malaysia, Taiwan, Japan, Philippines and Singapore¹².

As an organisation based on migrant rights, MFA would like to expand the scope of this input on reproductive rights beyond service provision regarding healthcare, as the realities faced by migrant domestic workers are far more complex and begin at the country of origin. The paper would be looking at policies and grassroots level activities at the destination and origin country with a perspective of following throughout the migration process.

DISCRIMINATION AT DESTINATION

Migrant domestic workers are arguably the single most disregarded segment of workers in national labour laws of destination countries within Asia. While there are specific policies to their recruitment processes and employment

contracts, living and working conditions as well as gender-responsive policies are few and far in between. The increasing value of the care economy deems it necessary for domestic workers to be present for long period of

¹ The members and partners are: NWWT (India), CMA (Philippines), Unlad Kabayan (Philippines), Our Journey (Malaysia), TWC2 (Singapore), SMJ (Japan), HMISC (Taiwan), Insan (Lebanon), Pourakhi (Nepal), AMKAS (Nepal), BNSK (Bangladesh).

time within the living space of the employer and are preferred as live-in. It becomes problematic for the workers themselves when they are made to live-in with the employers and this has primarily been identified as a major loophole where abuse and exploitation occurs.

The care economy in response to a growing ageing population has deemed domestic workers necessary and while their demand had been regulated through recent efforts at recruitment reform, policy and programme decisions in both countries of destination and origin have been found lacking. In many cases, they have been willfully ignorant of ground realities of abuse that occurs at the place of work, thereby dehumanizing the female migrant worker and removing her from accessing her human and labour rights.

Sexual and reproductive health rights are usually glossed over in general and female migrant workers suffer for this. For example, a migrant suffering from dysmenorrhea would prefer not to displease the employer and would reconsider approaching medical care due to costly fees and so they opt to endure the pain.

In most Islamic countries social contact between male and female who are not married is forbidden and, in some cases, maybe be considered a crime. In more open societies there is more social interaction between sexes that often lead to relationships and unwanted pregnancies. Formal/official programs and education on reproductive health in post arrival is still non-existent in most CODs.

Reproductive health education in a formal programmatic manner is often a service of civil society organizations, including trade unions, women's organizations, NGOs.

Commonly, access to healthcare depends on the country of destination but also on the circumstances of the pregnancy (within marriage, out of wedlock, rape, etc.). If the pregnancy was out of wedlock, it can possibly be grounds for detention or a case against immorality or adultery in the Middle East. Accessibility can also depend on one's legal status in the country of destination. Even if the female migrant can pay for the medical expense, hospitals will refuse to admit them because they consider the immigration status foremost. Migrant women who find themselves pregnant while in COD are often made to return to home country after facing penalties. Returnee female migrants are often preoccupied with economic and livelihood issues and reproductive healthcare per se is considered only if she is pregnant upon return.

Undocumented workers usually avoid access to reproductive health care for fear of arrest/detention. Workers that are caught and detained may either be repatriated or give birth while in detention. Specialized hospital wards within detention centres exist and civil society members recount cases where women are handcuffed to the hospital bed to prevent them from escaping. There are migrant workers who are unaware that babies born abroad must be registered with the embassy so there are incidents of children that are

classified as stateless, with no form of documentation from the country of origin and where they were born.

Some are forced to bring their children in detention centers with them, no space for children or privacy. If she is pregnant and has all her travel documents she is deported and if she does not have any travel documents she will be made to stay till documents are prepared. If childbirth has to be there it is taken care of and mother and child remains in the shelter or jail till they are deported.

In exceptional cases, such as victims of sexual assault/rape or pregnancies unwanted by their male partner, women continue with the pregnancy. Those who seek care from NGOs and/or religious institutions are able to access pre and post-natal care. The mothers are then repatriated back to COO.

Migrant women who do report sexual mistreatment or abuse by employer or sponsor, are referred to public attorneys to handle the case as it is criminal in nature. While the case is being heard, the women are unable to get a regular job and would be a great disadvantage to them. It is also difficult to find employers who would sign contracts with them. However, the challenge is to prove that such an assault has taken place, as domestic workers are usually isolated in their employers' homes. There are no outside witnesses and family members often support those accused of sexual offences.

Moreover, migrant victims in particular, feel hesitant to report sexual abuse

because of their fear of the attitudes and stigma in their own countries about such incidents. Both families concerned and the women themselves might decide that settling the case with monetary compensation to the worker and repatriating her is the best way to proceed.

Some victims of sexual abuse often experience further abuse because access to justice is too expensive for them as well as facing possible bias/racial discrimination against the victim.

MFA would like to stress that with regard to migrant women workers, the vital action is of removing the risk from work rather than removing the worker from a risky situation, the onus of which falls upon regulatory and monitoring bodies of labour migration within the country of destination. *We observe* that sexual and reproductive rights of female migrants are disregarded from the time of pre-departure till post-return, spanning the entire migration cycle. This is further compounded by religious and cultural conservatism and traditional attitudes around sex education and female reproductive rights. This effectively obstructs women from accessing reproductive healthcare due to disease and injury or even more critical situations of pregnancy and sexual assault. Lack of comprehensive gender-sensitive approaches mean that while domestic workers have access to measures of justice, their lack of freedom of movement, the fear of legal measures and consequent unemployment or repatriation, deter

them from approaching these routes of redressal.

MFA members and partners continually assist cases where the said domestic worker is suffering from reproductive health issues but without remedy or access to medical treatment. *We observe* that the labour system as well as local laws and attitudes within destination countries render domestic workers incapable of leaving the home of the employer without their permission. *We realize* that the such restrictive policies are inherently violent to the migrant woman, some of whom are inadequately aware of their right to healthcare and associated gender-based rights.

To ably discuss the differing modes of policies by destination countries, the countries observed for this paper are Lebanon, Malaysia, Thailand, Japan and Taiwan. The following have been looked into when attempting to expand the scope of inputs beyond access to healthcare facilities:

In **Lebanon**, the topic of reproductive health is in general a taboo for all women (both Lebanese and foreign). Apart from religious stigma, there is little to no sexual education and women are generally not informed about their rights and possibilities in this area, notably about contraceptive methods. Abortion is only legally permitted in one very restrictive situation being when the life of the mother is threatened. Access to the general healthcare system is limited by the fact that the public infrastructure is insufficient to deal with burgeoning demand. Healthcare run by private entities are expensive and

deters migrants from pursuing healthcare. This situation affects Lebanese people but also migrants who are usually confronted with additional barriers to their access to the healthcare system.

For migrant women, the Standard Unified Contract, compulsory by law, forces the employer to contract health insurance for the worker - a prerequisite for a work permit by the Ministry of Labor. However, generally the insurance policy contracted by the employer only covers work-related injuries and is not accepted by all hospitals and private clinics. In most cases, the worker is entirely dependent on the good will of her employer to access the healthcare system. It has been observed that regardless of the severity of the domestic worker's health issues, the employer would prefer only giving painkillers rather than taking them to a medical professional. What is more, the insurance papers as well as all identity papers of the workers are generally kept by her employer, leaving her with no possibility of going to medical facilities herself. Finally, in case the worker is taken to a consultation with a medical professional, it is common practice for the employer to deduct the amount paid to the practitioner from the worker's salary, when the standard unified contract required the sponsor to pay for all medical expenses of the worker.

If female migrant workers are victims of sexual assault or abuse, the first challenge is that, often time, the aggressor is their employer or a

member of their family (due to their live-in status as a domestic worker). Then as they are locked inside the household, they have limited to no possibility of accessing healthcare or seek legal assistance. Such elements lead victims to abscond or run away from their workplace. However, then they are considered by Lebanese authorities as 'irregular' the territory and can be subjected to detention and/or deportation. Usually these women are administratively detained at the General Directorate of the General Security Facilities, where they cannot benefit from the help or visit of any lawyer, although they may be provided basic healthcare which is inadequate for their needs.

Malaysia's Employment Act 1955 explicitly denies domestic workers the same rights as other workers. The Employment Act contains specific labour protections concerning leave and entitlements however, the First Schedule of the Employment Act specifically *excludes* domestic workers from being covered by the following provisions:

- Maternity protections, including leave and allowance entitlements (furthermore, employment contracts prohibit pregnancy)
- One rest day per week
- Provisions limiting hours of work, including specifying that employees should not work more than five consecutive hours without a period of leisure of not less than thirty minutes

³ Malaysia Medical Act 1971

and employees should not work for more than 48 hours in one week

- Paid public holidays
- Annual leave entitlements
- Sick leave, and
- Termination, lay-off and retirement benefits. Domestic workers are excluded from these notice periods and for them, there is a blanket 14-day period of notice of termination, regardless of length of employment.

Malaysia's Workmen's Compensation Act 1952 also excludes "domestic servants" from the list of occupations which fall under the category "workman", therefore leaving domestic workers without recourse to compensation for injury suffered in the course of their employment. Domestic workers and women migrant workers are required to undergo a mandatory pregnancy test at FOMEMA, a requirement to obtain a work permit and subsequent renewals of such documents.

Pregnant domestic workers and women migrant workers are classified as medically unfit and deported back to their home countries. Deportation due to pregnancy is also a clause included in the contract of employment.

In Malaysia as well as Lebanon, abortions may be carried out by a doctor ³ only under the following circumstances; that is risk of life or injury to the physical health of the woman or risk of life or injury to the mental health of the woman. With

limited avenues to seek a termination of the pregnancy coupled with the fear of deportation including social stigma in the host and home countries, migrant worker women resort to unauthorized abortions risking various medical complications and long-term effect on their health. The same situations are applicable in case the migrant worker conceived in her home state and recognized her pregnancy in the destination country – they are repatriated home or asked to pursue ‘other measures’ to deal with the situation. Civil society members recount situations where they individually intervene with employers to resolve the issue and allow for the worker to have a safe delivery in their home country and return to continue their work.

While **Taiwan** has been observed as putting forth progressive laws for migrant workers to enable their awareness, there continue to be loopholes in the system for female migrant workers. For example, workers are given a post arrival orientation at the airport itself with sufficient information as well contact information of non-governmental shelters in case of abuse. They have further banned pregnancy testing during the recruitment process while penalizing and prohibiting employers from terminating the contract and deporting a migrant worker who becomes pregnant. However migrants, especially low-skilled female migrant workers are unaware of their maternity benefits and grievance system. While female migrant workers are in a sense allowed to stay in Taiwan during the pregnancy,

they are not eligible for healthcare or documentation for their newborn child. This becomes problematic with most workers choosing to return or worse, abandon their child or perform a risky abortion procedure.

Thailand allows all migrants, regardless of documentation status, employment, nationality to access healthcare. Pregnant migrant workers can access pre-and post-natal care as long as they are able to pay for it. Their children are provided with documentation and are allowed to access basic needs and services. Migrant female workers are subject to a pregnancy test, however, when they apply for a work permit. According to officials, the test is for medical reasons related to administration of another drug that protects migrant workers from disease (particularly elephantiasis, whose preventive medicine is dangerous for pregnant women).

In **Singapore**, currently, female Work Permit holders be subject to pregnancy test every six months by law. Anyone found to be pregnant can remain in Singapore at work until either (a) the 24th week of the pregnancy -- which is the last possible date for legal abortion, or (b) the last "allowed to fly" date of airlines to her home country, whichever is earlier. female Work Permit holders suffer penalties for becoming pregnant while in Singapore. Penalties include immediate cancellation of the work pass and blacklisting against future employment. No employer shall need to be responsible for the payment of healthcare provision these unless by private contract. However, if the migrant

worker encounters an emergency situation during this period, the provision in the law that requires employers to provide "immediate and necessary" medical care to save her life is allowed for.

Furthermore, it was just in 2013 that domestic workers in Singapore were allowed to have a day-off once a week but employers are not keen on this due to the misconception that domestic workers might get lost, go on dates, or have sex.

Japan's government sponsored technical internship programme has also been criticized as being insensitive to gender considerations and discriminatory to the workers.

Technical trainees are required to sign a letter of consent that forbids them from "having any romantic relationship" and explicitly states that "males and females cannot visit each other's rooms". Although this part of pre-training programs, workers are reminded that company laws are similar and advised not to 'lose focus'. Certain pre-internship training organizations even ban trainees from having a romantic relationship and can impose a fine if they become pregnant.⁴

Such strict policies have been publicly criticized by government bodies such as the Justice and Labor ministries for interfering the private lives of their workers. The Justice Ministry further revealed reports from supporters of technical interns highlighting cases in

which pregnant trainees were threatened with dismissal.

While we can classify the pre-programme training as part of the workers post arrival orientation, we see similar information and modes of awareness adopted for pre-departure programs in countries of origin such as **Nepal** and **India**.

AT THE ORIGIN COUNTRY

While destination countries are to be held responsible for the conditions at the workplace and ensuring specialized intervention and rights-based treatment for domestic workers in particular, countries of origin are found to be equally negligent regarding gender-sensitive policies from the point of recruitment till after their return.

Countries of origin were found to have age restrictions in place for recruiting domestic workers as a response to abuse and trafficking concerns of domestic workers – particularly in India (women over 30), **Sri Lanka** (25 years to Saudi Arabia, 23 years to the other Middle Eastern countries), **Nepal** (23) and **Bangladesh** (25). It works upon the assumption that female migrants by a certain age are 'less naïve', 'more aware' or married with children, which means they are 'more likely' not to be trapped or involve themselves in prostitution and trafficking activities. Not only are such age restrictions entirely misplaced as we observe from grassroot level work, but it also deflects the responsibility of the country of origin

⁴ Asahi Shimbun. "Expectant trainees told to end pregnancy or leave Japan" (2 Dec 2018).

<http://www.asahi.com/ajw/articles/AJ201812020027.html>

to educate and generate awareness among domestic workers as well as provide them with critical assistance in destination countries.

At the start of the recruitment process, migrants are asked to undergo health/medical examination prior to employment and deployment overseas either by the destination country or to determine them eligible for employment. While it is primarily intended to ensure that they are physically fit to work, female migrants are additionally made to take a pregnancy test.

Based on the inputs from MFA members and partners, it is understood that in almost all origin countries, female migrants are poorly informed, if at all, about reproductive and sexual health. Due to conventional attitudes around reproductive health and sex education, such topics are not considered integral to the standard topics of pre-departure and pre-employment orientation. In fact, women migrants undergoing pre-departure orientation are given a list of “don’ts” regarding contact with the males and not given enough awareness regarding risks of sexual assault or harassment.

It was only in 2018 that **the Philippines’** Department of Education issued Policy Guidelines regarding the Implementation of the Comprehensive Sexuality Education (CSE) otherwise known as DepEd Order No. 31. This was in accordance to the Responsible Parenthood and Reproductive Health Act of 2012 (RA 10354) and in Section 4 (q) paragraph 7, it refers to education and counseling on sexuality and

reproductive health while Section 20 tackles Public Awareness. Before this issuance, there was no prior comprehensive sex education in the country. The closest means to a form of sex education would be the pre-marriage counseling, family planning, and responsible parenthood seminars that is required for couples who want to get married in the Philippines, although this is not being strictly enforced. The topic of HIV/AIDS is included in Pre-Deployment Orientation Seminar (PDOS) but insufficient and not consistently discussed. RA 10354 is the most comprehensive on reproductive health but does not make specific provisions for migrant women.

The following laws contain provisions on reproductive or marital status of women migrants, as women or as a general category of migrant women:

- *RA 9710: Magna Carta of Women – Section 4.c.5* defines and identifies migrant women as one sector. *Section 17* refers to women’s right to health-comprehensive health education and services. RA No. 9710 covered key elements to protect women and children (especially girl-children) in all aspects but does not provide specific provisions that would address the issues affecting migrant domestic workers including children specific to reproductive or marital/sexual status when deployed.
- *RA 8042: Magna Carta for Migrant Workers.*

- *RA 9262: Anti-Violence Against Women and Children (Anti-VAWC)*
- *RA 9208: Anti trafficking in Persons*

Nepal, India, Bangladesh and Sri Lanka have ratified or are a signatory to CEDAW where GR 26 is specially introduced to protect the human rights of migrant domestic workers, making governments of the countries of origin, transit and destination accountable. Despite this, all 4 governments have not created a stable, non-reactive and comprehensive policy regarding the gender-based rights for domestic workers.

In Nepal, due to a recent ban on deployment, female migrants still travel as undocumented workers with the support of local agents, due to which they do not have the opportunity to attend pre departure orientation training. Bangladeshi and Indian embassies at countries of destination continue to cooperate with local diaspora organizations regarding issues of domestic workers and provide temporary shelters for them till they are repatriated. Temporary shelters in embassies, however, do not have exclusive provisions for such cases except for taking the pregnant migrant worker or victim to hospitals or other services. In cases of sexual assault and trafficking, female migrant workers have to follow procedures of the destination country through legal recourse, etc. Embassies in such cases do provide legal assistance but due to resource and personnel constraints, their ability to follow such cases are

hindered and convince the female migrant to accept compensation and be repatriated. Few embassies provide documentation for children born in destination countries, unless in situations of return and repatriation of the victim.

Finally, returnee female migrants (who were victims of sexual abuse or pregnant/have a child conceived in the destination country) are fundamentally disregarded in programmatic and police measures in the countries of origin. This is particularly problematic as compared to other returnee migrants, this particular category of female migrants are subject to extreme physical, mental and sexual mistreatment and stigma, upon return.

Based on inputs received for the purpose of this paper, cases of returnee female migrants suffering from sexually transmitted diseases or returning pregnant due to sexual assault or returning with an unwanted pregnancy/child are rampant. In some situations, all these situations are combined, and the child born will also suffer from the same disease (particularly HIV/AIDS). Moreover, since they are deported back home with the baby, reintegration into their family and society with an 'unwanted' child is extremely difficult, as is the prejudice against victims of sexual assault. Female migrant workers are observed turning to depressive and suicidal tendencies and in some cases, facing severe mental trauma.

We observe that almost all countries of origin (considered for this input) are yet to develop coherent policy decisions

(instead of reactive ones such as banning deployment of domestic workers) regarding female migrants. Furthermore, there is scant regard and a *culture of silence* around reproductive health and sexual abuse, which leaves migrant women vulnerable to further forms of exploitation and at the mercy of a policy environment that is intrinsically violent against women and migrant rights.

Dehumanisation or a process of 'de-feminisation' of the female migrant hence begins at the country origin, where the workers rights to reproductive healthcare, awareness of reproductive health, and comprehensive support mechanism for victims of sexual assault and their children are disregarded in the larger interest of her being a 'worker first, woman second'.

RECOMMENDATIONS FOR PREVENTION OF VIOLENCE AND ENSURING REPRODUCTIVE AND MATERNAL RIGHTS OF FEMALE MIGRANTS

Recognizing gender-specific and migrant-specific rights of migrant domestic workers have been enshrined in international covenants such as the Sustainable Goals of Development as well as the Global Compact on Migration.

Sustainable Goals of Development have specific **goals 5.4** which emphasizes states to "*recognize and*

value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies..." as well as **goal 5.6** which aims at ensuring "*universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action*".

Under the **Global Compact on Migration**, **Objective 4** is to "Ensure that all migrants have proof of legal identity and adequate documentation", under which target **(e)** aims at "strengthening measures to reduce statelessness, including by registering migrants' births, ensuring that women and men can equally confer their nationality to their children, and providing nationality to children born in another State's territory, especially in situations where a child would otherwise be stateless, fully respecting the human right to a nationality and in accordance with national legislation". **Objective 7** aimed at addressing vulnerabilities in migration also has **target (d)** which stresses states to "review relevant existing labour laws and work conditions to identify and effectively address workplace-related vulnerabilities and abuses of migrant workers at all skills levels, including domestic workers, and those working in the informal economy, in cooperation with relevant stakeholders, particularly the private sector".

Objective 6 which is focused on ethical recruitment and decent work observes under **target (k)** to "review relevant

national labour laws, employment policies and programmes to ensure that they include considerations of the specific needs and contributions of women migrant workers, especially in domestic work and lower-skilled occupations, and adopt specific measures to prevent, report, address and provide effective remedy for all forms of exploitation and abuse, including sexual and gender-based violence, as a basis to promote gender-responsive labour mobility policies”.

As MFA, while we agree to the right of labour mobility and gender-responsive action regarding the same, we would like to emphasize that reproductive and sexual rights to healthcare and awareness is imperative in the discourse *prior to* the consideration of mobility of female migrant worker.

C183- Maternity Convention⁵ also protects against pregnancy discrimination but contains even more specific provisions than CEDAW. The Convention prohibits pregnancy testing for women applying for employment, prescribes at least 14 weeks of maternity leave, including a period of six weeks compulsory leave after childbirth, and includes specific provisions that ensure that women receive cash and medical benefits to meet their financial and health needs during the maternity leave, that include “prenatal, childbirth and postnatal care, as well as hospitalization care when necessary.”

The Convention places the onus on employers and governments to share the above responsibilities by provision and connecting it to a social security fund or schemes of social insurance for the female migrant worker. None of the countries whose inputs have been included as part of this paper have ratified or recognized this convention.

Specific recommendations include:

- I. Countries of Origin
 - a. To include gender-sensitive and progressive education and awareness on reproductive and sexual health as a mandatory part of pre-departure training for potential female migrants.
 - b. Including female domestic migrant workers as a group requiring specialized policy and programme initiatives beyond recruitment processes
 - c. Ensuring gender sensitization training for embassy and shelter personnel in dealing with migrants workers that are pregnant, have a child and/or are victims of sexual assault
 - d. Embassy involvement in ensuring provision of reproductive healthcare for migrant worker in countries of destination rather than only assisting in their deportation/repatriation

⁵ Fair Labour Association (2018). *“Triple Discrimination: Woman, Pregnant and Migrant:*

Preventing Pregnancy Discrimination among Temporary Migrant Workers”.

- e. Appoint or create space for a officer/staff at the embassies that is responsible for the issues of female domestic workers and victims of sexual assault and violence.
- f. Legal redressal for victims of sexual assault and assurance of documentation for the child born in destination countries.
- g. Specialized and tailor made programmes for returnee female migrant workers enabling reintegration, provision of mental and physical healthcare with the involvement of civil society organisations.
- h. Establish reporting and monitoring system specifically for issues pertaining to female domestic workers.
- d. Allowing for migrant female workers to safely give birth in country of destination, at least 6 months into their pregnancy.
- e. Formulation of strict policy to penalize those accused of sexual assault of the migrant worker as well as ensuring separation of immigration status/work permit and the maternity/healthcare rights of the migrant female worker.
- f. Establish a critical reporting system regarding such cases.

II. Countries of Destination

- a. Ensuring gender sensitization training of police, immigration and hospital personnel in dealing with issues of sexual assault, pregnancy and reproductive health.
- b. Including information of reproductive healthcare and rules of social contact in post-arrival orientation (as seen in Taiwan).
- c. Providing ease of access to healthcare and justice in cases of sexual assault and unwanted pregnancy, regardless of immigration /employment status.