View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by Repository@USM

A Toolkit for Women Migrant Workers' Empowerment in Malaysia: Meeting Sexual and Reproductive Health Needs

Copyright © 2019 by Centre for Research on Women and Gender (KANITA), USM

Hak cipta terpelihara. Tiada bahagian daripada terbitan ini boleh diterbitkan semula, disimpan untuk pengeluaran atau ditukarkan ke dalam sebarang bentuk atau dengan sebarang alat juga, sama ada dengan cara elektronik, gambar serta rakaman dan sebagainya tanpa kebenaran bertulis daripada Pusat Penyelidikan Wanita dan Gender (KANITA) terlebih dahulu.

All rights reserved. No part of this publication may be reproduced in any form or transmitted by any means, electronic or mechanical including photocopy, recording, or any information storage and retrieval system, without permission in writing from Centre for Research on Women and Gender (KANITA).

eISBN 978-983-44820-6-0

9 789834 482060

Diterbitkan di Malaysia oleh / Published in Malaysia by
PUSAT PENYELIDIKAN WANITA DAN GENDER (KANITA)
Centre for Research on Women and Gender (KANITA)
Universiti Sains Malaysia
11800 Pulau Pinang
Laman web / Website: http://kanita.usm.my
Email: kanitamiddlesex.srhr@gmail.com

Contents

Foreword

Malaysia continues to be one of the largest importers of labour in Asia. Women migrant workers constitute a significant workforce in its manufacturing, service and domestic sectors. It is estimated that women constitute almost 40 percent of its migrant population today[1]. Women migrant workers work under severe and punitive conditions in Malaysia, with few rights and entitlements at work and in their communities.

In this toolkit, we focus on advancing their sexual and reproductive health. Women's migration has wide-reaching implications for their sexual and reproductive health, but this aspect of their health has not attracted sufficient attention by the government, employers, health care providers, civil society or researchers in Malaysia. There is a lack of gender-sensitive policies overall, to address these needs and protection of this aspect of health and well-being is minimal. Consequently, little is known about the difficulties these women face in coping with sexual and reproductive health illnesses or when seeking treatment, or of interventions which can meet their sexual and reproductive health needs.

This toolkit is developed for use by NGOs and other actors who have contact with women migrant workers, to empower these women to claim sexual and reproductive health rights. It is the product of a twelve-month project (April 2017/8) funded by the United Nations Gender Theme Group to investigate how key actors and stakeholders can support these women's capacity to do so. We are grateful for UN support for this initiative, which allows us to investigate how problems and challenges in protecting the sexual and reproductive health of women migrant workers can be addressed.

In developing the toolkit, we adopted a feminist lens. Women migrant workers' voices and needs underpin the toolkit. Its objectives are threefold; first and foremost, to increase women migrant workers' knowledge and awareness of sexual and reproductive health; secondly, for these women to use this knowledge to secure their and their co-workers' health and well-being in the workplace; and finally, for them and their allies to influence policy and practice to advance sexual and reproductive health rights in their communities and countries. In these ways, the toolkit affirms and translates into practice, the objectives in the International Conference on Population and Development Programme of Action, the Beijing Declaration and Platform for Action, the Convention on the Elimination of All Forms of Discrimination against Women and the UN Sustainable Development Goals.

The toolkit both challenges and encourages NGOs, unions, health care providers, employers, foreign embassies and government in Malaysia to evaluate their

[1] Source: United Nations, Department of Economic and Social Affairs, Population Division (2017)

policies and practices against evidence-based good practice to support these women's empowerment in exercising sexual and reproductive health rights. It identifies areas where they can improve their practices to empower women in this aspect of their lives, not only so that these women become healthy workers, but also so that they can support and improve the quality of life of their families and communities. The toolkit is transferable to other Asian countries with broadly similar institutional contexts and migration regimes.

We thank our workshop participants, interview respondents and women migrant workers themselves, for giving up their time to provide critical insight into the challenges in meeting women migrant workers' sexual and reproductive health needs, and to offer practical solutions to improve these women's well-being in Malaysia. These insights resonate clearly in this toolkit, making it a locally (or community) embedded instrument sensitive to the local context. We are also indebted to fellow researchers in this area, whose published works on women migrant workers and their sexual and reproductive health provided a solid foundation upon which the toolkit could be built.

Lilian Miles[a], Suzan Lewis[a], Noraida Endut[b], Lai Wan Teng[b], Suziana Mat Yasin[c] and Kelvin Ying[b,d]

[a] Middlesex University Business School, UK

[b] Centre for Research on Women and Gender, Universiti Sains Malaysia, Malaysia

[c] School of Social Sciences, Universiti Sains Malaysia, Malaysia

[d] School of Health Sciences, Universiti Sains Malaysia, Malaysia

To cite this e-book: Miles, L., Lewis, S., Endut, N., Lai, W.T., Yasin, S. M., and Ying, K. (2018). A Toolkit for Women Migrant Workers' Empowerment in Malaysia: Meeting Sexual and Reproductive Health Needs. Retrieved from Centre for Research on Women and Gender website: https://kanita.usm.my/images/toolkit.pdf

Introduction

Sexual and reproductive health

The United Nations Population Fund (https://www.unfpa.org/sexual-reproductive-health) defines good sexual and reproductive health as a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life (when, and with whom to engage in sexual activity), and choose if, when and how often to have children.

Importantly, to maintain one's sexual and reproductive health, people must have access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be empowered to protect themselves from sexually transmitted infections. When they decide to have children, women must have access to services to help them have a health pregnancy, safe delivery and healthy baby.

There are several pre-requisites to ensuring good sexual and reproductive health, including affordable family planning services; contraceptive information and services; antenatal care, assisted childbirth from a trained attendant; comprehensive infant health care; infertility treatment; safe and accessible post-abortion care and, where legal, access to safe abortion services; prevention and treatment of sexually transmitted infections and reproductive cancers; information, education, and counselling; prevention of violence against women; and elimination of harmful practices such as female genital mutilation and early and forced marriage (see 1994 International Conference on Population and Development -ICPD- Programme of Action, Chapter 7).

Claiming sexual and reproductive health rights

Sexual and reproductive health is today, regarded as a human right, essential to human development and the achievement of the UN Sustainable Development Goals. It is enshrined in the 1994 International Conference on Population and Development (ICPD) Program of Action, the 1995 Beijing Declaration and Platform for Action and the UN Sustainable Development Goals.

Yet, the language of rights is not an abstract technical or legal question but is one which necessitates taking into account the real situation women find themselves in. In our case, women migrant workers face severe hardship in Malaysia, due not only to a harsh migration regime, but crucially also, the wider structures of gender inequality which constrain them. In other words, women migrant workers face hardship, firstly, because they are migrants, and secondly, because they are women. Their situation is precarious, and they are denied many rights which local citizens enjoy, including sexual and reproductive health rights. The denial of the latter has attracted much criticism but employment contracts which prohibit

pregnancies, for example, continue to be forced on women migrant workers, often, with severe repercussions for them.

Nonetheless, women migrant workers in Malaysia have allies, notably non-governmental organisations and unions which work to advance their rights and interests, including sexual and reproductive health. Additionally, health care providers seek to build healthy societies. Their ethics require them to promote the well-being of those who seek medical treatment. They too, can play a part in protecting women migrant workers' health. Finally, employers, home and host governments, all have an interest in safeguarding these women's health. This latter group of actors have an economic interest in ensuring the health and well-being of women migrant workers; their productiveness depend on their health. We consider how all these key actors and stakeholders can help meet the sexual and reproductive health needs of these women in Malaysia. We focus on women factory workers, since, for research purposes, they are a sizeable and accessible workforce.

Theory Informing Research

Feminist theoretical frameworks underpin the project. From a feminist viewpoint, the empowerment of women is viewed as a process in which women recognise their disadvantaged position compared to men and then take action (including collective action) to change relations of power.

The Social Relations Approach, Naila Kabeer

The Social Relations Approach (SRA) explains that there are structural causes of gender inequality, which must be reversed if gender equality is to be achieved. Institutions typically maintain and entrench gender inequalities. Examples of institutions are the state, the market, the community and the family. To understand how gender inequality is produced and reproduced through these institutions and through their interactions with each other, we must first recognise their core values and practices.

In challenging gender inequality, Kabeer emphasises the process of equitable power-sharing. How is this achieved? It is achieved through empowerment, whereby those who are disempowered become empowered to (re)negotiate power relations. Those who are disempowered, in this case, women, gain the ability to exercise agency in their own lives and in relation to the wider structures of constraint which regard them as being inferior to men. Kabeer explores empowerment through the dimensions of agency (the ability to define goals and act upon them), resources (the means which enhance the ability to exercise choice) and achievements (the outcomes of the exercise of agency). Importantly, empowerment is not something which can be handed over. Rather, the process of empowerment begins from within.

Kabeer also argues that collective action is crucial to empowerment. Collective action is more effective in challenging the structures which maintain gender inequality than individual action. Women's allies and grassroots organisations can play a critical role here in helping women challenge how institutions (see above) discriminate against them. They can help create space for women to politicise their demands, push for policies to redistribute power and put pressure on institutions to be more responsive to women's needs.

Kabeer, N. (1994) Reversed Realities, Verso, London

March, C. Smyth, I. & Mukhopadhyay, M. (1999) A Guide to Gender Analysis Frameworks, Oxfam, GB

These key points have previously been discussed in Miles, L. (2016) "The Social Relations Approach and Women Factory Workers in Malaysia" Economic and Industrial Democracy, 37, 1, 3-22 (a case study using the social relations approach to analyse the empowerment process of women factory workers)

Gender Empowerment Framework, Sara Longwe

Longwe argues that women's inequality and disadvantaged position are not due to their lack of productivity. Rather, it is the result of oppression and exploitation. Longwe envisages that to reverse this inequality women must be empowered. Women need to have equal control of resources, compared to men. She argues that empowerment takes place when women become able to challenge existing social relations and participate in decision-making on resource allocation.

Longwe's empowerment cycle consists of five linked stages of empowerment: welfare, access, conscientisation, participation and control. It is hierarchical in nature. At the lowest stage, the welfare stage, women have equal access to material welfare, compared to men. But, at this stage, women are not empowered. They have simply been given benefits, they do not produce these benefits for themselves. At the access stage, women gain equal access to resources through the removal of discriminative laws. Here, women can improve their own status through their own work because of this increased access to resources. At the conscientisation stage, women realise that their unequal position, their lack of status and welfare (compared to men) is not due to their inability or weakness, but from the discriminatory practices and rules that prioritise the interests of men. Women want to remove these discriminatory practices. They identify strategies for action. At the fourth stage, participation, women come together to analyse their problems, identify strategies to overcome discriminatory practices, and plan collective action with others. Finally, at the control stage, women achieve change and enjoy equal control in decision making about how resources are allocated. Here, there is a balance of control between men and women, with neither side dominating the other.

Longwe, S. (1991) "Gender Awareness: The Missing Element in the Third World Development Project" in Wallace, T. & March, C. (eds.) Changing Perceptions: Writings on Gender and Development, Oxfam (UK and Ireland), Oxford, pp. 149-157

Williams, S. (1994) Oxfam Gender Training Manual, Oxfam (UK and Ireland), Oxford

March, C. Smyth, I. & Mukhopadhyay, M. (1999) A Guide to Gender Analysis Frameworks, Oxfam, GB

Leach, F. (2003) Practising Gender Analysis in Education, Oxfam (UK and Ireland), Oxford

Method

The project brought together multiple key actors and stakeholders with an interest in sexual and reproductive health rights and/or women migrant workers to investigate how they can increase their capacity to empower women migrant workers to exercise these rights. Capacity building was an essential development tool, and thus constituted a central focus in the project. The rationale is that if these actors could improve their capacity to support the empowerment of women migrant workers in this area, this would ultimately lead to reduction of the effects of poor sexual and reproductive health practices, better health and healthier workforces.

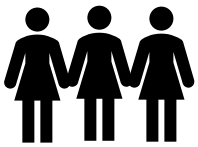
The toolkit is informed by a variety of sources; namely (a) rich information and discussion generated at a multi-stakeholder workshop convened in July 2017 which focuses on advancing the sexual and reproductive health rights of women migrant workers, (b) interviews with non-governmental organisations, unions, employer federations, health care providers, women migrant workers, government authorities and (c) a literature review we conducted to investigate research in this area in other Asian countries (for list of literature reviewed, see References section at the end of this toolkit). They are thus empirically based. Although not all of the strategies and interventions identified in the literature review were, at first reading, relevant for the Malaysian context (given different institutional and cultural contexts), they were rich and innovative in nature. We have tailored and adapted them for the Malaysian context, where possible.

Key actors and stakeholders have been uncomfortable with the phrase “sexual and reproductive health” given the negative connotations of the words “sex” and “sexual” in the Malaysian religious and social context. This toolkit therefore uses the word “women’s health” in place of “sexual and reproductive health”.

The Malaysian context: Themes which emerged during the research project

In the course of the project, (which included a workshop and interviews with multi stakeholders and women migrant workers), we uncovered many themes in the Malaysian context, which informed the development of the toolkit. In some cases, however, they also affirmed the enormity of the challenge in meeting the needs of these women. We detail these themes, to explain how the toolkit evolved.

Theme 1: Women migrant workers



Many women migrant workers had little knowledge of sexual and reproductive health †. Few were aware of the significance of physical symptoms, and many put up with discomfort caused by sexual and reproductive health conditions. Many women migrant workers feared that if they sought medical treatment for any illnesses (including sexual and reproductive health conditions), their employment would be terminated (a standard term in their contracts is that they must be healthy). Cost was a further factor discouraging them from seeking treatment. Many other women could not access health care because they were unable to leave the workplace. Employers (including immediate supervisors, HR managers) often disbelieved them when they said they were ill. Referrals to hospitals were a last resort. Factory clinics provided very little information to women migrant workers about the illnesses or discomfort they suffered from (including sexual and reproductive health illnesses), and provided only very basic treatment (e.g. painkillers). However, women migrant workers informed us that some agents and supervisors were sympathetic when they complained of pain or discomfort (including menstruation pain or reproductive tract infections, but never pregnancies or abortions).

Additionally, many women migrant workers were unfamiliar with the range of health care services offered, or the location of health care facilities (pharmacies, clinics, hospitals). The difficulties were compounded because they did not speak the local language and were unable to relate to health care providers about their health conditions. They also perceived that medical professionals discriminated against them, due to their migrant status.

Contracts which prohibit pregnancies and relationships continue to be imposed on women migrant workers. Women migrant workers are forced to undergo a mandatory health check and pregnancy test before entering the country, and would be refused a work permit if they tested positive. When they arrive in Malaysia, they are required to undergo another medical check-up, and if they tested positive for pregnancy, they would be deported. Fearing that they will lose their jobs, many pregnant women migrant workers resorted to abortions. Others resorted to medicines sold in pharmacies to induce abortions (self-prescription). We even found that some women blamed themselves for getting pregnant, and for breaking factory rules about pregnancies and relationships.

There was a sense of isolation on the part of the women we interviewed. Some of the women we interviewed had never heard of an NGO, or the services and support they could offer. Unions were not always allowed or recognised in the workplace. Employers discouraged interaction with unions. Relatedly, unions were not always supportive of these women's sexual and reproductive health rights (due to e.g. lack of understanding of these women's needs; women's sexual and reproductive health not union priority; women's sexual and reproductive

health needs were a sensitive issue for unions; union receptiveness also depends on the openness of the leadership of union officers). The women coped with sexual and reproductive health conditions (including pregnancy) largely on their own, sometimes not even involving their friends, for fear of the factory finding out. They typically did not approach their respective embassies or consulates, although some women informed us that these organisations intervened on their behalf in work-related matters (wages, workloads), and made sure that errant factories were penalised. (but again, never in cases of pregnancies or abortions).

†Women migrant workers explained that they experienced a range of illnesses and medical conditions; these were not limited to sexual and reproductive health issues. They also, for example, suffered from leg pain, lower back pain, fatigue, dizziness.

Theme 2: Non-governmental organisations and health care providers

Non-governmental organisations expressed the view that key actors and stakeholders often worked in isolation, but that there was scope to work more effectively together to meet the sexual and reproductive health needs of women migrant workers. One significant limitation was lack of resources, forcing individual non-governmental organisations to specialise rather than collaborate with other organisations. Many non-governmental organisations expressed the desire to do more to advance the sexual and reproductive health needs of women migrant workers but were frustrated that they did not have the means or capacity to do so. We recognise that this is a barrier to these organisations helping women migrant workers; we take this into consideration when developing the toolkit for them.

Non-governmental organisations were also concerned at the high numbers of legal or documented women migrant workers who become undocumented (over-staying their visas, or absconding from current employer). Meeting the sexual and reproductive health needs of undocumented migrants was extremely challenging, in that they are an invisible and inaccessible population.

One theme identified both by non-governmental organisations and health care providers was that once women were diagnosed with serious illnesses (which will likely impact on their productivity), their contracts were likely to be terminated. This was problematical on two fronts; (a) it discouraged women from seeking treatment and (b) it defeated the on-going efforts of non-governmental organisations and health care providers to meet these women's sexual and reproductive health needs.

Finally, whilst there was virtue in having leaders amongst women migrant workers who could represent their sexual and reproductive health needs, non-governmental organisations and health care providers emphasised that sometimes, leaders were elected because of their ability to "manage" the women and to make them work harder. †

† Incidentally, women migrant workers themselves were wary of leaders, even those appointed from their own group – often these women feared that if they confided in the leader about their health issues (especially unwanted pregnancies) that this would become public knowledge within the factory. Thus, whilst leaders are important in championing sexual and reproductive health rights, in the context of women migrant workers' extreme vulnerability, it is likely also to be a challenge to elect leaders who women migrant workers trust, or have confidence in.

Non-governmental organisations and health care providers were very helpful in sharing their insights on ways forward, suggesting low-cost and practical interventions which can be put in place to protect this aspect of women migrant workers' health.

Theme 3: Unions

A range of attitudes to women migrant workers were evident among unions. Some union leaders we spoke to were not at all familiar with the sexual and reproductive needs of women migrant workers. They perceived women migrant workers strictly as workers and their involvement with them in their other identity dimensions (as women experiencing women's health issues) was very limited.

Other union leaders believed that unions need not get involved in the area of women's health, as these women are capable of taking care of their own health issues, or they could call their embassy or their advisors or trainers for help. Thus, this was not perceived to be an area where the union intervention was necessary. Moreover, language barriers prevented unions from resolving women migrant workers' health problems.

Still other leaders explained that whilst they do promote health seeking behaviours for women workers, this was currently, only for local women workers, and not migrants. However, they acknowledge that this is a shortcoming which they intend to address. Divisions within unions worked in silo, there was no universal policy to address women migrant workers' needs, including women's health issues.

There was a sense of disconnect between unions and women migrant workers, overall. For example, one union leader (automotive sector) explained that women migrant workers were a small minority in the sector and therefore it was difficult to prioritise the issues which they faced. It was also difficult to motivate interest among women migrant workers to join unions. These women saw themselves as transient workers; they were not interested in becoming union members and paying a membership fee when they were only here on a temporary basis. Employers and foreign embassies discouraged workers from joining unions. Some employers are moving toward to adopting a zero-migrant worker policy due to a belief that if they paid local workers well, they would work harder. By the same token, women migrant workers did not approach unions when they faced difficulties, including health problems.

For these, and other difficulties arising from the many identity dimensions of women migrant workers in Malaysia, and how NGOs and unions address them, see:

Lilian Miles, Suzan Lewis Lai Wan Teng & Suziana Mat Yasin, "Advocacy for women migrant workers in Malaysia through an intersectionality lens" (2019), Journal of Industrial Relations, on-line first, https://doi.org/10.1177/0022185618814580 first published January 16, 2019.

Theme 4: Employers

As a key actor and stakeholder, employers we interviewed or spoke to were unwilling to be involved in helping to meet the sexual and reproductive health needs of women migrant workers. There were exceptions however, as evidenced in our interviews with women migrant workers. Some women informed us that their factories made efforts to treat their health issues (but never in cases of unwanted pregnancies as the contract prohibited women from getting pregnant); Some of these good practices are identified on page 26. These women migrant workers expressed gratitude and satisfaction to their managers and supervisors, with some expressing a desire to managers and supervisors to continue working even beyond their mandatory ten-year period.

Again however, there were a range of employer perspectives. A clear theme which emerged in our interviews was that women migrant workers wanted, but did not receive information about sexual and reproductive health at their workplaces. Employers did not regard protecting this aspect of health as their responsibility. They provided only basic health care services (occupational health related injuries, colds, fever, headaches). Pregnancy was strictly a taboo subject, and there was a blanket ban on relationships and pregnancies.

Other employers revealed that they were unwilling to bear further health-care related costs when employing women migrant workers. The announcement by the government on that employers will be required to pay additional levies for foreign employees (from January 2018) was particularly unwelcome. Employers argued that this policy had significant cost ramifications for their annual budgeting. They expressed frustration because they were not consulted prior to the policy coming into force.

Still other employers did not consider that migrant workers were discriminated against; on the contrary, they regarded migrant workers as privileged as they were provided accommodation, while local workers did not have this facility. They argued that sending countries needed to play a larger role in ensuring the health of their workers. Finally, there was a sense that migrant workers were entitled to work longer hours than local workers; and therefore; they were favoured over local workers.

Theme 5: Authorities

This section is brief due to the many problems we encountered when liaising with government departments. Government departments we contacted typically denied that they had responsibility for promoting health seeking behaviours on the part of women migrant workers. However, one government department we contacted (whilst also denying this responsibility), offered many suggestions involving collaborations among governmental authorities to promote women migrant workers' health, which we incorporated into the toolkit.

Focus of Empowerment Toolkit

How can key actors and stakeholders improve their capacity to, in turn, empower women migrant workers to exercise sexual and reproductive health rights? We focus on ways in which these actors and stakeholders can change or expand their practices and strategies to better help women migrant workers meet sexual and reproductive health needs.

Developing toolkit for the Malaysian context

Women's allies and grassroots organisations play a crucial role in empowering women migrant workers to achieve change, in this instance, to claim sexual and reproductive health rights. NGOs, unions and health care providers are examples of actors who can educate and inform these women about sexual and reproductive health, organise them, and encourage them to take collective action to reverse barriers which constrain their lives. This toolkit will be of particular interest to these organisations, as they seek to improve their capacity to help these women. These organisations are best positioned to empower the women who approach them for help.

But other (often/usually reluctant) actors need to recognise that they, too, have an interest in safeguarding the health of women migrant workers. Employers, host and home governments, all stand to gain from healthy workforces. These women contribute to economic wealth. Their health should, rightly, be of paramount consideration in these actors' policies and practices. This toolkit therefore, also suggests practical ways which they can adopt to promote women migrant workers' health.

Measuring empowerment

Research is clear that the empowerment process cannot be precisely measured. We can however, gauge or judge behavioural changes. In line with the empowerment frameworks we have utilised, and in light of the barriers and challenges to meeting the sexual and reproductive health rights of women migrant workers in Malaysia which we have identified, we would expect women's empowerment to claim their health rights to reflect the following, over time:

Increase in awareness and knowledge about women's health issues	Increase in self-confidence and self-efficacy in managing one's body, women migrant workers adopt health-seeking behaviours	Women migrant workers able to make decision about decisions to use contraceptives, as well as types of contraception
Increase in self-confidence and ability to discuss women's health issues with peers, supervisors, health providers, respective embassy and consulate	Knowledge of location of health facilities, types of services offered	Confidence and ability to travel to clinics
Women migrant workers become aware of their situation and the need for change	Belief or conviction that workplace practices must change and that they have a role in achieving this change	Becoming trusted team or work leaders representing the needs of women migrant workers in the workplace
Realise importance of building solidarity to challenge structures of discrimination	Participate in discourses in the community to challenge taboo around women migrant workers' health issues	Work with allies to influence practice and policy

TOOLKIT

This toolkit makes evidence-based recommendations for different stakeholders coming into contact with women migrant workers, to develop or change their practices in order to increase these women's awareness of women's health issues and to encourage health-seeking behaviours among them.

Toolkit: NGOs

NGOs are important allies of women migrant workers; in many senses, their teacher, their place of refuge, their voice

As alluded to earlier, we are aware and recognise that non-governmental organisations work under enormous resource constraints. Where we can, we have developed low-cost interventions. It may also be the case that non-governmental organisations will need to campaign for more resources to put some of the interventions recommended below, into practice.

Provide basic knowledge concerning women's health and rights; through distributing pamphlets, posters, booklets (ideally in native languages of women migrant workers)	Distribute maps and telephone numbers about locations and contact numbers of pharmacies and reproductive health care facilities nearby	Introduce women's health classes and workshops to increase knowledge and raise awareness of women's health issues, through using testimonies, photographs, diagrams and charts, role play, drama, dance and knowledge quizzes with prizes
Develop ways of working with health care providers so that women migrant workers experiencing women's health conditions (rape; HIV and other sexually transmitted diseases check-up/tests; provision of counselling regarding contraception) can be referred for treatment	Work with health providers to introduce self-awareness sessions on women's health issues e.g. breast self-examination, menstruation and feminine hygiene, contraceptives	Work with employers to conduct education programmes (lectures, workshops) on women's health and provide information on access to health care in workplaces and living quarters
Set up hotlines to call in case of emergency (anonymous, free, confidential and multi-lingual to cater for various nationalities)	Provide training programmes to enhance women migrants' leadership skills regarding women's health issues; ideally, introduce role models of women leaders	Challenge taboo surrounding women's health in society and promote open communications on sex and sexuality
Engage with women migrant workers in culturally sensitive ways; ideally enable native speakers (who speak the same language and who share similar life histories) to work with women migrant workers	In the longer term, foster unity among like-minded non-governmental organisations (campaigns, advocacy, policies and practices, joint work with women migrant workers) to promote women's health issues	Lobby governments to ratify and commit to universal declarations in support of women's development rights, such as CEDAW, ICPD Programme of Action, the Beijing Programme of Action, and Sustainable Development Goal 3

Indicators of Empowerment

- Women migrant workers approach NGOs
- Women migrant workers inform themselves about women's health issues through reading literature and making use of other sources of information (videos) on women's health issues disseminated by NGOs
- Women migrant workers attend training and education programmes conducted by NGOs in workplaces and living quarters on women's health
- Increase in knowledge, awareness and confidence among women migrant workers about women's health issues
- Women migrant workers make use of hotlines to seek advice
- Women migrant workers participate in media challenging taboo around women migrant workers' health issues

Toolkit: Unions

Unions can adopt an intersectional approach to advocacy on behalf of women migrant workers

Again, we are aware that union resources are limited. Many of the interventions below can, however, be incorporated or added into existing advocacy strategies and practices, to minimise cost. It may also be the case that unions need to campaign for more resources to put some of the interventions below into practice.

Include championing women's health issues as an essential part of union strategy

Provide basic knowledge concerning sexual and reproductive health and rights; through distributing pamphlets, posters, booklets (ideally in native languages of women migrant workers)

Distribute maps and telephone numbers about locations and contact numbers of pharmacies and reproductive health care facilities nearby

Introduce women's health classes and workshops to increase knowledge and raise awareness of women's health issues, through using testimonies, photographs, diagrams and charts, role play, drama, dance and knowledge quizzes with prizes

Organise support for women migrant workers around women's health issues through WeChat, Whatsapp, SMS services

Provide training programmes to enhance women migrants' leadership skills regarding women's health issues; ideally, introduce role models of women leaders

Work with employers and NGOs to conduct education programmes (lectures, workshops) on women's health and provide information about access to health care in workplaces and living quarters

Lobby governments to ratify and commit to universal declarations in support of women's development rights, such as CEDAW, ICPD Programme of Action, the Beijing Programme of Action, and Sustainable Development Goal 3

Set up support groups among women migrant workers through which women can learn amongst themselves about women's health issues, think and decide collectively; for example, role models can teach others about sexually transmitted diseases, contraceptives, monitoring development of symptoms, provide information about local health care resources

Indicators of Empowerment

- Women migrant workers engage with union activities
- Women migrant workers inform themselves about women's health issues through reading literature and making use of other sources of information (videos) on women's health issues disseminated by unions
- Women migrant workers attend training and education programmes on women's health conducted by unions in workplaces and living quarters
- Increase in knowledge, awareness and confidence among women migrant workers about women's health issues
- Women migrant workers report sexual violence against them
- Women migrant workers accept women's health as integral to their well-being at work
- Women migrant workers feel confident in discussing their health issues with supervisors, managers and colleagues
- Women migrant workers participate in unions' advocacy programmes to promote improved healthcare services in the workplace

Toolkit: Health Care Providers

Research demonstrates the important role health care providers can play in promoting women's health issues; increasing women migrant workers' knowledge about, and attitudes toward women's health, and helping women adopt healthy behaviours

Work with employers, NGOs and unions to conduct education programmes (lectures, workshops) on women's health and provide information about access to health care in workplaces and living quarters	Engage trust and collaborations with employers to implement education programmes about women's health issues and mobile clinics to treat women's health conditions	Publicise availability of services via leaflets, pamphlets, mobile technology and social media; women migrant workers need to know where they can go to exercise sexual and reproductive health care (ideally in native languages of women migrant workers)	Pilot mobile clinic programmes in factories to offer basic gynaecological service
Make available evening and weekend clinics to enable women migrant workers to access health care (we recognise that this may require more resources or better organisation, or both)	Set up hotlines in case of emergency (anonymous, free, confidential and multi-lingual to cater for various nationalities)	Put in place counselling services for women migrant workers to discuss women's health and promote health seeking behaviours	Provide information about women's health to women migrant workers asking for information via mobile technology (cover a wide range of women's health topics, SMS sent with regular frequency, content of SMS easy to understand, must be multi-lingual)
Increase availability of free or low-priced contraceptives in medical facilities	Build trust and relationship with migrant community	Challenge taboo around sexual and reproductive health in society	Offer services in a culturally accepted way; ideally enable native speakers (who speak the same language and who share similar life histories) to work with women migrant workers

Lobby governments to ratify and commit to universal declarations in support of women's development rights, such as CEDAW, ICPD Programme of Action, the Beijing Programme of Action, and Sustainable Development Goal 3

Indicators of Empowerment

- Women migrant workers visit health facility
- Women migrant workers feel confident in approaching health provider
- Women migrant workers attend lectures and classes in workplaces and living quarters to learn about sexual and reproductive health
- Women migrant workers make use of hotline and mobile technology
- Women migrant workers feel confident, and trust each other, in discussing sexual and reproductive health issues
- Women migrant workers refer others to health facility
- Women migrant workers engage in safer sexual practices and make use of contraceptives
- Proportion of unsafe abortions among women migrant workers are reduced
- Fewer repeat clients among women migrant workers for abortion services
- Women migrant workers are aware of their bodies and able to recognise symptoms of sexual and reproductive health conditions
- Women migrant workers feed back to health care providers about their needs

Toolkit: Employers

Employers need to realise that healthy workers are productive workers

Understand that women's health is an integral part of the woman migrant worker

Understand that women migrant workers are human beings with the full range of emotions and needs, as with local women

Provide training to HR managers and supervisors about basic women's health issues (women migrant workers are not machines)

Put up posters/education video/distribute leaflets/monthly lectures on women's health issues

Factory doctor to extend services to include treatment for women's health conditions where large numbers of women migrant workers are employed

Allow women migrant workers time to visit health clinics outside of the workplace, with no penalty

Making women's health counselling available in factory clinic

Provide private space in factory for women to discuss symptoms or concerns

Work with health care providers to introduce mobile clinics if services provided by factory clinic does not extend to sexual and reproductive health care

Increase subsidy when women seek medical treatment (not all employers cover the whole cost, some cover only a fifth of the cost of treatment)

Work with other stakeholders, such as non-governmental organisations, unions and health care providers, to promote women's health and access to health care through workplace-based educational programmes, lectures, or talks, and giving space for women to attend

Introduce policy specifically on women's health in the workplace (e.g. allow women to go to the toilet when needed, this will prevent occurrences of cystitis or reproductive tract infections caused by not being allowed to use the toilet; allow a woman who is menstruating and cannot stand for long hours to sit; allow women migrant workers to rest, away from the workplace, when they experience menstrual pain; disallow women who experience pain to carry out heavy duty work; do not discriminate between local and migrant women workers)

The factory is the most critical space to engage with women

Indicators of Empowerment

- Less sickness absence due to women's health conditions (healthier employees are absent less often)
- Women migrant workers attend lectures and workshops on women's health in the workplace and living quarters
- Increase in knowledge on the part of women migrant workers about women's health issues
- Women migrant workers feel able to and more confident in approaching supervisors about women's health issues
- Women migrant workers make use of counselling services in the workplace
- Women migrant workers trust counsellors
- Women migrant workers are able to make use of mobile clinics in the workplace
- Women migrant workers adopt health-seeking behaviours

Toolkit: Embassy, Consulates in or from Home Country

Home governments need to take care of women migrant workers; they are your citizens

Home country governments integrate women's health issues as part of pre-departure sessions, including location and availability of support groups and medical facilities in host countries

Embassy and consulates invite health care providers in host country to conduct women's health awareness programmes, to provide women migrant workers with information on women's health issues

Embassies and consulates to be a reliable point of contact and source of information on women's health issues for women migrant workers, not just work-related rights

Embassy and consulates subsidise health care for women migrant workers (currently employers bear partial cost of health care)

Embassy and consulates monitor employer and agents' treatment of women migrant workers' health and well-being

Indicators of Empowerment

- Women migrant workers demonstrate knowledge and awareness, and health seeking behaviours on arrival in host country
- Evidence of embassy and consulates working closer together with host government
- Women migrant workers feel able and confident in approaching embassy and consulates when they experience women's health issues, currently they approach embassy and consulates only if their work-related rights are violated (wages, working conditions, occupational health)

Toolkit: Immigration Department, Ministry of Human Resources, Department of Health

Research states clearly that governments have a responsibility to protect and advance the sexual and reproductive health rights of their women migrant workers

Integrate education on women's health and access to health care providers as part of orientation course when workers arrive: *Immigration Department, Ministry of Human Resources* and *Ministry of Health* singly, or jointly, conduct women's health awareness programmes, to provide women migrant workers with information on women's health issues

National Population and Family Development Board (under the Ministry of Women, Family and Community Development) conducts courses, inviting women migrant workers to come together to discuss sexual and reproductive health needs

Set up a separate group to be responsible for educating and raising awareness of sexual and reproductive health issues among women migrant workers (Health Ministry of Malaysia and from FOMEMA can be part of this group)

Ministry of Human Resources create incentives for worker agencies and employers (via a credit system) to invest in educational programmes and medical facilities to meet health needs of women migrant workers

Ministry of Human Resources require employers to provide more comprehensive health insurance cover, beyond basic health services to incorporate sexual and reproductive health (a holistic approach to workers' health)

Ministry of Human Resources monitor and ensure workers' access to health care is protected by making sure that overtime policies are not abused by employers

Ministry of Health to make available increased funding to train more medical staff to reduce waiting times, make available necessary medications, and improve training to reduce health care provider stigma against women migrant workers

Ministry of Health to subsidise cost of setting up mobile clinics in workplace

Government as a whole must encourage openness and discussion about women's health issues in society to remove stigma or taboo.

Indicators of Empowerment

- Government departments have clear responsibilities in promoting health of women migrant workers (currently no government departments claim responsibility, government departments tend to work in silo)
- Increase in numbers of mobile clinics and counselling service in factories to treat women migrant workers
- Quality of mobile clinics and counselling service in factories to help women migrant workers
- Frequency of lectures and workshops in workplaces and living quarters
- Clearer responsibilities and obligations on the part of employers about women's health issues among migrant workforce
- Better health insurance coverage for women migrant workers
- Open discourse about women's health issues in society

Exemplars of good practice

Informative and Awareness Short Videos

Women Friendly Safe Abortion Services in Malaysia- RRAAM Model Clinic

https://www.youtube.com/watch?v=k991aAeyIy8&feature=youtu.be

RUANG - SHORT FILM - Realiti kehamilan tidak terancang / Lived realities of unplanned pregnancies

https://www.youtube.com/watch?v=qIjfN_Fvf0k&list=PLhXoi8PA11yn13vbc7N5QC5JbRYbO3QIX&index=5

Report from NGOs to Malaysia Government

A report named “Towards A Comprehensive National Policy on Labour Migration for Malaysia” was launched in July 2017 to urge the government to come up with a comprehensive labour migration policy. This report, which was initiated by The Right to Redress Coalition (R2R), came about after a series of roundtables with representatives from different ministries and government agencies, embassies, employers’ organisations, workers’ organisations, migrant workers, civil society and the academia. It focused on recruitment, employment rights, undocumented labour, arrest and detention, social security, health and housing, family, children and socio-cultural rights.

Acknowledgement

We thank the United Nations Gender Theme Group, Malaysia, for its generous funding to carry out the project. We are also grateful to the many NGOs, unions, healthcare providers, employers, government agencies and women migrant workers who have spent valuable time with us in the twelve months of this project.

References

Belton, S. (2007) "Borders of Fertility: Unplanned Pregnancy and Unsafe Abortion in Burmese Women Migrating to Thailand" Health Care for Women International, 28, 419-433

Brody, C et al. (2016) "Are Text Messages a Feasible and Acceptable Way to Reach Female Entertainment Workers in Cambodia with Health Messages? A Cross-Sectional Phone Survey" JMIR Mhealth Uhealth, 4, 2, e52

Brody et al (2017) "Mobile phone use among female entertainment workers in Cambodia: an observation study" mHealth, 30, 3, 1-12

Dahal, S. et al (2013) "Sexual Behaviour and Perceived Risk of HIV/Aids among Returnee Labour Migrants from Overseas in Nepal" Health Science Journal, 7, 2, 218-228

Decat P et al. (2011) "Determinants of unmet need for contraception among Chinese migrants: A worksite-based survey" The European Journal of Contraception and Reproductive Health Care, 16, 26–35

Decat, P et al (2012) "Promoting Contraceptive Use among female rural-to-urban migrants in Qingdao, China: A Comparative Impact Study of Worksite-based Interventions" The European Journal of Contraception & Reproductive Health Care, 17, 363-372

Dong, YY et al (2015) "Multiple abortions and sexually transmitted infections among young migrant women working in entertainment venues in China" Women Health, 55, 5, 580–594

Ford, K. & Chamratrithirong, A. (2014) "Social Integration, AIDs knowledge and Factors related to HIV Prevention among Migrant workers in Thailand" AIDs Behaviour, 18, 390-397

Gao, X et al (2015) "Effect of improving the knowledge, attitude and practice of reproductive health among female migrant workers: a worksite-based intervention in Guangzhou, China" Sexual Health, 12, 1, 13-21

Gazi, R. Parveen S. & Kabir, H. (2009) "Risk Behaviour Network and Vulnerability to HIV Infection of Migrant female sex workers in Teknaf, Bangladesh" Pakistan Journal of Women's Studies, 16, 1/2, 55-70

Hadi, M. (2017) "Historical Development of the Global Political Agenda Around Sexual and Reproductive health and Rights: A Literature Review" Sexual & Reproductive Healthcare, 12, 64-69

Haider, A. (2008) "Out of the Shadows: Migrant Women's Reproductive Rights under International human rights law" Georgetown Immigration law Journal, 22, 3, 429-457

Hegde SS. et al (2012), "Unsafe abortion as a birth control method: maternal mortality risks among unmarried Cambodian migrant women on the Thai-Cambodia border" Asia Pac J Public Health, 24, 6, 989-1001

Huang YM et al (2014) "The free perinatal/postpartum contraceptive services project for migrant women in Shanghai: effects on the incidence of unintended pregnancy" Contraception, 89, 6, 521-527

Huang W. et al (2016) "HIV risk and sexual health among female migrants in China" Health Promotion International, 31, 3, 595-605

Islam M. Conigrave, K. Miah, M. & Kalam, K. (2010), "HIV awareness of outgoing female migrant workers of Bangladesh: A pilot study" Journal of Immigrant and Minority Health, 12. 6, 940-946.

Jordal, M. et al (2013) "Negotiating Respectability: Migrant Women Workers' Perceptions of Relationships and Sexuality in Free Trade Zones in Sri Lanka" Health Care for Women International, 35, 658-676

Kim, A. et al. (2012), "Health services for reproductive tract infections among female migrant workers in industrial zones in Ha Noi, Viet Nam: An in-depth assessment" Reproductive Health, 9(1), 4-14

Lasimbang, H. et al (2016) "Migrant Workers in Sabah, East Malaysia: The Importance of Legislation and Policy to Uphold Equity on Sexual and Reproductive Health and Rights" Best Practice & Research Clinical Obstetrics & Gynaecology 32, 113-123

Liu, ZY. et al (2011) "Reproductive health knowledge and service utilization among unmarried rural-to-urban migrants in three major cities, China" BMC Public Health, 11, 74-82

Lu, C. et al (2012) "Sexual and Reproductive health status and related knowledge among female migrant workers in Guangzhou, China: A Cross Sectional Survey" European Journal of Obstetrics & Gynaecology and Reproductive Biology, 160, 60-65

Manoyos, V. et al (2016) "Sexual Risk-Behaviours for HIV Infections among Young Cross-Border Migrant Workers living in urban Chiang Mai, Thailand" Journal of Health Research, 30, 5, 347-353

Mendelsohn, J. et al (2015) "Design and implementation of a sexual health intervention for migrant construction workers situated in Shanghai, China" Emerging Themes in Epidemiology, 12, 16, 1-13

Merali, I. (2000), "Advancing Women's Reproductive and Sexual Health Rights: Using the International Human Rights System" Development in Practice, 10, 5, 609-624

Merali, I. (2001) "Advancing Women's Reproductive and Sexual Health Through Empowerment and Human Rights" Journal of Obstetrics and Gynaecology Canada, 694-700

Musumari PM, Chamchan C. (2016) “Correlates of HIV Testing Experience among Migrant Workers from Myanmar Residing in Thailand: A Secondary Data Analysis” PLoS ONE, 11, 5: e0154669. doi:10.1371/journal.pone.0154669

Nodzenski, M. et al (2016) “New Prospects in Regional Health Governance: Migrant Workers’ Health in the Association of Southeast Asian Nations” Asia & The Pacific Policy Studies, 3, 2, 336-350

Qian, X. et al (2007) “Promoting contraceptive use among unmarried female migrants in one factory in Shanghai: a pilot workplace intervention” BMC Health Services Research, 7, 77-86

Right to Redress Coalition, (2017) “Towards A Comprehensive National Policy on Labour Migration for Malaysia”

Sen, G. (2014) “Sexual and Reproductive Health and Rights in the post-2015 development agenda” Global Public Health, 9, 6, 599-606

Sijapati, B., (2016). Women’s Labour Migration from Asia and the Pacific: Opportunities and Challenges (No. id: 10782).

Singh SK, Siddhanta A. (2017), “Cross Border Migration and HIV Vulnerability in South Asian Countries” J Transm Dis Immun. 1, 1-6

Tangmunkongvorakul, A. et al, (2017) “When I first saw a condom, I was frightened": A qualitative study of sexual behaviour, love and life of young cross-border migrants in urban Chiang Mai, Thailand” PloS ONE, 12, 8, 1-13

Troung, T. et al (2014) “Intersectionality, Structural Vulnerability, and Access to Sexual and Reproductive Health Services: Filipina Domestic Workers in Hong Kong, Singapore, and Qatar” Migration, Gender and Social Justice, Hexagon Series on Human and Environmental Security and Peace Book Services, 9, 229-239

Tuccio, M. et al (2017), “Determinants of Intra-ASEAN Migration” Asian Development Review, 34, 1, 144-166

Ullah, A. (2010) “Premarital Pregnancies among Migrant Workers: The Case of Domestic Helpers in Hong Kong” Asian Journal of Women’s Studies, 16, 1, 62-90

UN Women, (2017) “Women Migrant Workers in the ASEAN Economic Community” ISBN: 978-974-680-413-4, at http://asiapacific.unwomen.org/en/digital-library/publications/2017/06/women-migration-workers-in-asean#view

United Nations, Department of Economic and Social Affairs, Population Division (2017a). Trends in International Migrant Stock: The 2017 revision (United Nations database, POP/DB/MIG/Stock/Rev.2017).

Unnithan, M. & Ally, S. (2015), “Migrant Women’s Sexual and Reproductive Health and Family Planning” Submission to the UK-APPG on Population, Development and Reproductive Health: Population Dynamics in the Post-2015 Development Agenda; at http://www.appg-

popdevrh.org.uk/Migrant%20Women's%20Sexual%20and%20Reproductive%20Health%20and%20Family%20Planning.pdf

Vu, L et al (2016) "mHealth information for migrants: an e-health intervention for internal migrants in Vietnam" Reproductive Health, 13, 55, 1-9

Wang, Y. et al (2013) "Sexual and Reproductive Health among Unmarried rural-urban Female Migrants in Shanghai China: A Comparative Analysis" International Journal of Environment Research and Public Health, 10, 3578-3589

Webber, G (2007) "The Impact of Migration on HIV Prevention for Women: Constructing a Conceptual Framework" Health Care for Women International, 28L 712-730

Webber, G. et al, (2010), "Life in the big city: The multiple vulnerabilities of migrant Cambodian garment factory workers to HIV" *Women's Studies International Forum*, 33, 3, 159-169

Webber, G. et al (2012) "Facilitators and barriers to accessing reproductive health care for migrant beer promoters in Cambodia, Laos, Thailand and Vietnam: A mixed methods study" Globalisation and Health, 8, 21-39

Webber, G. et al (2015) "Migrant beer promoters' experiences accessing reproductive health care in Cambodia, Laos, Thailand, and Vietnam: lessons for planners and providers" Asia Pac J Public Health, 27, 2, 1-17

Yi, SY et al (2015) "Factors associated with Induced Abortion among female entertainment Workers: A Cross Sectional Study in Cambodia" BMJ Open, 5, 1-9

Zhu, CY et al (2014) "Impact of an Educational Programme on Reproductive Health Among Young Migrant Female Workers in Shenzhen, China: An Intervention Study" International Journal of Behavioural Medicine, 21, 4, 710–718

Key Informant Interview Guide: Research Instrument

Guidelines for Interviews

Begin interviews with a discussion /explanation of SRHR. Perhaps provide a handout for those unfamiliar with the term. Consider using the term "women's health" rather than SRHR.

Explain what the interview will cover: there are FOUR AREAS 1) practices, SRHR promotion and barriers, 2) knowledge and Information about SRHR, 3) strategies for support and change, and 4) empowerment

In the interviews consider using techniques such as probing, summarising and reflecting back e.g. so what you are saying is that…. "Is that right?" "So, you are saying" To show that you are listening and give them opportunities to expand if they want to. Let them think and respond, do not use "machine gun" approach

Always use the vignette "Siti" as a base – conduct the interviews, always with Siti as an example to initiate discussion

You might want to send "Siti" to organisations, prior to the interview, to enable organisations to familiarise themselves with what you are going to ask them

	Focus: **We will ask participants questions around the following areas:** 1) Practices, SRHR promotion and barriers 2) Knowledge and information about SRHR 3) Strategies for support and change 4) Empowerment
	Interview questions for key Informants

No.	NGOs	Union	Employers	Embassy	Ministry	WMW
1.	**Section 1. Practices, SRH promotion and barriers** Can you tell me about your work with wmw? (purpose: To get an overview of the respondent NGOs' connection with wmw)	**Section 1. Practices, SRH promotion and barriers** Can you tell me about your work with wmw? (purpose: To get an overview of the union's connection with wmw)	**Section 1. Practices, SRH promotion and barriers** Please tell me about your responsibilities/ job role? (purpose: To get an overview of the company's connection with wmw) Probes: do you have any responsibility for the well- being of	**Section 1. Practices, SRH promotion and barriers** Please tell me about your responsibilities for wmw? (probe: To get an overview of the embassy's connection with wmw) Probe: at what points does the embassy have contact with	**Section 1. Practices, SRH promotion and barriers** Please tell me about your responsibilities for wmw? (probe: To get an overview of the embassy's connection with wmw) Probe: at what points does the Ministry have contact with	**Section 1. Practices, SRH promotion and barriers** Please describe your background (probe: years in Malaysia, education, origin country, marital status, if married, where's husband, number of children, age etc) and employment.

			WMW? Does that include SRHR? If not, who would be responsible for this? What might be the consequences if nobody from the employer is concerned about this?	WMW? Eg in country of origin, on arrival in host country, when problems arise?	WMW? Eg in on arrival in host country, or only when problems arise?	
2.				(How) do you prepare wmw to cope with srhr problems when they come to Malaysia?	(How) do you prepare wmw to cope with srhr problems when they come to Malaysia?	
3.	Can you tell me what your organisation does to promote health seeking behaviours on the part of wmw? Probes: (promote in terms of giving information, enabling access to health care, raise awareness on the part of wmw of	Can you tell me what your organisation does to **promote** health seeking behaviours on the part of wmw? Probes: (promote in terms of giving information, enabling access to health care, raise awareness on the part of wmw of	Does your organisation **promote** health seeking behaviours on the part of wmw? (promote in terms of giving information, enabling access to health care, raise awareness on the part of wmw of choice and ability, giving them access to social contacts and networks)	Do you **promote** health seeking behaviours on the part of wmw? (promote in terms of giving information, enabling access to health care, raise awareness on the part of wmw of choice and ability, giving them access to social	Do you **promote** health seeking behaviours on the part of wmw? (promote in terms of giving information, enabling access to health care, raise awareness on the part of wmw of choice and ability, giving them access to social	Do you know what srhr is? Best to use the word "women's health" What do you do when you experience srhr problems in your work place, e.g. focus on something wmw may have experienced eg period pains, reproductive tract infections,

	choice and ability, giving them access to social contacts and networks) What does or would help you in promoting health seeking behaviours on the part of wmw? Probe- but let them think about it and speak first: is it more resources – be specific; better relationships with employers etc - how would that have helped?	choice and ability, giving them access to social contacts and networks) What does or would help you to promote health seeking behaviours on the part of wmw? Probe: but let them think about it and speak first: is it more resources – be specific; better relationships with employers etc - how would that have helped?	What would help you in promoting health seeking behaviours on the part of wmw? Probe: but let them think about it and speak first: more resources – be specific; better relationships with unions, medics, etc, more government support (specify) - how would that have helped?	contacts and networks) What would help you in promoting health seeking behaviours on the part of wmw?	contacts and networks) What would help you in promoting health seeking behaviours on the part of wmw?	sexually transmitted disease, pregnancy
4.	What are the barriers/ difficulties/ you encounter when trying to help	What are the barriers/ difficulties/ you encounter when helping wmw with		What are the barriers/ difficulties/ you encounter when helping wmw with	What are the barriers/ difficulties/ you encounter when helping wmw with	Who have you approached? Who has helped you? How? What did they

	wmw with srhr problems and issues? e.g. abortions, pregnancy related difficulties, sexually transmitted diseases, reproductive tract infections, ovarian or breast cancer, vaginal pain, breast pain, period related problems?	srhr problems and issues? e.g. abortions, pregnancy related difficulties, sexually transmitted diseases, reproductive tract infections, ovarian or breast cancer, vaginal pain, breast pain, period related problems? Probe – if they don't do anything to help WMW what would be the expected barriers or would make it easier?		srhr problems and issues? e.g. abortions, pregnancy related difficulties, sexually transmitted diseases, reproductive tract infections, ovarian or breast cancer, vaginal pain, breast pain, period related problems? Probe – if they don't do anything to help WMW what would be the expected barriers or would make it easier?	srhr problems and issues? e.g. abortions, pregnancy related difficulties, sexually transmitted diseases, reproductive tract infections, ovarian or breast cancer, vaginal pain, breast pain, period related problems? Probe – if they don't do anything to help WMW what would be the expected barriers or would make it easier?	do? What makes a difference? (Again, try to get them to tell you their stories- what What are the barriers/ difficulties you encounter when you seek help from NGOs/ embassy / employers etc with a srhr problem?
5.	**Section 2, Knowledge and information** In your experience, do	**Section 2, Knowledge and information** In your experience, do	**Section 2, Knowledge and information** In your experience, do wmw understand	**Section 2, Knowledge and information** In your experience, do wmw understand	**Section 2, Knowledge and information** In your experience, do wmw understand	**Section 2, Knowledge and information**

	wmw understand srhr or prepare themselves to deal with problems? Probe- examples – beyond a yes/no answer	wmw understand srhr or prepare themselves to deal with problems? Probe- examples – beyond a yes/no answer	srhr or prepare themselves to deal with problems? Probe- examples – beyond a yes/no answer	srhr or prepare themselves to deal with problems? Probe- examples – beyond a yes/no answer Do wmw complain to you about difficulty in accessing health services when they experience srhr problems?	srhr or prepare themselves to deal with problems? Probe- examples – beyond a yes/no answer Do wmw complain to you about difficulty in accessing health services when they experience srhr problems?	What help would you like from employers, unions or NGOs or others? Could embassies help? What about doctors or nurses?
6.	How do you or could you increase knowledge and training of wmw about srhr?	How do you or could you increase knowledge and training of wmw about srhr?	How do you or could you increase knowledge and training of wmw about srhr?	How do you or could you increase knowledge and training of wmw about srhr?	How do you or could you increase knowledge and training of wmw about srhr?	
7.	How do you or could you increase knowledge and training of your personnel about wmw's srhr?	How do you or could you increase knowledge and training of your personnel about wmw's srhr?	How do you or could you increase knowledge and training of your personnel about wmw's srhr? (especially if they are men?? Does that make a difference???)	How do you or could you increase knowledge and training of your personnel about wmw's srhr?	How do you or could you increase knowledge and training of your personnel about wmw's srhr?	How do you manage at the moment? What kind of health services do you use when you have srhr problems? -(probe: panel clinic, ngos, traditional medicines/ practices, etc)

No.	NGOs **Section 3: Strategies for Change**	Union **Section 3: Strategies for Change**	Employers **Section 3: Strategies for Change**	Embassy **Section 3: Strategies for Change**	Ministry **Section 3: Strategies for Change**	WMW
8.	Do you work with/collaborate with other organisations, and grassroots organisations represented by migrant workers themselves, to promote srhr for wmw? Involve different agencies in organising awareness or educational campaigns? (probe: If yes, how do you do it? How does it help? What makes it possible If not, why not?) What outcomes?	Do you work with/collaborate with other organisations, and grassroots organisations represented by migrant workers themselves, to promote srhr for wmw? Involve different agencies in organising awareness or educational campaigns? (probe: If yes, how do you do it? How does it help? What makes it possible If not, why not?) What outcomes?	Do you work with/collaborate with other organisations, and grassroots organisations represented by migrant workers themselves, to promote srhr for wmw? Involve different agencies in organising awareness or educational campaigns? (probe: If yes, how do you do it? How does it help? What makes it possible If not, why not?) What outcomes?	Do you work with/collaborate with other organisations, and grassroots organisations represented by migrant workers themselves, to promote srhr for wmw? Involve different agencies in organising awareness or educational campaigns? (probe: If yes, how do you do it? How does it help? What makes it possible If not, why not?) What outcomes?	Do you work with/collaborate with other organisations, and grassroots organisations represented by migrant workers themselves, to promote srhr for wmw? Involve different agencies in organising awareness or educational campaigns? (probe: If yes, how do you do it? How does it help? What makes it possible If not, why not?) What outcomes?	
No.	**NGOs** **4. Empowerment**	**Union** **4. Empowerment**	**Employers** **4. Empowerment**	**Embassy** **4. Empowerment**	**Ministry** **4. Empowerment**	**WMW**

9.	(How do you) increase the confidence of women migrant workers to challenge the structures which discriminate against them, preventing access to srhr care? (probe: Do you or could you encourage wmw to establish a group for health rights? Probe – if they do- get more info, if not get them to consider if feasible and useful	(How do you) increase the confidence of women migrant workers to challenge the structures which discriminate against them, preventing access to srhr care? (probe: Do you or could you encourage wmw to establish a group for health rights? Probe – if they do- get more info, if not get them to consider if feasible and useful		(How do you) increase the confidence of women migrant workers to challenge the structures which discriminate against them, preventing access to srhr care? (probe: Do you or could you encourage wmw to establish a group for health rights? Probe – if they do- get more info, if not get them to consider if feasible and useful	(How do you) increase the confidence of women migrant workers to challenge the structures which discriminate against them, preventing access to srhr care? (probe: Do you or could you encourage wmw to establish a group for health rights? Probe – if they do- get more info, if not get them to consider if feasible and useful	Do you think it is important for you or someone else to act as leader to spread the information/ knowledge/awareness of srhr in your country of origin so that issues can then be tackled at source to prevent SRHR from becoming a problem in the host country? What are the barriers and challenges of doing so?
10.	Is there a role for forum or activity (e.g. self-confidence workshops, discussion groups, role play, games) whereby women themselves can	Is there a role for forum or activity (e.g. self-confidence workshops, discussion groups, role play, games) whereby women themselves can	Is there a role for forum or activity (e.g. discussion groups, meeting with supervisors and managers) whereby wmw can discuss their srhr problems?	Is there a role for forum or activity (e.g. self-confidence workshops, discussion groups, role play, games) whereby women themselves can	Is there a role for forum or activity (e.g. self-confidence workshops, discussion groups, role play, games) whereby women themselves can	What steps can be taken to improve knowledge of srhr among wmw in host countries?

	come together to discuss their srhr problems? How can/do you initiate this?	come together to discuss their srhr problems? How can/do you initiate this?	How can you initiate this?	come together to discuss their srhr problems? How can/do you initiate this?	come together to discuss their srhr problems? How can/do you initiate this?	
11.	How do or could you build solidarity among women migrant workers to bring change in the area of sexual and reproductive health? (Probe: Women coming together means their voice is stronger. stronger voice means better chance of change. so, do you help women migrant workers come together with each other? if not, why not? do you see value in this? maybe introduce them so they make	How do or could you build solidarity among women migrant workers to bring change in the area of sexual and reproductive health? (Probe: Women coming together means their voice is stronger. stronger voice means better chance of change. so, do you help women migrant workers come together with each other? if not, why not? do you see value in this? maybe introduce them so they make		How do or could you build solidarity among women migrant workers to bring change in the area of sexual and reproductive health? (Probe: Women coming together means their voice is stronger. stronger voice means better chance of change. so, do you help women migrant workers come together with each other? if not, why not? do you see value in this? maybe introduce them so they make	How do or could you build solidarity among women migrant workers to bring change in the area of sexual and reproductive health? (Probe: Women coming together means their voice is stronger. stronger voice means better chance of change. so, do you help women migrant workers come together with each other? if not, why not? do you see value in this? maybe introduce them so they make	

	friends with each other? maybe help them set up whatsapp group? maybe through leadership training and then wmw leader can reach out to others? maybe through awareness lessons where many wmw can come together?)	friends with each other? maybe help them set up whatsapp group? maybe through leadership training and then wmw leader can reach out to others? maybe through awareness lessons where many wmw can come together?)		friends with each other? maybe help them set up whatsapp group? maybe through leadership training and then wmw leader can reach out to others? maybe through awareness lessons where many wmw can come together?)	friends with each other? maybe help them set up whatsapp group? maybe through leadership training and then wmw leader can reach out to others? maybe through awareness lessons where many wmw can come together?)	
12.	How do you help women migrant workers to diagnose what they need in relation to srhr? (if you do, please give few examples, Probe e.g. do you use drama, testimony, role play, health education classes etc?)	How do you help women migrant workers to diagnose what they need in relation to srhr? (if you do, please give few examples, Probe e.g. do you use drama, testimony, role play, health education classes etc?)	How can employers help women migrant workers to diagnose what they need in relation to srhr? Are there practical strategies which can be put in place at work? What do you do- or could you do? Eg. In house doctor, drop in centre, leaflets to explain srhr Probe: many of these examples are cost free!	How do you help women migrant workers to diagnose what they need in relation to srhr? (if you do, please give few examples, Probe e.g. do you use drama, testimony, role play, health education classes etc?) Probe: many of these examples are cost free!	How do you help women migrant workers to diagnose what they need in relation to srhr? (if you do, please give few examples, Probe e.g. do you use drama, testimony, role play, health education classes etc?) Probe: many of these examples are cost free!	

13.	**Giving WMW a voice** Do you involve wmw in campaigns to improve their srhr? (if yes, please give example; if not, please tell the reason) (Probes: In which phase of your campaign involved the wmw? Organising phase? As participant?)	**Giving WMW a voice** Do you involve wmw in campaigns to improve their srhr? (if yes, please give example; if not, please tell the reason) (Probes: In which phase of your campaign involved the wmw? Organising phase? As participant?)		**Giving WMW a voice** Do you involve wmw in campaigns to improve their srhr? (if yes, please give example; if not, please tell the reason) (Probes: In which phase of your campaign involved the wmw? Organising phase? As participant?)		
14.	In an ideal world, what bigger changes would help you help wmw access their srhr? (Probe: If you were to choose **three factors** that could assist you in helping the wmw	In an ideal world, what bigger changes would help you help wmw access their srhr? (Probe: If you were to choose **three factors** that could assist you in helping the wmw	In an ideal world, what bigger changes would help you help wmw access their srhr? (Probe: If you were to choose **three factors** that could assist you in helping the wmw to, for example, increase	In an ideal world, what bigger changes would help you help wmw access their srhr? (Probe: If you were to choose **three factors** that could assist you in helping the wmw	In an ideal world, what bigger changes would help you help wmw access their srhr? (Probe: If you were to choose **three factors** that could assist you in helping the wmw	Do you know of any grassroots organisations represented by migrant workers themselves? End with- if you could have just some small changes in your life, what wold make it easier for you to

	to, for example, increase own knowledge about sexual and reproductive health issues, build confidence to combat discrimination, realise what would make life easier for them if they experience srhr illnesses, access healthcare services like clinics and hospitals, get together with other wmw and build solidarity, enable them to have access to social contacts and networks, involve wmw in campaigns to promote their srhr, what will it be?)	to, for example, increase own knowledge about sexual and reproductive health issues, build confidence to combat discrimination, realise what would make life easier for them if they experience srhr illnesses, access healthcare services like clinics and hospitals, get together with other wmw and build solidarity, enable them to have access to social contacts and networks, involve wmw in campaigns to promote their srhr, what will it be?)	own knowledge about sexual and reproductive health issues, build confidence to combat discrimination, realise what would make life easier for them if they experience srhr illnesses, access healthcare services like clinics and hospitals, get together with other wmw and build solidarity, enable them to have access to social contacts and networks, involve wmw in campaigns to promote their srhr, what will it be?)	to, for example, increase own knowledge about sexual and reproductive health issues, build confidence to combat discrimination, realise what would make life easier for them if they experience srhr illnesses, access healthcare services like clinics and hospitals, get together with other wmw and build solidarity, enable them to have access to social contacts and networks, involve wmw in campaigns to promote their srhr, what will it be?)	to, for example, increase own knowledge about sexual and reproductive health issues, build confidence to combat discrimination, realise what would make life easier for them if they experience srhr illnesses, access healthcare services like clinics and hospitals, get together with other wmw and build solidarity, enable them to have access to social contacts and networks, involve wmw in campaigns to promote their srhr, what will it be?)	manage your SRH and your work? In an ideal world what bigger changes would help

Vignette

Siti is an Indonesian migrant worker who works as an assembler of electronic products in a large factory in an industrial zone. She has worked in the factory for 1 year. Due to the nature of her work, she is required to stand for several hours at a time, on the production line.

Siti has suffered from reproductive tract infections since undergoing a badly performed abortion two years ago. However, she does not know that she is suffering from RTI. She has never attended school and her knowledge about health issues is very limited. She experiences a lot of pain and discomfort, but she is afraid to raise this with her supervisor. She mentioned her pain and discomfort once before, but was chastised severely by her supervisor: "you sitting down or resting will hold production up", "we do not pay you to sit down to rest", "if you do not work I will tell the manager to dismiss you". All her supervisors and managers are men, and feel that 'female' problems should not stop women from working. Similar to many other workers, Siti is reluctant to complain because she fears losing her job.

Lately, her condition has flared up again and the pain is very intense, making it difficult for Siti to stand for long periods of time. Siti worries that she might have cancer. Her worry is affecting her performance at work and she is very depressed.

Siti confides in her work colleagues. Some informed her that they have suffered similar symptoms before, but that these symptoms always went away. They did not want to worry themselves by thinking about what the problems could be. There is no in-house doctor on the factory premises. One or two colleagues suggested that Siti should visit the local clinic, but Siti is reluctant to do so because when she accompanied a friend to the clinic previously, she noticed that the nurses and doctors were very rude to them, due to their foreign status. Siti speaks basic Bahasa Malaysia and does not know how to describe her symptoms in the local language. The clinic is also very far away from the workplace. Most of all, Siti is anxious that she should save, rather than spend money on seeking medical treatment.

Siti reflects on the information given to her and other workers in their "pre-departure orientation sessions for migrants", in Indonesia. Although plenty of information was given to them, this related to employment issues only. There was very limited information about health issues, sexual and reproductive health, what workers should do in the event that they fell ill, or who they should contact in the case of medical emergencies. Due to her undergoing the abortion, she suspects that her symptoms are what women (rather than men) experience, but she does not have sufficient knowledge to make concrete assumptions.

Moreover, once Siti and her work colleagues entered Malaysia, they were immediately put to work in the factory. They were not invited to attend any health-related training in the factory.

She was told that migration policies in Malaysia revolved around regulating migrants' employment, and that the Malaysian government did not care when migrants fell ill. She does not know whether this is true.

Siti feels isolated and angry because no one seems to care. She does not know who to approach. There is a union in the workplace, but it is not friendly to migrant workers. The union also does not get on well with the factory supervisors and managers, and there is a breakdown of communication between them. Siti has heard that there are women's organisations who can help women in her position (they specialise in women's health), but she does not know how to approach them, neither does she know whether they would be interested in helping migrant workers.

Siti has decided that the only thing to do is to seek treatment after she returns to Indonesia in two years' time, and that in the meantime, she should just put up with the pain and discomfort.

Brief Fact Sheet

1. What is sexual and reproductive health?

Sexual and reproductive health is firmly regarded as part of the basic human rights of peoples everywhere - they are universal rights, recognised in many international conventions and documents.

It means people have a right to exercise control over their own sexuality and reproduction.

It means that women have a right to control their bodies and to make decisions about their bodies in the way they want to. It requires others to respect these decisions. It means that women have sufficient information to make decisions about their sexual and reproductive life (e.g. whether to have children, to seek treatment for sexual and reproductive health conditions). It means that women are able to afford to pay for services to keep them healthy, or to manage sexual and reproductive health conditions and illnesses which have developed. It means that women have access to these services, which are not withheld or denied to them.

2. What does this mean for women migrant workers?

Exercising sexual and reproductive health rights means that women migrant workers can access the following:

- Affordable healthcare for sexual and reproductive health conditions and illnesses;
- Safe, effective and affordable contraception method of their choice;
- Prevention and treatment of sexually transmitted infections (STIs) including HIV/AIDS, breast and cervical cancers, reproductive tract infections, menstruation problems;
- Prevention of sexual violence, such as rape, against women;
- Sexual health information, education, and counselling to promote health-seeking behaviours

3. How may sexual and reproductive health rights of women migrant workers be violated?

- Forced testing against pregnancy
- Bans against, or heavy penalties (imprisonment, deportation) in the event of, pregnancy and abortion
- Rape and sexual violence in the workplace
- Discrimination on the part of health care providers, when women migrant workers attend clinics or hospitals to seek medical treatment for sexual and reproductive health conditions and illnesses
- Employers refusing permission when women migrant workers want to seek medical treatment for sexual and reproductive health conditions and illnesses
- Government ignoring the sexual and reproductive health needs of women migrant workers

Authors

Dr. Lilian Miles (UK) works at Middlesex University Business School. She has an interest in the specific barriers which low-skilled and low-waged women face in the workplace, and in how the capabilities of these women can be enhanced. She is familiar with the work of many women non-governmental organisations in Malaysia and is interested in exploring the ways in which they can be instruments for women's empowerment. The completion of the project has enriched her knowledge of women, migration and activism in developing countries.

Professor Dr. Suzan Lewis (UK) is a Professor of Organisational Psychology at Middlesex University Business School. Her research focuses on gender and "work-life balance" issues and workplace practice, culture and change, in diverse national contexts. She played a pivotal part in guiding the development of the research instrument in our work with non-governmental organisations under this project.

Professor Dr. Noraida Endut (Malaysia) is the Director of the Centre for *KANITA* (Centre for Research on Women and Gender), Universiti Sains Malaysia. She has researched and published on issues around women's livelihood, women and the law, and gender-based violence in Malaysia and the Asia Pacific region. She helped conceptualise, plan and supervise the research component of this project.

Dr. Lai Wan Teng (Malaysia) is a lecturer/ researcher at *KANITA* (Centre for Research on Women and Gender), Universiti Sains Malaysia. She has extensive fieldwork experience in researching vulnerable groups, including women factory migrant workers, foreign domestic workers, and male labourers in the construction and services sectors. She also has extensive work experience with women's non-governmental organisations prior to her career as an academic. Given her background, Wan Teng is well-placed to participate in this research project.

Dr. Suziana Mat Yasin (Malaysia) is a Senior Lecturer in the Department of Development Planning and Management, School of Social Sciences, Universiti Sains Malaysia (USM). Her research interests include international migration, immigrants' settlement and mobility patterns, and the impact of immigration in local development and population studies. Given her experience of empirical work with migrant workers, and her connections with non-governmental organisations, she made a valuable contribution to this research project.

Mr. Kelvin Ying @ Tang Shee Wei (Malaysia) is currently a PhD candidate in Interdisciplinary Health Sciences Unit, School of Health Sciences, Universiti Sains Malaysia. His current research interest is to explore mental health and social well-being of marginalised or niche population through the lens of health and social psychology. His working experience as project research officer in *KANITA* helped to ensure this project run smoothly.