

## ORIGINAL ARTICLE

# At the limits of “capability”: The sexual and reproductive health of women migrant workers in Malaysia

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## Abstract

Despite the centrality of sexual and reproductive health (SRH) to UN Sustainable Development Goals (SDGs), women migrant workers in Malaysia face an environment inimical to their SRH needs. Drawing on qualitative case study material, we present the first empirical application of the capability approach (CA) to explore the reproductive health needs of women migrant workers in a developing country, offering an original analysis of the capability for SRH of these women. Specifically, we explore the resources available to them; their opportunities and freedoms (“capabilities”); and factors that mediate transformation of resources into capability sets (“conversion factors”). While SRH information and health care are notionally available, women migrant workers face multiple challenges in converting resources into functionings, constraining the achievement of capability for SRH. Challenges include language barriers, personal beliefs, power relations between workers and employers and the consequences of current migration policy. We consider the scale of the challenges facing these women in securing SRH rights, the difficulties of operationalising the CA within such a setting, and the implications of our findings for the adequacy of the CA in supporting marginalised populations.

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**INTRODUCTION**

Sexual and reproductive health (SRH) rights are high on the international development agenda, given their centrality to UN 2030 Sustainable Development Goals related to health (SDG3) and gender equality and empowerment (SDG5). There are strong positive correlations between women's ability to regulate fertility and outcomes such as earning an income (John et al., 2020), educational attainment and employment rates (Pande et al., 2020) and enhanced job mobility and transition into higher-paying occupations (Bahn et al., 2020).

Malaysia is a major destination for migrant labour within the Association of Southeast Asian Nations (ASEAN) region. Robust economic growth attracts low-paid and low-skilled migrant workers from Indonesia, Bangladesh, Vietnam, Myanmar and the Philippines—and they constitute over 20% of Malaysia's workforce (International Labour Organization, 2016). Approximately half of migrant workers are women, concentrated within the manufacturing, service and domestic industries and working under difficult conditions, with few rights and entitlements in the workplace and wider society. Migration can have positive effects on women's life chances such as improved self-confidence, enhanced ability to plan for their economic futures and increased influence in family decision-making (Shakya & Yang, 2019). They attain economic independence (Balderrama & Nijenhui, 2016) and develop self-worth and recognition of their own abilities (Shrestha et al., 2020). Yet, women migrant workers, like their male counterparts, face specific disadvantages in their host countries, one of which is health protection (Pocock et al., 2018).

We focus in this article on the SRH needs of women migrant workers. While SRH needs and vulnerabilities are common to both men and women migrant workers, women are more vulnerable than their male counterparts. For example, only women experience pregnancy and childbirth. Some sexually transmitted infections (STIs) may have a more severe impact on women than men, and women are more likely to be subjected to sexual violence. These vulnerabilities are magnified in the context of migration, prompting researchers to call for a gender-based analyses of migration (Bastia, 2014; Fleury, 2016; Hennebury & Petrozziello, 2019). The SRH concerns of women migrant workers within ASEAN member states include STIs (Manoyos et al., 2016), reproductive tract infections (Le et al., 2018) and unwanted pregnancies (Thein & Theptien, 2020). These remain unmet due to prohibitive cost, limited access to health care and lack of SRH knowledge (Tangmunkongvorakul et al., 2017). Cost pressures are compounded by financial demands from families within migrants' countries of origin, and inability to speak the local language within their host country impairs communication with health service providers (Webber et al., 2015). These combine to reduce opportunities for early detection and treatment.

Malaysia offers a compelling site for investigation of the SRH rights of women migrant workers because its migration regime is intolerant of these needs (Lasimbang et al., 2016; Loganathan et al., 2020). Non-Malaysian citizens require a valid permit to live and work legally within Malaysia. Women migrant workers who fall pregnant have violated the conditions in their work permit and are liable to deportation (Immigration Department of Malaysia, 2020b), and those who stay on without such a permit become undocumented. Malaysia offers no specific provision of SRH care for migrant workers, who must submit to two phases of health screening to certify that they are healthy and free from dangerous or contagious diseases prior to taking up employment. The first phase consists of

biomedical screening within their countries of origin, and the second is a medical examination conducted post-arrival as part of a comprehensive Foreign Workers' Medical Examination Screening System ("FOMEMA"), undertaken by an appointed company on behalf of the Ministry of Health (Immigration Department of Malaysia, 2020a). Both men and women migrant workers receive health screening for HIV and syphilis, and women migrant workers are additionally screened for breast abnormalities/swelling and pregnancies (FOMEMA, 2020a, 2020b). Migrant workers must obtain certification that they are free from malaria and tuberculosis and are in good general health—and not pregnant—by a medical centre registered with FOMEMA. Screening costs are borne by the employer. Migrant workers who fail the screening test are deported; those who pass must be re-screened each year for the first 3 years of their stay, then every alternate year up to a maximum of ten years. If they fail a screening test, they are deported, and after ten years, they are no longer eligible to remain.

FOMEMA services are limited to screening. SRH care is available from the Ministry of Health (MOH) and Ministry of Women, Family and Community Development, National Population and Family Development Board (LPPKN) and Ministry of Education, and NGOs (Manimaran et al., 2017). However, accessibility for migrant workers is significantly lower than for Malaysian nationals. Migrant workers are excluded from antenatal care as they are prohibited by law from becoming pregnant and face deportation if they are (Lasimbang et al., 2016). While primary care SRH services are universally available, knowledge and utilisation remains low generally (Othman et al., 2019). Within secondary care services, while the Hospitalisation and Surgical Scheme for Foreign Workers (SPIKPA) covers some medical fees, this cover is limited. Migrant workers must also pay full medical fees at government hospitals as they are excluded from the subsidies available to Malaysian nationals (Lim et al., 2020). The high cost of services thus acts as a barrier to access (Table 1). Women migrant workers may purchase medical products from nearby pharmacies. While they have access to a factory clinic—which is open only during factory working hours—for treatment for common ailments, they must usually obtain permission from a supervisor to visit the clinic. Such clinics are not always staffed by doctors, and nursing staff may not be qualified to diagnose or prescribe treatments, forcing women migrants to seek medical services outside of the factory.

Proof of SRH status is thus a condition for employment for migrant workers, despite this requirement being contrary to international human rights law (Fair Labour Association, 2018). Contracts prohibiting pregnancy are enforced, resulting in cancellation of work permits and repatriation. Such policies are defended on the basis that allowing short-term workers to have children leads to undesirable social outcomes (Augustin, 2018). Consequently, women migrant workers may endanger their lives by inducing abortions for fear of losing their jobs (Loganathan et al., 2020). Migrants who have contracted STIs are deported as they are considered a threat to public health. Those seeking health care risk discrimination by health-care providers in hospitals based on their immigration status and must produce documentation (passport) before treatment is given (Loganathan et al., 2019). The net effects limit women migrant workers' ability to manage their SRH.

Penang is the second most densely populated state in Malaysia. It is a major centre of production of electronic goods and hosts global manufacturers of semiconductors and computer hardware within the Bayan Lepas Free Industrial Zone (FIZ). Migrant workers employed in factories face highly regulated employment conditions. Employment contracts detail basic salary, overtime, shift work patterns and subsistence allowance. Shifts are spread across eight hours per day six days per week, and Sunday is a rest day. Workers may additionally undertake voluntary overtime up to 4 h per day. While Malaysian labour law does not prohibit migrant workers from joining trade unions, they are not allowed to form their own unions, nor become office-bearers (Trade Union Act 1959, Section 28(1)). In practice, many companies discourage migrant workers to join trade unions' activities (Chung, 2019).

**TABLE 1** Comparison of hospital charges for Malaysian and non-Malaysian citizensSource: <http://www.hkl.gov.my/index.php/advanced-stuff/hospital-charges>

Types Of Hospital Charges	Malaysian Citizen				Non-Malaysian			
	Ward Class	Medical	Surgery	Maternity & O&G	Ward Class	Medical	Surgery	Maternity & O&G
Ward Deposit	First Class	RM1050	RM 1650	RM 800	First Class	RM 7,000	RM 11,000	RM 7,000
	Second Class	RM 200	RM 400	RM 350	Second Class	RM 3,000	RM 5,000	RM 5,000
	Third Class	RM 20	RM 30	RM 15	Third Class	RM 1,400	RM 2,800	RM 2,800
In-Patient Treatment Charges (Daily Charges)	WARD CLASS		Public/Private		RM 100			
	1		RM 15					
	2		RM 5.00					
	3		Free					

Costs last updated 12<sup>th</sup> August 2020 – current as of January 2021

Reference 'Kuala Lumpur Hospital, 2020

Costs last updated 12 August 2020—current as of January 2021.

We explore women migrant workers' experience of SRH in Malaysia by applying empirically a capability model (Sen, 1999, 2005). Despite being very influential in development policy, the capability literature shows a dearth of examples of the application of the framework to SRH (Dejong, 2006; Jayasundara, 2013). We address this gap directly, applying the approach to frame discussion of how these women's capability for SRH in Malaysia may be realised. In the following sections, we present a critical summary of the capability approach (CA) and consider its limited previous application within health and migration studies. We next outline our research questions and methodology and apply the CA as a conceptual framework for an analysis of the experience of women migrant workers in Malaysia in meeting their SRH needs, before considering the challenges involved in applying the CA in this context and the implications of our findings for the CA itself.

### The capability approach (CA)

Sen (1980, 1992, 1999) defines human development in terms of agency and freedom—those processes that enable people to exercise reasoned agency—rather than resources held. The CA focuses on expanding the freedoms and opportunities (“capabilities”) available to individuals to live a life they value.

The CA is underpinned by core concepts “functionings,” “capability” and “agency.” Four key elements define the space of human flourishing. “Well-being achievement” concerns the attainment of functionings. In contrast, “well-being freedom” refers to the range of substantial freedoms (capabilities) to achieve those things that make up one's wellbeing (Sen, 1992: 57). The ability to drive, having

a good job and being in good health are functionings, which contribute to well-being achievement. Having the opportunity to learn to drive, to have a good career or to be healthy is capabilities. Human flourishing goes beyond wellbeing to include agency, which can mean “agency freedom” or “agency achievement.” The first refers to the freedom to choose and bring about the achievements one has reason to value, while the second concerns the realisation of goals and values a person chooses and has reason to pursue (Sen, 1992: 56, 57).

The relevant evaluative space “is neither that of utilities (as claimed by welfarists), nor that of primary goods (as demanded by Rawls), but that of the substantive freedoms—the capabilities—to choose a life one has reason to value” (Sen, 1999: 74). Resources are important to the extent that they engender such capabilities, which is contingent on other factors. Sen (1999; pp. 70–71; Sen, 2005; p. 154) identified five such mediating conversion factors (personal heterogeneities, distributions within the family, differences in relational positioning, varieties in social climate and environmental diversities) summarised by Robeyns (2005; p. 99) as three: personal (e.g. metabolism, skills), social (e.g. norms, hierarchies and power relationships) and environmental (e.g. climate, location and infrastructure) (see Hvinden & Halvorden, 2018: 869–870). For example, education is a resource, but people vary in their ability to convert resource into functioning, for example because social customs dictate that it is not worthwhile for girls to go to school because they will be married at a young age.

The CA is not a comprehensive theory of justice, rather a normative tool. Sen remains “assertively incomplete in his theorizing” and does not specify a list of functionings and capabilities (Hamilton, 2019: 68), preferring instead to leave their determination to “social choice processes of evaluation that would have to be carried out in each and every context” (ibid). Yet, Sen does recognise the centrality of health to human life and a human capability that would be reasonable to value (Sen, 2002, 2004). Others extend this, affirming a health capability defined as the ability to attain good health and avoid preventable illness (Ruger, 2006) arguing a moral right to health capability (Venkatapuram, 2011) and regarding good health, including reproductive health, as a critical capability (Nussbaum, 2000).

Recognition of the myriad factors mediating conversion of resources to functionings accommodates human diversity and is consistent with the CA’s ethically individualist orientation. Individual rights are not subsumed within collectives of family, clan or community, which allows exploration of feminist concerns related to individual experience within gendered social structures (Robeyns, 2006).

## Critiques of the CA in the literature

A number of extant critiques have special significance for expanding freedom and opportunities for managing SRH of women migrant workers in Malaysia and, by extension, women subject to similar migration regimes elsewhere.

As a proponent of democracy as a means of development, Sen advocates a “social choice” exercise within society to determine which capabilities it should promote. This task does not fall on national or local guardians, or political rulers or cultural experts. In the event of disagreement, Sen argues that people directly participating in the exercise should decide which, and how, capabilities should be chosen (Sen, 1999: 31–32, 78–79). Such exercises require participants to set aside their interests and reach agreement on the capabilities that society should promote through exercise of reason (Sen, 2005). Yet, this fails to consider conflicts arising from different conceptions of wellbeing—even within democratic societies—and whether the effect of such conflicts on those capabilities deemed worthy of promotion may be resolved through deliberation (Corbridge, 2002; Deneulin & McGregor, 2010). Unequal social relations influence the extent to which social choice exercises yield positive outcomes for all (Dean, 2009; Deneulin & McGregor, 2010). Indeed, those whose interests emerge victorious

may triumph at the expense of others—and they may do so by subverting democratic processes to secure their own advantage (Evans, 2002). These difficulties are compounded in undemocratic societies with deep power inequalities and where political participation is effectively denied to the weakest, casting doubt over the ability of those less privileged in such contexts to participate effectively and secure the capabilities they value (Deneulin, 2008).

The CA is also considered unduly individualistic (Stewart, 2005). Societal structures within which individuals live are considered important only to the extent that they advance individual freedoms. Yet, individuals are part of, and inextricably linked to, these very structures to the extent that they derive their identities from the values, norms and cultures within their societies (Evans, 2002); individual agency develops socially according to “structures of living together” (Stewart & Deneulin, 2002). While some of these structures provide favourable conditions for development of individual agency, others do not (Deneulin, 2008). Given the link between “structures of living together” and the development of capabilities, the former may be reformed to better promote specific capabilities (Stewart & Deneulin, 2002).

Finally, the CA is silent on wider injustices created by global economic conditions (Dean, 2009; Pogge, 2002). Approaches such as the “girl effect project”—advanced by development organisations under the rubric of capability to empower women in the developing world through skills development and labour market integration (Koffman & Gill, 2013)—are premised on liberal concepts of freedom and individual agency. Thus, traditional social norms as enacted within pre-modern kinship and gender relations must be replaced as they restrict women's independence and life chances (Hickel, 2014). The CA provides space for the assertion of either traditional pre-modern kinship and gender relations or their replacement with liberal skills development and market integration—this is to be determined within the social choice exercise. Such replacement may suggest the women are exposed to new forms of subordination; that far from advancing gender equality, “feminist grammars” of empowerment may themselves be used for the purpose of exploitation, in which women in the global south are cast as debtors in expanded credit markets as a source of cheap labour (Boyd, 2016). Indeed, women's involvement in an array of initiatives associated with neoliberal development raises the question of whose interests are primarily served (Chant, 2016). Behind development initiatives such as “girl effect” is the assumption that it is possible to separate individuals from local and traditional mores/desires such that they exist outside of their cultures. Yet, the abstract individual outside of time and place is an impossibility. Agency is itself an effect of the disciplinary power of social norms, and such norms are generative, to the extent that their performative effects shape the development of agentic subjects (Hickel, 2014: 1368). The possibility remains, however, that such consequences may be ruled out within the deliberative process as undesirable—normative preferences elicited through deliberative processes. In this way, the CA conceptually allows for the idea of “bad functionings”—those with a negative value—as well as good ones, first defining relevant functionings and capabilities, then engaging in deliberation about which capabilities to focus on (DeJaeghere, 2012).

Concerns over economic exploitation have particular resonance for women in labour-abundant countries seeking economic expansion. In Asia, where migration has been spurred by neoliberal economic globalisation (Gills & Piper, 2002), Indonesia, Myanmar, The Philippines and Nepal are major exporters of female labour. Paid employment is promoted as a pathway towards empowerment and has generated a large migrant recruitment and employment industry. While the economic benefits of migration are celebrated by states and market actors, less visible are its gendered aspects, or the challenges women migrants face because of the gender relations they are embedded within (Bastia, 2013; Pearson & Sweetman, 2019). As with “girl effect” projects, female migration is presented as a pathway to women's emancipation, yet little attention is paid to the gendered social norms, which create conditions for their exploitation and worse their inability to escape from this marginal position.

## Application of the CA to health and migration

The CA is highly influential in informing health policy and practice (Anand, 2005). It has been used as a moral (Venkatapuram, 2011) and philosophical (Ruger, 2006) justification for a right to health. It has guided development of mental health initiatives (Lewis, 2012), informed policymaking for people with disabilities (Broderick, 2018; Trani et al., 2011) and effected the development of a range of metrics and indicators of health capabilities (Anand et al., 2008; Lorgelly et al., 2015; Mitchell et al., 2017). Its application to SRH, however, is infrequent (see Teerawattananon et al., 2011 who apply the CA to evaluate the relationship between HIV prevention interventions and outcomes in individuals; and Greco, 2013, Greco et al., 2015, 2018 who use it in assessing women's quality of life and wellbeing, of which SRH is one aspect).

The CA has also informed migration research, including migrants' complex experiences and motivations to migrate and factors influencing the decision (Bonfanti, 2014). While the capabilities approach celebrates agency and the possibility of economic benefits, individual rights and economic development may conflict, and caution needs to be exercised to safeguard migrants' intrinsic human rights (Preibisch et al., 2016). Used as an analytic lens, the approach may reveal barriers to legal redress experienced by labour migrants even where formal legal rights exist (Hastie, 2017). It thus promises to be better able to achieve social justice for migrants than systems based solely on formal rights (Briones, 2011).

While the CA has been applied to address the *health* needs of migrants to expand their capability for health in Cyprus (Pithara et al., 2012), this is the first application of the approach to address the SRH needs of women migrant workers in a developing country. We apply the CA to assess the experience of SRH of women migrant workers in Malaysia, focusing on individual freedom and agency, human heterogeneity and diversity and paying particular attention to the conversion factors that give rise to particular vulnerabilities for these women, as women (Robeyns, 2006). We explore their experience against core CA concepts to address the following research questions:

RQ1: What opportunities and freedoms, in the local context, make up capability for SRH?

RQ2: What resources do women migrant workers need in order to meet SRH needs?

RQ3: What factors influence the conversion of resources into functionings in this context?

## METHOD DESIGN

Our qualitative case study (Stake, 1995) design is informed by principles of rapid appraisal (Kumar, 1993), used widely within development studies and informed by snowball sampling of key stakeholders. This allowed us to explore workplaces, health-care providers and voluntary organisations serving as sites of community, opportunity and empowerment (Shinn, 2015) and inform SRH capabilities of women migrant workers in Malaysia. We conducted semi-structured interviews, exploring issues from the various perspectives of a sample of women migrant workers employed in product assembly operations for global firms within the consumer electronics and electronics component sector. Additionally, we interviewed respondents drawn from wider stakeholder groups comprised of employers, union officials, staff from NGOs and health-care providers. We undertook 14 interviews with women migrant workers and an additional 10 with stakeholders.

Our topic guide explored the following:

- How women and stakeholders currently address these women's SRH needs, including barriers and challenges;

- How SRH knowledge and training among stakeholders and women can be increased;
- What strategies for support and change stakeholders can adopt to address SRH needs of women migrant workers; and
- How women's confidence, voice and solidarity to address SRH needs can be nurtured.

Participants were encouraged to elaborate responses through prompting “how,” “when,” “why” and “where.” We outlined the voluntary nature of participation, obtained explicit informed consent, and recorded the interviews digitally for transcription and translation into English. The funder required ownership of the research governance process and undertook ethical review of project methods prior to commencement.

## Sample selection and recruitment

The Malaysian authors used their knowledge of the local advocacy context to identify initial stakeholders. They had previously conducted research on migrant labour working conditions and rights in Malaysia and are familiar with NGOs involved with migrant populations. These stakeholders were invited to take part and subsequently nominated other organisations for inclusion. We applied snowball sampling techniques (Goodman, 1961) to identify additional relevant stakeholders drawn from health-care providers, unions, NGOs, employers and relevant government departments, recruiting 10 stakeholders in this way (Table 2). Stakeholder interviews were conducted in English as participants were all fluent English speakers.

Access to women migrant workers is problematic given their long work hours and secluded accommodation. Unsurprisingly, women are guarded in their interactions with others due to language barriers and their awareness that they are widely perceived as an undesirable population. These conditions necessitated a pragmatic approach to participant recruitment through local gatekeepers (one union and one health-care provider) drawn from our sample of stakeholders. Gatekeepers provided potential participants with information on the project supplied by the research team and made arrangement for the research team to

TABLE 2 Organisations represented by stakeholder participants ( $n = 10$ )

		Language used during interview
NGO1	A women's rights and health advocacy group campaigning for better access to sexual and reproductive health and rights for women in Malaysia	English
NGO2	A local NGO promoting family wellbeing and community development through provision of SRH services	English
NGO3	A human rights organisation advocating the rights of women, children, migrants and refugees in Malaysia	English
TX	An activist championing the rights of Indonesian migrant workers in Malaysia	English
U1	A local union representing women workers' rights	English
U2	An industry-level union in Malaysia	English
Gov1	A state-level government department responsible for immigration matters	English
Gov2	A state-level government department responsible for human resource and labour	English
E1	An employer association	English
H1	An academic and medical practitioner specialising in community health	English



TABLE 3 Socio-demographic characteristics of women migrant worker participants ( $n = 14$ )

Respondent code	Age	Years of working in Malaysia	Home country	Education level	Marital status	SRH needs while employed	Language used during interview
WMW1	36	9	Indonesia	High School	Single	Menstrual pain, UTI and bladder pain	Bahasa Malaysia
WMW2	28	4	Indonesia	High School	Married	Menstrual pain, UTI and bladder pain	Bahasa Malaysia
WMW3	32	5 months	Indonesia	High School	Divorced	Abortion	Bahasa Malaysia
WMW4	29	13	Indonesia	High School	Single	Did not discuss	Bahasa Malaysia
WMW5	30	8	Indonesia	High School	Single	Did not discuss	Bahasa Malaysia
WMW6	25	7	Indonesia	High School	Single	Menstrual pain	Bahasa Malaysia
WMW7	39	8	Indonesia	High School	Single	Menstrual pain, UTI and bladder pain	Bahasa Malaysia
WMW8	22	1	Indonesia	High School	Single	UTI and bladder pain, unusual vaginal discharge	Bahasa Malaysia
WMW9	21	2	Nepal	College (Dropout)	Married	Abortion	English
WMW10	43	20	Indonesia	High School	Married	Did not discuss	Bahasa Malaysia
WMW11	22	2	Nepal	High School	Married	Abortion	English
WMW12	26	2	Indonesia	High School	Single	Menstrual pain	Bahasa Malaysia
WMW13	30	2	Indonesia	High School	Single	Menstrual pain	Bahasa Malaysia
WMW14	29	9	Indonesia	High School	Single	Menstrual pain	Bahasa Malaysia

interview interested participants. Due to topic sensitivity, and potential vulnerability of women migrant workers consenting to take part, we were careful to ensure that all elicitation of informed consent and data collection was undertaken by female Malaysian members of the research team. They are well known within the factories, NGOs, health-care providers and unions—they are a “familiar face” to women migrant workers and are known as researchers on this topic. The women migrant worker respondents were recruited through local gatekeepers (unions and health-care providers) whom they trust. Therefore, they welcomed and trusted the Malaysian female researchers. We recruited 14 women migrant workers to the study, all employed in the consumer electronics and electronics component sector in product assembly operations for global firms (Table 3). All worked in labour-intensive and high-pressured environments, overseen by supervisors driven by tight production deadlines. For Indonesian women migrant workers, who formed the large majority of our participants (Table 3), interviews were conducted in Bahasa Malaysia. This was their preference as the language is widely understood. Additionally, we conducted interviews in English for two Nepalese participants who indicated a preference for the English language.

## Data analysis

Given our research questions, we undertook an abductive thematic analysis of the qualitative interview data (Tavory & Timmermans, 2014) and report our results below as a series of subthemes derived iteratively from the data. The analytic process consisted of initial categorisation of data segments into material related to each of our research questions—(RQ1) local opportunities and freedoms that make up capability; (RQ2) the resources available to agents; and (RQ3) the factors that prevent conversion of resources into functionings. These questions are themselves informed by elements of Sen's CA framework. Data segments were then organised into subthemes within each of these questions, to reflect the range of participants' responses. The data from which our findings are derived are available from the corresponding author upon reasonable request.

## FINDINGS

In the sections below, we present an abductive thematic analysis of respondents' perspectives, to address the three research questions and which capture the range of participants' responses.

### **RQ1. What opportunities and freedoms, in the local context, make up capability for SRH?**

Several capabilities were identified as critical to enabling management of SRH, explored in sequence below

#### *Opportunities to acquire SRH knowledge*

Women migrant workers expressed a desire for SRH knowledge as a first step to improved SRH management. However, they were resigned to having few opportunities to become competent in SRH knowledge so that they could understand the significance of symptoms and what they should do about them. Their day was focused on meeting production targets, and their factories did not take their SRH needs seriously. One woman explained that factory provided only minimal health information to women, for example about “fever, body pain” but not about women's issues “they won't inform us. We have to find it ourselves” (WMW3). Another (WMW5) informed us that some women migrant

workers were being sent back to their countries of origin, because of illness. Yet, factories made no effort to relay to these women the nature of their illnesses. Information was withheld even if health issues resulted in deportation (TX).

When asked how opportunities for SRH education might be expanded, women suggested that the factory was the best site for developing this knowledge:

Our company. They can invite people (medical officer) from outside, such as doctor specializing in women's health

(WMW1)

Seminar. Meeting among the women migrant workers in whole factory to distribute SRH knowledge to them, such as- what is women health. Free clinic for women to consult, to share experience, without any difference or discrimination between local and foreign workers.

(WMW5)

#### *Freedom to access SRH health care*

Opportunities to access SRH care were also indicated as an important factor in achieving the functioning of being healthy. Given the centrality of the workplace to these women's daily lives, women expressed a wish for SRH facilities within the factory setting itself:

It will be great if we have clinic for women [in the factory], convenient for us if we are not feeling well. So that they can tell us what's the problem is.

(WMW2)

I wish they [the factory] will have special medical check-up for women. Maybe half year once. Scare maybe we have cervical cancer. Problem with our breasts. If we have any medical symptoms, we can get to know earlier and take care of it earlier.

(WMW1)

Such opportunities were rare, however. Factory clinics did not cater for SRH conditions, rendering them undiagnosed and untreated.

They won't explain to you what's wrong

(WMW8)

If it's our factory clinic, they will provide us the same medicine for period pain and fever. Regardless of your symptoms, you'll get the same medicine...Whenever I went to the factory clinic, they will always say operating is the only way, there are no other choices. Or, take your medicine and you will be fine. That's it. Last time I asked for referral letter for operation, but they didn't give me that also.

(WMW7)

Travel to seek treatment outside the factory may seem an obvious solution to a lack of SRH services within factory clinics. But opportunities to travel remained notional. For some, travel was problematic

because they were not familiar with where external clinics were located (WMW9). In other cases, women were reluctant to make the journey because they feared discrimination on the basis of their migrant status (WMW10, H1). Additionally, travel, even though possible, can be time-consuming, which prevents them from meeting work schedules. Women further wished for affordable health-care services, indicating that cost was a barrier to access (WMW3). Nonetheless, women often had to pay for cost of health-care themselves.

Doctor gave her medicine every month, hormonal medicine. Doctor said she has hormone problem. But now she is ok, after taking the medicine. But it is expensive.

(WMW4)

### *Prospects for SRH leadership training*

Women migrant workers indicated the importance of “SRH leaders” to teach and share SRH knowledge among them. They regarded highly the presence of leaders from among their own within the factory to act as focal points to share and disseminate SRH information to enable women to address these needs. One woman migrant worker valued leaders simply because:

It is convenient for us, to have someone to talk to or complain to.

(WMW7)

Women desired opportunities to train as leaders. They attached great significance to this role, some even claiming that as leaders, they would be able to raise awareness and knowledge of SRH among women migrant populations even before they arrived in Malaysia. WMW5 said:

Who doesn't want to be a leader? Everyone wish to be a leader. I want too, but within my minimum knowledge, I have to learn more. I must have knowledge and sharing from friends, we need guidance from others.

These ambitions contrasted significantly with a lack of a sense of entitlement, reflecting what Sen terms “adaptive preferences.” Women dared not aspire towards health goals beyond earning wages and presented their lives as centred on work. They accepted the contractual consequences of falling pregnant, perceiving that this was their fault and that they had no right to expect support from the factory:

We should follow factory's rules and laws right? Before we came into work, the factory already asked us “Are you ready?” Work in this factory, you can't do this and that. We agreed and signed. But we break the rules right? So it's our fault.

(WMW3)

This sense of the inevitability of the consequences was deeply held—to the point that any challenge seemed unthinkable:

WMW4: *Law is law. We were well informed during our time in Indonesia. If it's stated in contract and you still got pregnant, factory send you back.* (WMW4)

Interviewer: Can you complain about pregnancy at the Consulate?

WMW4: *No. As I have told you, we were well-informed about the rules on our contract back in Indonesia.*

## RQ2. What resources do women migrant workers need, in order to manage SRH?

SRH education programmes, access to medications and appropriate health care, and social capital were identified as essential resources.

Some health-care providers and NGOs worked together to organise SRH lectures and distribute SRH material in factories (NGO1, NGO2). Health-care providers offered access to contraception and counselling services to women migrant workers. Abortion services were additionally offered, despite the controversial nature of such a service in this context. Women migrant workers indicated that they welcomed such services (WMW3).

Women migrant workers made use of social media to build relationships. Facebook was a valuable tool in linking women migrant workers to others, facilitating friendships and bringing women together:

We sat down and talk, talk about our workplace.

(WMW4)

Such friendships provided the means for developing solidarity and self-confidence. Friends, and the friends of friends, became a primary source of information about health issues:

Sometimes my friends got information from other friends as well.

(WMW4)

Social capital was manifested in other ways. Some women willingly took leave, despite incurring displeasure on the part of their supervisors, so that they could accompany colleagues to obtain SRH care in external private clinics (WMW9).

Women migrant workers also resorted to homeopathic and traditional medicines to manage their sickness:

Always I experience intense period pain. So, I go to toilet to apply some balm/oil.

(WMW6)

Finish it in one shot. Back in Indonesia, our mother will make that [jamu- traditional medicine for promoting internal health] for us also. Here we don't have time but some of them are hardworking and they can make this Jamu. So we buy from them

(WMW5)

Body massage. So when I lift heavy items, I will feel as if my stomach is falling down. So when we go to massage, we pay for ourselves

(WMW5)

Resources were limited. Health-care providers, unions and NGOs are typically small organisations with limited capacity. Despite stakeholders' willingness to organise SRH lectures and distribute SRH material in factories, this was only possible on an ad hoc basis and dependent on factory owners' approval (NGO2; NGO3).

Women migrant workers complained of unsympathetic clinical personnel within factory clinics:

Nurse in the factory clinic, frankly speaking, Malaysian nurse has shitty attitude. We were treated like rubbish. We know our medical fee were covered by factory. But we are human being. This is your duty according to the agreement. Please respect us, please appreciate us. Although it's insurance and we pay cheaper, please appreciate us. Many clinics out there do not appreciate foreigner like us at all.

(WMW5)

In contrast, one employer stated that foreign workers were, in fact, privileged. In comparison with local workers, migrants benefitted from free accommodation and were able to work for longer hours, increasing their earning capacity. As they were favoured, under the law, over and above local workers, they did not have a legitimate reason to demand more resources (E1).

Unions too offered resources, such as health workshops and health materials. However, they prioritised the concerns of local workers and issues directly related to employment—including sexual harassment but not SRH. One union respondent representing a branch for women workers indicated that "... we have no experience with women migrant workers..." because issues facing women migrant workers did not fall within its remit (U1).

### **RQ3. What factors influence the conversion of resources into functionings in this context?**

Women migrant workers' abilities to translate available resources into desired functionings associated with access to, and use of, SRH services were mediated by a range of personal and societal factors. Additionally, some women drew on specific resources to achieve the desired instrumental functioning of testing as pregnancy-free to retain their employment contracts—opting for actions that were *reactive* in the light of pregnancy, rather than *proactive* in its avoidance. We consider these in sequence below.

At a personal level, access to SRH services was mediated by their degree of proficiency in the local language, sufficient enough to explain SRH concerns effectively to health-care providers. Similarly, proficiency in English was required in order to access services offered by NGOs, as information about such services is typically provided in English:

So, our problem with our hotline is that...we are communicating mainly in English... our website...is in English. Also, if you type Malay, "penguguran" (abortion), on google, our hotline number does not appear. It is because you cannot search using key words in Malay for a kind of thing like this.

(NGO1)

At the societal level, SRH is considered culturally taboo. Women migrant workers who were fearful of myths surrounding the use of contraceptives were disinclined to use them:

If you explain...for example like IUD and stuff ... which they don't know. They are scared because there are a lot of myths. Like, if you put it in, it might get stuck and a lot of problems and all that kind of things.

(NGO1)

Similarly, the existence of policies that discriminate against women migrant workers' SRH needs made it easier for employers to decline opportunities to better inform women migrant workers of available SRH services:

...there is a lot of resistance from the employers to acknowledge the fact that their women workers were sexually active. So, they didn't want us to be too open about ... giving women migrant workers information on contraceptive services and giving them information that if the contraception fails, they can have abortion, especially if it is an early abortion which is very simple.

(NGO1)

Women migrant workers expressed similar concerns:

We have to beg our factory. But factory doesn't want to know. They just want us to work. They don't want to know whether we are healthy or not... Like my factory, they will only give us a medical certificate if we faint... Factory don't want to know about our health, they just want to know whether we can work.

(WMW3)

One employer expressed concern that promoting SRH awareness among women migrant workers could be construed as promoting sexual freedom among them, which was considered unacceptable (E1).

Similarly, government policy in Malaysia did not support this aspect of health, despite wide availability of SRH facilities. Officials regarded their role as ensuring women's compliance with migration regulations and employment contracts. One official stressed women migrant workers should check their SRH with health centres in their home countries prior to arriving in Malaysia. This denies any responsibility for these women's health, although this implies that other government departments and employers could take responsibility for SRH education (Gov1). To explore these possibilities, we arranged an interview within another government department. However, officials there sought to impose conditions on the reporting of findings, which indicate a reticence for discussions on women migrant workers' SRH to be shared:

... You may be required to sign an undertaking letter not to openly share any of the said information with any other third party without the Ministry's prior consent

(Gov2)

The factors above mediate the extent to which women were able attain desired functionings associated with access to, and use of, SRH services. Yet, our participants also differed in the functionings that they valued. One woman indicated a desire to avoid official designation as "pregnant" in an environment in which to be so invites severe negative consequences. The desired functioning here is not to avoid pregnancy—rather, it is to not be declared pregnant when tested by the employer. This required timing the use of available abortion services in order to avoid detection, requiring access to a sympathetic health-care provider:

Like me, in March, I must go through medical check-up to continue 2 years' contract. If I don't do the abortion earlier, later my factory knows about it, I will be sent back.

(WMW3)

NGOs were aware of this strategy and provided additional advice on the potential need to substitute the urine sample provided for the factory routine pregnancy test with a sample from someone else—typically the woman's partner:

When they know that they are pregnant they straightaway come here... The abortion is done and there is no more problem. But, we have to warn them that they mustn't get their urine tested within 2 weeks of the abortion because it will still be positive... when you go for your medical check-up, get your boyfriend urine. Ha. It works every time. So, that's it, you know. After all, she is not pregnant anymore, so why should she be discovered?  
(NGO1)

As women who fall pregnant have violated the terms of the work permit they face a limited number of options. They may either secure a clandestine termination; leave employment to continue with their pregnancies in their home countries; give their baby away (adoption); or remain as undocumented migrants:

Cannot get pregnant - if pregnant, will be sent back.... Some stay here without permit, some went back to Indonesia. They ran away and I don't know where are they now.  
(WMW2)

Like my friend last time, she didn't want her baby. After that, she found someone local who took care of her. They bear every expenses from her 8 months pregnancy until she gave birth. They took away the baby and my friend couldn't do anything.  
(WMW4)

## DISCUSSION

The CA provides an analytic framework to assess the extent to which development outcomes are achieved. While we acknowledge the explanatory power of the framework, our findings suggest that it has limited utility in developing the capabilities of the women in our study. We address the implications of our findings in terms of resources and conversion factors, consider the challenges faced in operationalising the CA in the present study, and the implications of our findings for the approach itself.

### Converting resources into valuable health functionings

Our findings indicate the limited range of resources available to these women from which SRH wellbeing can be achieved. Education, health-care provision and social capital were only minimally accessible. Clearly, additional resources are required. State provision could fill these gaps, but is unavailable in Malaysia due to state intolerance of these needs on the part of migrant worker populations. The task of meeting resource needs likely continues to fall on civil society and NGO advocates.

The literature on meeting women migrant workers' SRH in other Asian countries suggests a range of resources, which can enable women migrant workers to achieve SRH wellbeing. They include culturally responsive interventions (Boonchutima et al., 2017; Manoyos et al., 2016), SRH care delivered through social media and mobile technology (Brody et al., 2016), SRH telephone hotlines (Vu et al., 2016), SRH training programmes (Zhu et al., 2014) and health-care packages that accommodate



working hours (Webber et al., 2015). Women were able to use these resources to reach a certain level of functioning achievement (e.g. being SRH aware, able to access health care and free from disease).

Yet, the prognosis for study participants does not appear promising, because access to such resources is uncertain. There are broader factors here than simply the factory context within which they work. These include societal and religious beliefs about sex, xenophobia, separation of SRH needs from mainstream activism, social policies that frame migration primarily as a security concern, and limited incentives for inter-governmental agency interest in SRH. Public policies that regard migrants instrumentally and that deny them access to resources available to citizens mean that women migrant workers cannot convert health care, education, and the welfare system into the functioning of SRH health. Thus, women migrant workers face many constraints on their agency freedom, preventing them from realising their capability for SRH.

Nevertheless, some changes are occurring. We note efforts by coalitions of NGOs and activists to “normalise” perceptions that migrants are a part of Malaysian society should not face discrimination and that their productive and family rights deserve legal protection (Migrant Workers’ Right to Redress Coalition, 2017). Similarly, the Federation of Reproductive Health Associations promote comprehensive sex education for local and migrant communities within Malaysia and advocate access to SRH resources for marginalised and vulnerable populations including migrants and refugees (Jiar et al., 2018). The question is to what extent such advocacy can shift public and governmental perception of migrants to change current policy. In order to realise their capability for SRH, public policies should enhance these women’s agency freedoms as much as possible so that they can expand their SRH wellbeing. Public policy can offer resources such as those discussed earlier in this section to these women, encourage the acceptance of migrants into society and incentivise employers to make available facilities that meet SRH needs. In the context of long-held government and societal intolerance of migrants and their welfare needs, however, this is improbable.

It is also instructive to consider whether we should focus solely on functioning attainment, as studies increasingly show that priority is accorded to the *capability* to improve health outcomes (Mitchell et al., 2017)—it is not so much women’s health outcomes but their ability to make decisions about health in contexts where unequal gender norms prevent their access to health care which matter (Mabsout, 2011; Nikiema et al., 2012). Increases in income, working conditions, access to social capital, associational memberships and sense of belonging have been found to reduce the likelihood of poor health and policies to redistribute income, improve employment security, enable people to control their work processes, improve social connectedness and enhance peoples’ capabilities that are required to reduce health inequalities (Hall et al., 2013; Julià et al., 2017; Novoa et al., 2017). These studies, which capture the *opportunity* aspect of the CA, have relevance for the participants in our study in achieving their valued health outcomes. Our findings showed that women migrant workers prioritised wages. Wages were paramount, which characterised their outlook in life. Since the ability to earn income is so crucial to these women and given that it is a health capability-enhancing resource, how employment security can be protected so that they are guaranteed a decent wage is critical avenues of research.

## Challenges in operationalising the CA

A major strength of the CA lies in its acknowledgement of human diversity, particularly useful when seeking to understand issues faced by marginalised groups. However, it proved difficult to gain access to these women and explore their aspirations for life, health issues and barriers to health care. These women are isolated from their communities, work long hours and live in factory-provided

accommodation. Many did not prioritise their SRH but rather focused on earning wages, which were remitted back to their home countries. In order to interview women migrant workers, we were obliged ethically to go through their gatekeepers—typically the union. Ironically, unions can be possessive over these women; one claimed “ownership” of them and the research team found themselves enmeshed in a power relationship with the union. Some gatekeepers refused our requests to seek women’s informed consent to take part—despite our best efforts to inform them of the nature of the study in accordance with professional ethical standards. While refusal of access is of course in the gift of gatekeepers, the exercise of an embargo despite our best efforts to inform them of the emancipatory focus of the study is telling.

Developing trust with employers was also problematic. Despite being a key means of addressing the SRH needs of their women migrant workforce, typically employers did not perceive meeting the SRH needs of women migrant workers as their responsibility and, unless employers decided that there was value to them doing so, they rejected such initiatives. The challenge for NGOs and other stakeholders thus lay in successfully convincing employers that SRH interventions would bring financial rewards—a healthy workforce is more productive.

Meanwhile, these women’s advocates themselves did not always accept the value of working together to enhance capability for SRH. Union leaders engaged with women migrant workers solely as workers and did not engage with matters related to their status as women with specific SRH concerns. Use of the term “sexual and reproductive health” was controversial among these advocates.

## Implication of our findings for the CA

The women in our study valued opportunities for education, and access to health care and to train as leaders, each of which they saw as integral to developing capability for SRH. Yet, their fulfilment required prerequisites that were absent. While the CA focuses on expanding opportunities and freedoms available to individuals to live a life they choose, our findings have implications for the utility of the CA, which we consider in turn below.

Sen advocates strongly for the adoption of “social choice” exercises as technologies to determine collectively capabilities deemed valuable, emphasising the utility of public reasoning and democratic consensus in determining the nature of these capabilities. Yet, Malaysian economic and political elites exert strong control over groups that they consider undesirable. Exclusion of such groups from participation means that the capabilities they value will not be considered. Migrant workers have very limited political leverage in Malaysia. They are excluded from participation in health-care and public services (Noh et al., 2016). They cannot participate in public deliberations, and political organising is impossible because migrants are prohibited from establishing their own organisations. Although it falls to local groups to take up the issue of their rights and entitlements, migrant needs are typically unrepresented in their advocacy (Piper & Rother, 2011). While migrant workers are not prohibited from joining unions, many employers prevent them by inserting such a clause into contracts. Migrants who join unions cannot become union leaders, because the law stipulates that all union officers must be Malaysian nationals. These restrictions remove opportunities for migrants to advance their interests through participation in “social choice” exercises (Sen, 1999) and conceal the refraction of public values and preferences by powerful groups.

Similarly, “structures of living together” in Malaysia also limit migrant workers’ ability to advocate for their valued SRH goals. Migration policies are framed as security concerns, and migrant status carries a social stigma. Migrants are typically shunned, blamed for high crime rates and sexual promiscuity, and regarded as fit only to perform “dangerous, dirty and difficult” jobs (Aw, 2016).

Migrants are portrayed in media outlets as a threat to local citizens' security, and their concerns silenced (Idrus & Ismail, 2013; Kaur, 2013). Such "structures of living together" reduce the ability of women migrant workers to exercise agency in achieving valued capabilities, including for SRH. While the CA facilitates this analysis, it is silent on how current "structures of living together" may be refashioned. Without such change, women migrant workers face considerable obstacles in converting SRH resources—however limited or extensive they may be—into valued capabilities.

More widely, can women migrant workers in these contexts truly exercise independent choice, realise their own conceptions of the good and act on their own authentic agency? Globally, millions of such women work long hours in export processing zones, isolated from local communities. Their stays are transient, on yearly rolling contracts. Despite their economic productivity, they remain marginal (Boyd, 2016; Chant, 2016). Far from experiencing liberation and empowerment, they continue to be disciplined by the operation of global markets. We found little evidence that the women in our study prioritised their SRH. They are driven to work and largely resign themselves to the conditions in which they must do so. Opportunities to develop capabilities for SRH appear limited under these conditions—the promise of empowerment through economic development masking a darker reality in which women migrant workers are enmeshed in new forms of subservience (Hickel, 2014).

Further, women in our study used social media to build social capital. Often, the ability of individuals to choose the life they value often depends on the possibility of acting together with others who hold similar values (Evans, 2002: 56). Sen himself notes "the advantage of group activities in bringing about substantial social change" (Sen, 1999: 116) yet, the individual level is prioritised under the approach. An emerging body of work addresses the extent to which collective action may augment individual freedoms (e.g. Ibrahim, 2006; Miles, 2014; Thapa et al., 2012). For women migrant workers such as those in our study, there is a case for exploring the relationship between collective action and outcomes on individual health wellbeing.

## CONCLUSIONS

Our principal contribution is the application of the CA to explore ways of realising the capability for SRH of women migrant workers in Malaysia. We identify not only what resources are needed to support development of capability for SRH, but the factors that limit their ability to convert resources into such capabilities. Secondly, we document empirically the SRH experiences of women migrant workers in Malaysia, a country notorious for its surveillance of, and attempts to control, its migrants' SRH. Thirdly, we explore the specific challenges of applying the approach in such a context, as well as limitations within the approach itself, to achieve change for this group of women.

We encourage researchers, advocates and policymakers to address the significant obstacles to such women migrant workers' capability for SRH, not least of which is the ability of such women to participate meaningfully in national processes to negotiate the capabilities that they value. While we acknowledge the virtues of the CA—its emphasis that people should become independent, realise their own conceptions of the good and act on their own authentic agency—it is also bring into focus ambiguities within the approach, which impact these women's chances for developing life-enhancing capabilities. These ambiguities require further theorising. Where women migrant workers cannot escape from relationships of inequality and extraction, their potential to flourish and develop valuable capabilities, including capability for SRH, will remain unrealised. Our findings further suggest that attainment of UN SDG3 (Health) and SDG5 (Gender equality and empowerment) objectives will require capacity-building within civil society, development of capabilities and careful attention to the factors that mediate conversion of resources into desired functionings.

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## AUTHOR CONTRIBUTION

**Tim Freeman:** Conceptualization (lead); Formal analysis (equal); Methodology (lead); Writing-original draft (lead). **Lilian Miles:** Conceptualization (equal); Formal analysis (lead); Funding acquisition (lead); Investigation (equal); Methodology (equal); Project administration (lead); Writing-review & editing (equal). **Kelvin Ying:** Formal analysis (equal); Investigation (equal); Writing-review & editing (equal). **Suziana Mat-Yasin:** Formal analysis (supporting); Investigation (supporting); Writing-review & editing (supporting). **Wan Teng Lai:** Formal analysis (supporting); Investigation (supporting); Writing-review & editing (supporting).

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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