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Migration-health nexus
Exploring health risks of Bangladeshi Labour Migrants

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This study explores the extent of health problems Bangladeshi migrant workers in Hong Kong and Malaysia are exposed. Questionnaire survey was administered on 126 randomly selected respondents. An overwhelming majority of the migrants suffered from diverse health problems. Majority had unsafe sex. Most of them lived in unhygienic environment. A significantly higher percentage ($P<0.000$) of the respondents in Hong Kong (HKRs) visited clinics compared to the respondents in Malaysia (MRs). There is significant difference ($P<0.005$) in the prevalence of STDs between two groups.

Key words: Bangladesh, illegal migrants, health risks, unsafe sex, health seeking.

Background

Migration-health nexus has been gradually gaining space in contemporary migration studies (Taran, 2002). However, widely known that limited health regimen offered to the migrant workers has placed them diverse health vulnerabilities. Migration scholars and international agencies have started raising the issue of limited access of migrant workers to health services in the country of employment despite their growing demand in the labour market (Rashid, 2002:3).

It is owing to the fact that global economy has observed an escalating population flow in the international labour market over the last few decades. In Asia, it is estimated that over the 1995-99 period, some 2.6 million workers left their country every year under contract to work abroad. The South Asian countries accounted for 46 percent of this outflow. South East Asia, mainly Filipinos, Indonesians, Thais, Burmese and Vietnamese made up the rest 50 percent (Haque, 2002:1). In Southeast Asia some nations play as the receiving, some origin countries and some both. Malaysia and Hong Kong are known for their dependence on migrant workers. Eventually, migrant workers have become a part of Hong Kong and Malaysian history (Ullah, 2007).

Malaysia has been experiencing sustained high economic growth by migrant workers in some certain sectors since its independence in 1957 (see Piper, 2006:7; Athukorala and Menon, 1999:6). In 1998, 10 percent of Malaysia's population and about 27 percent of the country's labour-force were made up of foreigners constituting the highest percentage of foreign workers in the world (Migrant News, Nov 1999; Aidcom, 1999:3; Pillai, 1999:3; Inqilab Daily, 28 July, 2004; Khan, 2004). Hong Kong is also unique in its historical reliance on migrant workers for economic growth (see Hewison, 2004:318-9; Athukorala

and Manning, 1999:6; Skeldon, 1990:501). Hong Kong has long had acute labour shortages from the late 1980s to early 1990s. Notably, as the 2001 census reported, over 40 percent of the Hong Kong population was foreign born (see Hewison, 2003:3). The government introduced the General Labour Import Scheme on the basis of industry quota system. In 1997, the supply of foreign workers from Asian countries numbered 436,000, while 121,000 were from Western countries (Stahl, 2003: 33). Foreign domestic helpers (FDH, hereafter) dominate Southeast Asian migration to Hong Kong who are mainly from the Philippines, Indonesia and Thailand (Li, Findlay and Jones, 1998:191) constituting around one-fourth of the total migrant workers. Studies suggest that the morbidity and mortality associated with illegal migration are substantial. Due to the conditions associated with the secret movement of people, the adverse health effects of migration are likely to be of greater magnitude in the illegal migrant populations. The hotly debated issue of the rights of non-citizens which revolves around the proposition that: are the migrants' 'social exclusion' or 'assimilationist' element (Maharaj, 2004:7) connected with the issue of vulnerabilities? Wherever the debate comes to, both legal and illegal migrant workers had limited access to the social services in many countries and so are in Hong Kong and Malaysia.

Migrant workers are generally susceptible to diverse forms of exploitations in the host environment; however, their undocumented status aggravates their level of vulnerability further. Existing studies on the vulnerabilities to exploitations are available; however, little attention has been attached by existing research to health risks of the migrants especially the Bangladeshi migrants. The present study intends to explore the risks of Bangladeshi migrants in Hong Kong and Malaysia that are generally caused by health hazards and its implication on health-seeking behaviour. Attempts were made to measure the psychological and social indicators perceived/developed by the migrants themselves. The variables were described in frequency and compared between the HKRs and the MRs. This paper delves into the relationship between migration and health risks among migrant workers in Malaysia and Hong Kong. Undocumented migrants are generally more vulnerable to any kind of health risks (for more see Ullah, 2007). By the end of 2001 there were 81,000 Bangladeshi undocumented migrants in Malaysia (Battistella, 2002:352-3) (Table 1). According to *the daily Jugantor*[1] (7 July 2004), there were 40,000 illegal Bangladeshi labourer in Malaysia. However, this discrepancy in the statistics exists due to the lack of official data. Many of the workers who got to Malaysia legally had extended their stay after their contract expired, resulting in thousands of Bangladeshis continuing to work illegally or with fake travel documents (Netto, 2001; Dannecker, 2003: 4). Though it is difficult to stay illegally in Hong Kong, an estimated of around 50,000 Filipinas, 10,000-15000 Bangladeshis and thousands of illegal Mainland Chinese enter Hong Kong every year.

[1] A widely circulated Bengali newspaper in Bangladesh.

Table 1. Illegal workers in Malaysia, 2001

	Hong Kong	Malaysia
Source countries		
Indonesia	-	333000
Philippines	100,000	9000
Thailand	25,000	-
Bangladesh	5000	81000
Others		27000

Note: "-"means that no data are available. Source: Battistella, 2002: 352-3.

Dynamics and magnitude of health problems

The kind of job offered determines the living and working conditions of migrant workers at destination country. Male factory workers are generally provided with accommodation nearby areas often within the factory premises by their employers. Some migrants live together with other compatriots. The situation in case of female migrants varies depending on the working conditions. Siddiqui (2001a) found that some women were employed as domestic helpers were satisfied with their accommodation. Siddiqui (2004) in another study found a contrasting picture. Besides, women who were engaged in factory works used to live in hostels provided by the employers which were situated either within the factory premises or outside.

Issues of migrants' vulnerabilities to HIV/AIDS have received broad attention by the researchers and global development community and policy planners as well. Various forms of sexual, socio-political behaviour take place among the migrants with increased vulnerabilities to various types of diseases from physical to mental, specifically STDs and HIV/AIDS (Wolffers, Ferdanandez, Vergis and Vink, 2002:459). There is also an association of a rheumatologic disease and an infectious agent in a group of Asian migrants trafficked by watercraft. However, the correlates of migration and other diseases such as typhoid, Malaria and other psychological illness have remained still very much a trivial issue. Trafficking of would be migrants by watercraft is associated with considerable loss of life when overcrowded vessels flounder bad weather (Ullah, 2005). Data show that frequency of sufferings, pattern of morbidities vary between the HKRs and the MRs. This study further revealed that only six percent of the respondents visited health centres when their sickness turned severe. Fever, stomach-ache, and diarrhoea have been the most common diseases they suffered. A question may be raised what is the relation of this disease with migration. According to the migrants, the suffering from those diseases prolonged and aggravated due to their illegal status in the host country. The living and working conditions of the majority of Bangladeshi migrants are far from satisfactory due to their status as semi-skilled or unskilled workers.

More analysis to be done

Table 2. Diseases suffered in a year* (Multiple response)

Morbidity	Hong Kong		Malaysia	
	f	% (of n=56)	*f*	% (of n=70)
Fever*	52	92.83	114	162.86
Typhoid*	6	10.71	26	37.14
Severe cold and cough*	49	87.5	21	30.0
Diarrhea*	4	7.14	56	86.0
Dysentery*	13	23.24	61	87.14
Rheumatism	10	17.86	5	7.14
Allergy	17	30.36	31	44.29
Severe headache*	42	75.0	25	35.7
Severe stomachache*	36	64.29	58	82.86
Jaundice	8	14.29	22	31.43
Malaria	10	17.86	34	48.57

Source: Computed from survey data 2004-5. *Multiple times counted (frequency of sufferings in a year * frequency of respondents). **Based on their respective perceptions, pain in urinal channel, scar on the sex organ etc.

Complaints related to occupations

Migrant workers are highly vulnerable to workplace injuries due to employers' failure to comply with safety standards resulting in workers' physical disability and often death. The status of migrants often precludes the enforcement of labor standards. Unsafe standards in manufacturing industries may lead to accidents and may cause loss of any limbs as they are always at greater risk of falling down from buildings. The number of industrial accidents and injuries is higher among migrant workers than among citizens, especially those who work in construction and public works. In the agricultural sector, unprotected exposure to pesticides and other chemical products is also a potential problem (Carballo and Nerukar, 2000:5). Occupational accidents are largely caused due to unhealthy working conditions with little or no access to prevention and care (Rashid, 2002:4). This study shows that the MRs suffer more occupational hazards than the HKRs. Data show that seven of the MRs reported suffering fatal accident in the working place while none of the HKRs was fatally injured. The category of work the migrants are offered involves a lot of health risks. The highest percentage of the HKRs suffered lesion related problem, while the MRs suffered from fever. Lesion related suffering was the second highest among the MRs.

Table 3. Occupational hazard suffered

Hazards	Hong Kong		Malaysia	
	f	% (of n=56)	*f*	% (of n=70)
Cut injury	15	26.79	31	44.29
Fatal accident (head)	-	-	7	10.0
Broken legs and hands	3	5.36	12	17.14
Burned skin (Chemical and fire)	5	8.92	9	12.86
Cut part of the body	11	19.64	17	24.29
Total	34		76	

Note: "-"means that no data are available. Source: Survey 2004-5.

Exploring psychological complaints

The migration process may imply a number of stressors and strains that influence migrants' morbidity in several ways. Migrants may be exposed to health risks before, during and after leaving their countries of origin. Some of the risks experienced after arriving in the recipient country include imprisonment, long-lasting asylum seeking processes, language barriers, lack of knowledge about health services in the new social context, discrimination and marginalization (Worth et al, 1975). Migrants often live in a social context where new social, political and language realities result in great demands on their coping skills and adaptability [2, 5]. Some of the difficulties faced by migrants are unemployment, discrimination, loss of social status and change of roles, e.g. within the family (Mygind 2006). Social network especially, may be of importance to migrants' mental health and health behaviour. Lack of social support, large geographic distances to members of the social network, and high expectations from relatives in the countries of origin are sometimes additional stressors leading to mental health problems and risky health behaviour among migrants (Syed, 2003). Some degree of psychological stress is always involved whether migration is planned or not, voluntary or forced. Separation from family, friends, and established social networks; departing from traditional routines, value systems, and accepted ways of behaving and having to adapt to new social and psychosocial environments due to migration often cause psychological illness.

Psychosocial stress of migrant workers emanates often from the cultural shock and adaptation[2] difficulties as they leave behind familiar socio-cultural system (Taran, 2002). Acculturative stress is a phenomenon that may underlie poor adaptation, including a reduction in the health status of individuals, identity confusion and problems in daily life (Berry, 1992). Despite the potential magnitude of the problem, the psychosocial health of migrant remains poorly addressed. Communicability i.e. language proficiency contributes to mental health, however, barriers to good communication compound feelings of isolation. The capacity to communicate can influence healthcare-seeking behavior, underreporting, poor explanation of health problems and symptoms, inappropriate diagnoses and the capacity of immigrants to comply with treatment regimens. Very often mental pressure is generated from working long hours. Specially women migrant workers engaged in domestic works or factories suffer mental stress due to extended job hours, low wage and arbitrary deprivation of liberty (Rashid, 2002:4).

The study shows that 21 percent of the HKRs and 76 percent of the MRs suffered from depressive disorders that developed during their initial 12 months away from home. Many immigrants say they "long for home" and report exaggerated memories of familial events, the ways they lived, and things they experienced. Fantasies about home and returning home are often described as "migrant's opium," and although these responses are not necessarily serious, they are often psychologically debilitating. High levels of

[2] According to the expert's opinion, adaptation of individuals in new place constituted by a combination of three strategies- adjustment, reaction and withdrawal (Rashid, 2004:4).

anxiety among the migrants have been linked to their inability to get back home (Carballo and Nerukar, 2000:7).

Scarcity of resources necessitates trade-offs resulting in an opportunity cost.[3] Therefore, migration decision that involves a choice between 'to stay' and 'not to stay' options has an opportunity cost. Due to migration they had forgone other alternatives. Furthermore, once migrants realize the real cost of a chosen alternative, they may begin to mull over the economics of their psychology because every migrant had to pay 'psychological price' while abroad due the estrangement from the kin group. Isolation and separation from family and friends and a different culture and environment can produce adverse mental health effects in trafficked migrants.

Data reveal that the MRs suffered more as compared to the HKRs in all the psychological indicators. A significantly higher percentage of the MRs suffered mental anxiety than the HKRS (P<0.001). This means that the HKRs suffered less stress as they visited their family as and when they wished, which was impossible for the MRs due to shortage of money, high travel expense, lack of leave days etc. In terms of the frequencies of 'suffering morbidities', 'increased level of depression', 'changes in sleeping pattern', 'changes in motivations', 'changes in fooding pattern', 'decreased involvement in social activities' exhibited significant difference between HKRs and MRs.

Table 4. Forms of psychological problems Multiple response

Psychic indicators*	Hong Kong		Malaysia		Significance
	f	% (n=56)	*f*	% (n= 70)	(HK vs M)
Depressive disorder/anxiety	12	21.43	53	75.71	P<0.001
Frequency of morbidity/Unstable physical condition	18	32.14	41	58.57	P<0.003
Increased level of depression	29	51.79	64	91.43	P<0.004
Changes in sleeping pattern	8	14.29	51	72.86	P<0.000
Changed motivation	11	19.64	48	68.57	P<0.002
Changes in fooding pattern	7	12.5	29	41.43	P<0.001
Emotional change	15	26.79	34	48.57	P<0.002
Decreased involvement in social activities	3	5.35	26	37.14	P<0.000

Source: Computed from survey data 2004-5. *According to the respondents

Migration and risk behavior

Migration may influence risk perceptions and risk behaviour in several ways. Firstly, losses related to e.g. socialisation, identity processes, and minority status may affect migrants' risk perception and thereby their health behaviour. This happens because migrants may react to the experienced losses by focusing on their past, i.e. turning their

[3] While the cost of a service is often thought of in monetary terms, the opportunity cost of a decision is based on what must be given up (the next best alternative) as a result of the decision. The advantage forgone as the result of the acceptance of an alternative should also be considered. Whatever course of action is chosen 'to stay' or 'to move' the value of the next best foregone alternative course of action is considered the opportunity cost.

attention towards their past in their countries of origin, instead of focusing on the future. There has been an increasing trend of tracing relationship between HIV/AIDS and migration. Risky sexual behaviour can be viewed in the context of the number and types of partnerships, sexual acts and orientation (Cohen and Trussell, 1996; Dixon-Mueller, 1996). It is argued that due to loneliness and homesickness, migrant workers tend to buy sex to access easy entertainment. Entering into such intimate physical relationships, often without protection, increase the vulnerability to HIV/AIDS (Rashid, 2002:4). Alcohol abuse among male migrants is increasing and reflected in higher mortality rates associated with liver cirrhosis, which are twice as high as they are for men born. However, many migrants try to adjust and develop sexual relationships with others. These can include sex workers, girlfriends and boyfriends (Bloem *et al*. 1997; Wolffers and Fernandez, 1999).

The association between perception of risk of HIV infection and sexual behaviour is poorly understood, although risk is considered to be the first stage towards behavioural change from risk-taking to safer behaviour. Studies that have examined the association between the perception of risk and sexual behaviour remain open to doubt because of the intricacy of disentangling the complex relationship between the two variables (Cleland, 1995). Sexual behaviour and social customs in Hong Kong and Malaysia are much freer than in Bangladesh.[4] Boys and girls can easily meet and become friends which allow them to establish romantic relationships. Denied of regular company of partners, they may find other ways of dealing with physical needs. They develop friendships and eventually sexual relationships with local people, fellow countrymen or other foreigners. Many of the latter may have wives or other partners with whom they have sexual contact during home visits. Infecting these partners with an STI/HIV is possible, but it can also happen the other way around (Lurie *et al.* 2000). A higher percentage of the MRs had unsafe sex while significantly higher percentage of the HKRs, had multi-partnered sex. Among the MRs, man-man sex was higher in frequency than those of the HKRs.

Table 5. Risk behaviors of the HKRs and the MRs Multiple response

Risk behaviours	Hong Kong		Malaysia		Significance
	f	% (n=56)	*f*	% (of 70)	(HK vs M)
Unsafe sex **	36	64.29	54	77.14	P<0.006
Multi-partnered sex	23	41.1	9	12.86	P<0.000
Man-man sex	4	7.15	11	15.71	P<0.000
Substance abuse	11	19.64	9	12.86	P<0.007
Excessive alcohol	8	14.29	5	7.14	P<0.000
Visiting nude bar	7	12.5	18	25.71	P<0.000
Street base sex workers	12	21.43	7	10.0	P<0.000

Source: Computed from survey data 2004-5. *According to the respondents; ** include oral, anal sex, sex without condom

Country of destination is an important factor affecting sexual opportunities. In the host countries, the migrants are seen as a temporary human resource to build up the local

[4] Being a conservative society, Bangladeshi culture does not allow openness in sexual relationships. Involvement in sexual relation before marriage is prohibited in Bangladesh.

economy, but also are blamed for bringing in diseases (Haour-Knipe, 1993, Haour-Knipe and Dubois- Arber, 1993, Goodwin-Gill, 1996, Sherr and Farsides, 1996, Linge and Porter, 1997). Some migrants travel from countries with strict codes of conduct to countries where these codes are more liberal or at least different. Others travel from countries with relatively flexible codes of behaviour to countries with stricter rules. The latter may be put in a situation where the sexes are rigidly segregated or may meet only migrant women, who may come from a third country, with different rules again (Varga, 2001:353).

Table 6. Diseases suffered in a year* (Multiple response)

Morbidity	Hong Kong		Malaysia		Significance
	f	% (of n=56)	*f*	% (of n=70)	
STDs/STIs**	24	42.86	68	97.14	P<0.000
Urinal infection	25	44.64	54	77.14	P<0.000

Source: Computed from survey data 2004-5. *Multiple times counted (frequencies of sufferings * frequencies of respondents). **Based on their respective perceptions, pain in urinal channel, scar on the sex organ etc.

The level of awareness and practice

Most of the respondents regarded the risk of contacting sexually transmitted diseases as a natural consequence of having sex with sex workers. Despite their engagement in sexual activities with different partners, misconceptions concerning STIs and HIV/AIDS are prevalent. They were unequivocal in their stance that awareness of infection risk status did not deter them from engaging in risk behaviour. The study shows that most of the respondents were well aware of the pandemic of the HIV/AIDS with varied degrees of knowledge. A frequently expressed sentiment was purposeful ignorance of health status in order to prolong the positive psycho-emotional aspects of life in the face of HIV infection (Varga, 2001:354). It was interesting to note that awareness on the risk of the pandemic does not work. Of the 126 migrants who reported not using condoms, 21 percent of the HKRs and 31 percent of the MRs said that "sex happened suddenly". Many of them said "condom reduces pleasure". Migrants generally planned sex within a 'time pass' relationship and used condoms, unless "sex suddenly happened" or they "got an unexpected chance for sex". They did not use condoms during oral or anal sex with other males.

Table 7. Reasons for not using condom (Multiple response)

Psychic indicators*	Hong Kong		Malaysia		Significance
	f	% (n=56)	*f*	% (n= 70)	(HK vs M)
Sex suddenly happened	12	21.43	22	31.43	P<0.004
Condom not available	9	16.1	11	15.71	P<0.067
Condom is expensive	3	5.36	20	28.57	P<0.000
Feel shy to buy	11	19.64	29	41.43	P<0.005
Partner insisted not to use	4	7.14	9	12.86	P<0.007
Do not know how to use a condom	1	1.79	2	2.86	P<0.018
Don't use intentionally	18	32.2	31	44.29	P<0.005
Forgot to bring	5	8.93	11	15.71	P<0.006

Reduce pleasure	16	28.57	21	30.0	P<0.016
No response	24	42.86	29	41.43	P<0.036

Source: Computed from survey data 2004-5

Access to treatment and treat -seeking Behaviour

Most host societies consider migrants as social exclusion indicating the distance of the migrant workers to the social services provisions. Therefore, from an exclusionist point of view, access to welfare services is very limited, thus in the health services. In Hong Kong migrants requiring consulting a physician (public or private) has to produce their ID cards or any other legal documents. However, such documents are not required for the MRs to produce to see a doctor. Without a legal status, they had to pay for medical services exorbitantly. The study however shows that the migrant workers normally [either HKRS or MRs] did not see physicians until the sickness went beyond their tolerance. However, reluctance to visit a doctor is more evident among the MRs than the HKRs. Misbehaviour both from the doctors and the hospital staff discouraged the MRs to visit hospitals. They were given neither any emergency nor priority service when required, they claimed.

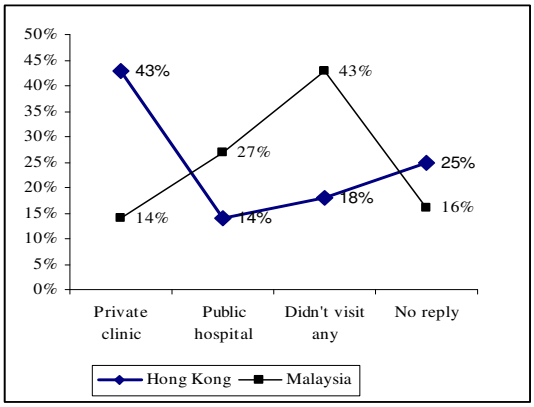

Figure 1.Showing the health seeking behaviour

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Data confirm that a higher percentage of the HKRs visited physicians as compared with the MRs. They were reluctant to visit a doctor for minor casualties (i.e. minor injuries, wound). Different factors discouraged both MRs and HKRs seeing doctors. Data further show that a higher percentage of the HKRs visited private clinics as compared with the MRs.

Conclusions

Knowledge about the health status of migrants is often limited due to lack of data. This is because migrants are often excluded from surveys. However, existing data show greater morbidity among migrants, especially concerning mental health problems, depression, post-traumatic stress syndrome, psychosomatic complaints and anxiety; certain chronic diseases, such as diabetes; and infectious diseases, such as tuberculosis and hepatitis B (Syed, 2003; Bhugra, 2004; Carta, 2005). Some studies show that the morbidity patterns among migrants are not markedly different from the background population in the recipient country; other studies indicate a lower prevalence of certain diseases among migrants compared to the background populations in the recipient countries, e.g., depression (Syed, 2003; Sonne, 2005).

Migrant workers are susceptible to a variety of exploitations, and their health risk is also another such dimension of their vulnerabilities. Studies correlated the issue of migration to

the HIV/AIDS infection. Other diseases and physical sufferings received only a very little attention. The study revealed that illegal migrants are considered as exclusions in the host society and therefore have limited access to welfare packages. But, the result further shows, in term of health risks, and vulnerabilities, the HKRs held a better position than those of the MRs. Bangladeshi migrants in Hong Kong and Malaysia are not only suffering from diverse health risks upon their arrival but also they are the victims of health hazards during their way to the destination. The process of being trafficked without proper documents, often under the auspices of criminal networks, places migrants under physical hazard and danger. Subservience is often achieved through violence, and the perpetrators operate in the knowledge that these migrants find themselves without access to social or legal protection.

Risks of detection, detention and judicial censure, physical and psychological stress, and economic exposure are all in favor of the trafficker and to the disadvantage of the migrant. Migrants may be carried, concealed, or hidden in conveyances, goods, or cargo and transported across borders. Transportation of this kind may subject the trafficked individual to a variety of injuries and illnesses depending upon the type and duration of the journey. In the cases where migrants are trafficked in containers or hidden in other compartments of vehicles and conveyances, lack of access to breathable air, nutrition, or water may result in injury or death. Transportation is one health risk factor for illegal migrants. The illegal or clandestine nature of people smuggling or migrant trafficking is reflected in the mode and method of transportation including aircraft and water and land conveyances. The health risks for migrants are subsequently influenced by and vary with the method of transportation utilized. Migration may have negative health consequences due to physical and psychosocial strains experienced by migrants throughout the entire migration process. These strains may lead to stress and risk behaviours having a negative effect on the migrant's somatic and mental health. The health effects of migration make it relevant to consider how migrants' health can be improved. Fundamentally, there is a lack of knowledge regarding migrants' exposure to risk factors, morbidity, and psychosocial needs. A systematic survey of these factors could provide a basis for the design of more adequate health services. There is a need for both cross-sectional and cohort studies as well as intervention studies in order to discover the multiple influences of migration on health and the possibilities for designing and implementing effective health services for these population groups.

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