

A rights-based approach to labour migration of People Living with HIV from India to the United Arab Emirates: Proposing an alternative legal and policy framework

By

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We acknowledge and respect the lək' wəŋən peoples on whose traditional territory the university stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical relationships with the land continue to this day.

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Abstract

The emergence of the Human immunodeficiency virus (HIV) epidemic was a defining event of the late twentieth century. Like most global health emergencies, it revealed sharp conflicts between civil liberties and public health across the world. Historically, the mobility of humans has consistently been singled out as a major factor in the transmission of contagious diseases. However, more than seven decades after the adoption of the Universal Declaration of Human Rights (UDHR), People Living with HIV (PLHIV) continue to face discrimination in cross-border movement and migration for work. These curtailments were seen in the forms of discrimination, derogation of human rights through quarantine measures, and restricted movement, particularly of low literate blue-collar foreign labourers.

To curtail the epidemic, countries such as the United Arab Emirates (UAE) introduced the communicable disease prevention law i.e., Federal Law 14 of 2014, which specified the policy framework mandating HIV testing for migrant workers. It had a profound impact on the recruitment of foreign workers to the UAE, specifically from India, the origin of UAE's largest migrant workforce. Issues such as temporary employment contracts, safety, and abuse of the socioeconomic rights of the foreign workers in the host nation along with discriminatory immigration laws have been persistently highlighted by the local and international media.

This thesis seeks to link migration governance and regulations, healthcare access and equity, and human rights, into an actionable framework that can be adopted as a foundation to protect the rights of foreign workers with communicable disease in the UAE.

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Finally, I would like to thank Mr. Rohit Saini, whose life experience and personal journey inspired me to explore this topic. I hope this thesis will stimulate pertinent discussion on the legality of immigration policies to promote equality among workers of all classes and health status.

Dedication

This thesis is dedicated to every person in the world living with HIV/AIDS and to those working tirelessly to put an end to discrimination and stigma associated with it.

Introduction

International labour migration is a key aspect of global and regional economies and at times the sole means of livelihood for the labour workforce. Recent United Nations (UN) estimates suggest that approximately 169 million people are working in manual labour in foreign countries across the world.¹ While these workers possibly gain access to increased opportunities for financial stability, both the home and host countries also reap benefits. The home country receives a relatively reliable source of revenue, while the host country enjoys the workers' contribution to its infrastructure, economy, and society at a relatively low price.

In this age of increased international mobility, the impact of public health legislation and policy on foreign labour in host nations has not been closely assessed. New migrant workers, who are otherwise at disadvantage in their home countries, are faced with new challenges with respect to health laws, further jeopardizing their positioning in the host society. There has been an exponential rise in migration of Indian labourers to the UAE over the last six decades, bringing about much change to the social and economic landscape of the host country.

The migratory history between the UAE and India traces back to the 1970 oil and gas boom in the Gulf. With the desire for better financial opportunities, there was considerable movement of labourers from India to the UAE and has since increased significantly in the last 50 years. Today, Indian migrants constitute more than 37% of the total population the UAE, of which 65% are employed as blue-collar workers.² Numerous sociocultural, economic, and political factors in the host country led to the introduction of Federal Law No. 14 of 2014 as an attempt to protect the State's public health.

¹Rakotonarivo, Andonirina. "ILO Global Estimates on International Migrant Workers: Results and Methodology." (2021). Print.

²Embassy of India. "Indian Community in UAE." (2022). Print.

Federal Law No. 14 of 2014 promoted the prevention of communicable diseases, and consequently influenced changes in UAE's immigration policies. This Law required compulsory HIV testing of foreign workers before entry to the host state and renewal of the work visa. Failure to comply resulted in risk of deportation or loss of employment, revenue, and temporary residency status. These consequences contradict the international agreed standards for informed consent, confidentiality, counselling, and referrals for PLHIV; thus, introducing several human rights violations for the foreign labour force and in this case the Indian migrant labour force.

Apart from the negation of international policy standards, the Emirati state does not posit its legislation on any of the recent scientific developments with regard to the medication, functionality and life-expectancy of PLHIV. At present thirty different forms of antiretroviral therapies (ART's) either singly or in combination are being used to treat patients with human immunodeficiency virus. Although these life-long therapies are not curative yet their simplified dosage, diminished side effects has led to reduction in the treatment dropout rate leading to a substantial reduction in the death rate due to infection, transforming the virus from a rapidly lethal disease into a manageable condition, compatible with long survival.³

Though the responsibility of ensuring PLHIV rights lies with the host state, there are glaring international discrepancies in terms of access to healthcare resources and the level of commitment to the principles of social justice and equality. These issues also raise a legal concern on the universal enforcement of human rights. The gap between international frameworks and their implementation into national law are major impediments to ensuring

³ Cohen.S,Myron, et al 'Prevention of HIV-1 Infection with Early Antiretroviral Therapy', The New England Journal of Medicine, Aug 11, 2011, DOI: 10.1056/NEJMoa1105243, Online< https://www.nejm.org/doi/full/10.1056/nejmoa1105243#article_citing_articles>

the rights of Indian PLHIV in the Emirati state. These discriminatory conditions can be changed through a human rights-based approach to migration governance, which includes ensuring access to adequate social protection, work, and occupational health and safety of temporary migrant workers.

The incorporation of international human rights and labour standards and evidence-based policy actions is essential to halt and reverse the discrimination against PLHIV. This thesis aims to highlight barriers in healthcare access, and discriminatory labour and immigration policies of the host nation that violate the rights of PLHIV. It also attempts to propose an alternative policy mechanism that could allow rights-based movement of the infected labour population from India to the UAE. A broader global policy agenda also needs to be developed to tackle the preventable inequalities and disadvantages that still restrict the lives of many Indian workers.

This thesis critically investigates the profound impact of UAE's Federal Law 14 of 2014 on Communicable Disease on its foreign workers, specifically those from India. This law was introduced to protect the State's public health through mandatory communicable disease testing, restrictive quarantine measures and at times strict migration policies based on disease status. This thesis seeks to propose policy and legislative reforms to provide equitable opportunities specifically for PLHIV and consequently allow for unrestricted movement of labour forces leading to economic, political, and social growth within the host country.

1.1 Literature Review:

Since its introduction, the impact of UAE's Federal Law 14 of 2014 has heavily debated and criticized by many advocacy groups in the sub-continent, considering that one-third of UAE's population are comprised of Indian blue-collar workers. In view of the future plans and

economic ambitions of the Emirati state, the participation of the Indian workers will steadily increase soon, thus introducing several changes to country's economic and social environment. As cross-border migration continues to rise between India and UAE, the intersection of public health and migrant population becomes increasingly pertinent.

In examining the current literature, I explore the academic discussions pertaining to issues concerning HIV healthcare access of immigrant workers in the UAE, their socio-economic positioning, federal laws governing their temporary employment, and the prevailing conditions in their home country. Through the analysis of these varied contributions, the objective of this literature review is to lay a robust groundwork for identifying gaps, addressing unresolved questions concerning the vulnerability of workers, and further delving into their expectations from the healthcare system in the host nation, underscoring the imperative for comprehensive social protection measures.

The work of K. Sudhakar⁴ and Joe Williams⁵ sheds light on the notion of health inequality in India, outlining numerous barriers to the successful implementation of domestic HIV strategies. These hurdles encompass issues concerning lack of sexual health awareness, further compounded by the stigma associated with the virus. They also argue that despite the considerable impact of various initiatives and focused interventions by the Indian government in enhancing access to antiretroviral therapy programs, challenges persist due to the country's unequal, asymmetric healthcare infrastructure and economic disparities.

I realised that the available literature is notably limited, in the context of the needs, expectation of the migrating workers, especially with regard to holistic healthcare

⁴ R. Sudhakar, et al, 'HIV/AIDS Epidemic in India and predicting the impact of the National response: Mathematical modelling and analysis', *Mathematical Biosciences and Engineering*, Vol.6, No.4, 2009, Online < <https://www.aimspress.com/article/10.3934/mbe.2009.6.779> >

⁵ Joe William et al, Health Inequality in India: Evidence from NFHS 3, *Economic and Political Weekly*, Vol. 43, No. 31, Aug. 2008, Online. <www.epw.in/journal/2008/31/special-articles/health-inequality-india-evidence-nfhs-3.html>

access in the UAE, underscoring the need for further research and scholarly attention in this area. This is especially crucial within the context of the host nation, where domestic laws have conventionally exhibited discriminatory tendencies against immigrants. The exploitation of migrant workers in the UAE have been extensively documented in regional, global newspapers, reports of International Labour Organisation, International Labour Organisation, United Nations and Amnesty International. This thesis further explores the works of Looney (1994), Kapiszweski (2001), Kamrava, and Babar (2012) in order to identify the conventional challenges faced by immigrant workers in the host society. While, the Emirati state has taken some recent steps to improve the labour laws, they are merely a fraction of what is required.

In reference to Liamputtong's research,⁶ the problem of the legal system lies in its failure to comprehend the social-structural forces that perpetuate violence against PLHIV both in the home and host societies. The stigma arises from the society's perception of the affected individual's deviation from socially accepted norms of 'normality', which could be an outcome of infodemic, or deliberate misinformation perpetuated by the state to justify its extra-legal⁷ measures of pandemic control.

Temin (2010)⁸ investigated the evidence on HIV-sensitive social protection programs that promote treatment, enhanced care, examining a range of interventions including social transfers and social health protection. She argues that few studies were previously explored due to lack of monitoring and evaluation. Miller and Samson (2012)⁹ reviewed the social protection initiatives in African nations, by exploring the impact of care, expansion of

⁶ Pranee, Liamputtong, *Researching the Vulnerable: A Guide to sensitive Research Methods*, Published Sage Publications Limited, 2006, print

⁷ Extra-legal character of values means that they are not defined in terms of content in legal regulations, and thus do not form part of the legal axiology, usually arising out of calls for swift and decisive executive action.

⁸ Temin, M. (2010) *HIV-sensitive social protection: What does the evidence say?* Geneva: UNAIDS and UNICEF

⁹ Miller, E. and Samson, M. (2012) *HIV-Sensitive Social Protection: State of the Evidence 2012 in Sub-Saharan Africa*

sustainable HIV-sensitive social protection. Their report stressed upon the need for integrating social and holistic health protection for both the citizen and expatriate populations to address multiple vulnerabilities being faced by People Living with HIV. She further argues that the potential of social protection to increase access to 'social vaccines'¹⁰ of health protection and health education, having potential to prevent increased incidence of transmission.

They further stress on essential measures for holistic social protection such as affordable insurance for contagious diseases such as HIV or government-funded health services that protect against the economic losses and social distresses, which can be used to address wider problems related to HIV epidemic. Such protections lift barriers in accessing a wide range of health services; hence, positively improving indicators of human development. Adato and Bassett (2007)¹¹ observe that access to social protection interventions such as healthcare (based on the tenets of WHO's Universal health coverage) should be provided on an inclusive basis without any prejudice.

1.2 Research Methodology

This thesis uses socio-legal research methodology. This method appropriately allows for an interdisciplinary analysis on health law, legal phenomenon, and relationships between these and the wider society. Both theoretical and empirical work is included, and sources are drawn from the humanities particularly history, health, society, economics, and politics for comprehensive and multidisciplinary analysis on health and migration laws.

¹⁰ Actions that address social determinants and social inequities in society, which act as a precursor to the public health problem being addressed

¹¹ Adato, M Bassett, International Food Policy Research Institute (IFPRI) – United States of America What is the potential of cash transfers to strengthen families affected by HIV and AIDS? A review of the evidence on impacts and key policy debates, Published-2007

This kind of methodology also allows the exploration of contemporary, historical, political and social forces that have contributed towards the development of the restrictive laws by the Emirati state, helping the thesis by creating better understanding of the Emirati legal system as a form of social formation and its inter-relationship with other facets of society, further assessing the vulnerabilities of the Indian workers affected by its immigration regime.

1.3 Limitations of the Study

The primary limitation faced by this thesis is the paucity and inaccuracies of numeric data with regard to number of rejections of visa applications due to HIV status, and the number of deportations due to UAE's public health law. Thus, it was difficult to fully comprehend the impact of the legislation on different ethnographic and demographic groups of the Indian workers without appropriate quantitative measures.

1.4 Overview of the Chapters

This thesis attempts to critique the impact of UAE's Communicable Disease laws on the Indian migrant workforce, and as a result propose probable public health and legal reforms to ensure equitable rights for PLHIV. The following chapter investigates the restrictive executive policies that have emerged in the last few centuries in response to infectious diseases, pandemics, and epidemics. Pandemics have been used to justify quarantine, confinement and restriction on movement that have led to a sustained rights trade-offs for the purported larger benefit of public health. Therefore, the chapter will also present perspectives on the long-term use of such policies and its impact on human rights.

Chapter 3 explores the inherent vulnerability of the Indian labour population and the underlying issues around HIV in the context of their migration. It is essential to appreciate the

vast diversity of the socio-economic conditions that these migrants face, which could assist policy makers to identify policy reforms for Indian migrants in the host nation.

Chapter 4 investigates the migrant flow from India to the UAE, and the contemporary challenges the migrants are faced with in the host country. The first part of the chapter analyzes the historical, social, cultural, and economic development of the Middle Eastern region. The second part traces several points of transition of the state's Ethnocentrism approach towards foreign migrants, which has since become more favourable towards migrant workers.

Chapter 5 evaluates the positioning of the foreign labour population in the Emirati market and its future growth. It explores the need for social growth of the Indian labour workforce and the fiscal strength of the UAE to provide adequate health infrastructure and protection to its foreign workforce. It further analyses the potential of the UAE as a host state to create an equilibrium between its economic and public health interests while adopting rights-based policy framework PLHIV labour migrants.

Chapter 6 explains legislative action and policy to address the healthcare needs of migrants in response to HIV, in the context of cross-border migration. The contours of the policy and strategic landscape are presented as a point of departure for ascertaining governance framework for migrants. It further provides summaries of international declarations, and globally agreed frameworks relevant to health, migration, and HIV.

After a thorough critique of the current state of public health infrastructure and policies for Indian migrants in the UAE, this thesis finally proposes a reformed framework that would protect the migrants' health, employment and residency rights. It also presents recommendations for alternate strategies that could help the UAE to ameliorate its existing policy to construct a rights-based framework for the HIV infected labour migration from India.

Chapter 2: The History of Pandemics

2.1 Lessons Learned?

Pandemics and epidemics have been a central part of human history; a focal point of human sociology, social codes, and behavioural norms. They have been a substantial challenge to manage for medicine, science, and technology; a peril to economic solidarity and national-international development; and an extraordinary defiance to governance and law. Historical evidence show that exceptional and extraordinary exercise of executive powers is required to contain the virus and its spread. At first glance it seems that the disease and infection are the central characters of the pandemic but further investigation of 'The Big Four Pandemics,' which include The Plague, Cholera, Influenza, and The Spanish Flu, reveals historical, social and governance paradigms in pandemic management.

The Ancient Roman Empire faced several pandemics: the Antonine Plague (165-80 CE), the Plague of Cyprian (250-65 CE), and the Justinianic Plague (541-44 CE) that required the use of emergency powers.¹² The Roman model was based on direct executive approval where the Senate could direct the consuls to appoint a ruler for up to six months to deal with health emergencies expeditiously¹³. Although this power was developed to handle foreign invasion and military clash, pandemics were considered no less than a wartime affair. Governing with emergency powers was a political, social, and economic necessity for the Roman Empire, because it was a loosely integrated congeries of subsistence-level societies with lack of centralized authority to handle pandemics.

¹² Meier, Mischa. "The 'Justinianic Plague': The economic consequences of the pandemic in the eastern Roman empire and its cultural and religious effects." *Early Medieval Europe* 24.3 (2016): 267-292.

¹³ Ferejohn, John, and Pasquale Pasquino. "The law of the exception: A typology of emergency powers." *International Journal of Constitutional Law* 2.2 (2004): 210-239.

The Black Plague of the Middle Ages killed an estimated 40 to 60% of the population in Europe, Africa, and the Middle East¹⁴. It was during this pandemic that the first identifiable and traceable legal mechanism for governing through contagion was developed. Popular pandemic governance terms, concepts and restrictions now like social distancing, quarantine and self-isolation, were legally introduced in the medieval times during the European fight against the Black Plague infamously referred to as the Black Death¹⁵. The Adriatic port city of Ragusa was the first to pass legislation requiring the mandatory quarantine of all incoming ships and trade caravans to screen for infection. In his book, Mark Bailey elaborated on the governance through contagion during and after the Black Death in England:

The Black Death provides a prominent and early example of a government taking decisive action at a moment of national crisis to protect what it regarded as the welfare of its people and to promote its notion of a good society.¹⁶

The world has been witnessing a severe pandemic every century¹⁷ and several decadal epidemics with the potential to become pandemic any time¹⁸. One of the primary lessons from historical analyses of pandemic is that even if the timings and severity of a pandemic could not be predicted, laws, society, health, and state could be strengthened to govern through and throughout contagion with theoretical justification and applicative principles of pandemic emergency powers.

A more contemporary comparison could be drawn between the Cholera epidemic in Europe and South Asia in the 19th century, and the global Influenza pandemic of the 20th

¹⁴ Green, Monica H. "Editor's introduction to Pandemic disease in the medieval world: rethinking the Black Death." *The Medieval Globe* 1.1 (2015): 9-26.

¹⁵ Roos, David. "Social distancing and quarantine were used in Medieval Times to fight the Black Death." *History* 25 (2020).

¹⁶ Mark Bailey, Book- *After the Black Death: Economy, Society, and the Law in Fourteenth-Century England*, Oxford University Press

¹⁷ Barry, J. M. *The Great Influenza: The epic story of the deadliest plague in history*, Penguin Books, 2004, print

¹⁸ Killingray, David, and Howard Phillips, eds. *The spanish influenza pandemic of 1918-1919: new perspectives*. Routledge, 2003.

century. During the Cholera pandemic, executive powers were primarily focussed on containing the pathogen through state-wide lockdowns, while disregarding the social and economic consequences of closing cities and cutting food supplies.¹⁹ From 1817, the terrible disease spread in waves from its home in India to Afghanistan, Russia and the rest of Europe.²⁰

Prussian authorities imposed stricter controls on movement of goods and people and implemented absurd regulations like the burial of affected victims after nightfall and endorsing the death penalty as a threat for violation of quarantine.²¹ Use of extraordinary and executive powers led to public resentment and aggressive disobedience across Europe, ultimately resulting into unsuccessful military cordons, quarantine and policy measures. The situation in the colonial world was far worse where the use of extraordinary powers by states in Asia and Africa disrupted the food supply chains in India and Africa leading to the biggest famine in human history.

The 20th century brought the Spanish flu of 1919, one of the biggest pandemics the world has seen. The World Health Organization (WHO) declared the Spanish Flu (H1N1) as an “exceptional, and the deadliest event in human history.” There were approximately 1.7 million deaths in the United States and around 360 million deaths worldwide during this pandemic²². This pandemic occurred during and after the First and Second world wars providing perfect opportunities to use extraordinary emergency powers which resulted in worldwide violent protests against restrictions. Legislations, institutions and political powers were overwhelmed since they had to tackle both the pandemic and the World Wars. Executive powers that were exercised for public health reasons, treated citizens as the enemy

¹⁹ De Waal, Alex. *New pandemics, old politics: Two hundred years of war on disease and its alternatives*. John Wiley & Sons, 2021.

²⁰ Evans, Richard J. "Epidemics and revolutions: cholera in nineteenth-century Europe." *Past & Present* 120 (1988): 123-146.

²¹ Daly, Walter J. "The black cholera comes to the central valley of America in the 19th century-1832, 1849, and later." *Transactions of the American Clinical and Climatological Association* 119 (2008): 143.

²² World Health Organization. "Past pandemics." (2010). Web. <[www.who.int/europe/news-room/fact-sheets/item/evaluation-of-the-response-to-pandemic-\(h1n1\)-2009-in-the-european-region](http://www.who.int/europe/news-room/fact-sheets/item/evaluation-of-the-response-to-pandemic-(h1n1)-2009-in-the-european-region)>.

and reinforced the philosophy of the original public health legislation, which classified diseased persons as a public health risk that must be removed and excluded from society. Most of the states during these pandemics and epidemics have consistently used this model of executive powers which had been unrestrictive. The aftermath of the World Wars and post-colonial world emerged with ideas of integrated mobility, and porous borders for trade and employment, which were in sharp contrast to the dividing borders of the past. Cross-border migration of workers was encouraged as a solution to post-war labour shortages and demographic insufficiencies.²³

As a result, the issue of right to free movement became incredibly central to the human rights model. Post-war modern states understood the need for greater economic and political cooperation to meet shared challenges and goals. However, regardless of these new ideas, the world continued to be underprepared in infrastructure and resources to manage health crises like the HIV and Coronavirus pandemics, resulting in a legal and policy vacuum.

Essential questions with respect to pandemic preparedness remained unanswered when HIV emerged in the 1980's. Unfortunately, states failed to identify legal or policy impediments in establishing robust surveillance and public health mechanisms to contain and manage such pandemics. Like historical management, the current world continues to slip into the similar kind of response to public health issues, and it is unclear why this issue is recurrent despite decades of learning. During this phase, most of the Emergency legislations like the executive orders of the medieval times curtailed individual liberties and rights to enable officials to respond flexibly and quickly to health emergencies. These legislations approached public health policy through the prism of national security and law enforcement by assuming that

²³ Castles, S., and M.J. Miller. *The Age of Migration: International Population Movements in the Modern World*. Palgrave Macmillan, 2009. Print.

nations should trade-off liberty for public health security. Thus, instead of helping communities through education and provision of healthcare, these pandemic preparedness policies focussed much on coercive, aggressive action against those who are at risk of infection or infected.²⁴ Further, these legislations also lacked any cogent scheme for mitigating health crisis. These concerns were largely ignored until the Coronavirus pandemic emerged in the 21st century. Yet again, gaps in public health preparedness, resource allocation, and lack in global coordination by the WHO in response to the Coronavirus were revealed. Thus forth, these issues will continue to haunt legal academicians as to why states neither learn nor prepare their infrastructure to manage pandemics successfully. The ability of states to learn from health emergencies will determine not only their success in responding to future pandemics but also in tackling global challenges.

2.2 Emergence of the HIV Epidemic

The history of past pandemics, epidemics that emerged prior to the HIV had the following features distinct from the virus. Firstly, while remaining highly contagious; they proceeded on a stage limited in duration; followed by waves of increasing magnitudes; moving finally towards closure. In contrast to the rapid and highly contagious nature of past pandemics, the spread of HIV relied on specific conditions. Furthermore, the social and cultural dimensions of HIV/AIDS presented unique challenges, including pervasive stigma and discrimination. Its long incubation period, evolving understanding of transmission routes, and

²⁴ Annas, J., George et al, 'Pandemic preparedness- The need for public health – Not a Law enforcement National security approach', American Civil Liberties Union, Published January 2008, Online https://www.aclu.org/sites/default/files/field_document/asset_upload_file399_33642.pdf

the challenges associated with its management and prevention distinguish HIV/AIDS from past pandemics, making it a distinctive and an enduring public health concern.

By the end of 1960's, many in the field of medicine believed that all forms infectious diseases had been conquered.²⁵ A reference of it can be found in the swaggering statement of the U.S Surgeon General in 1967- 'that time had come to close all the books on infectious diseases'.²⁶ With the advent of the HIV, this statement was found to be extremely short-sighted and western-centric. By the year 1983, the widespread global impact of HIV encouraged many sovereign nations as well as the WHO to classify the virus as an epidemic.²⁷ A few research institutions, such as the National Cancer Institute of the United States, conducted extensive epidemiological research to understand not only the nature of the virus, but also its origin. One of the primary claims that dominated the media was its origin, which was linked to unnatural or aberrant sexual behaviour, and intravenous drug users (IVDU).²⁸ Thus, the beginning of HIV was characterised by a peculiar form of moral unacceptability which in many ways stereotyped the infected individuals. The infodemic²⁹ during the first few years of the virus outbreak created a climate of fear, social shaming and harassment by both governmental agencies and the public.

Another identifiable difference between the HIV epidemic and historical pandemics was that it was prevalent among young and middle-aged individuals due to increased sexual activity in this age group. While the Western world blamed Africa's social,

²⁵ Weiss RA. 'HIV and AIDS in relation to other pandemics. Among the viruses plaguing humans, HIV is a recent acquisition. Its outstanding success as an infection poses immense scientific challenges to human health and raises the question "What comes next?". EMBO Rep. 2003 Jun;4 Spec No(Suppl 1):S10-4. doi: 10.1038/sj.embor.embor857. PMID: 12789398; PMCID: PMC1326444.

²⁶ Upshur R. Ethics and infectious disease. Bull World Health Organ. 2008 Aug;86(8):654. doi: 10.2471/BLT.08.056242. PMCID: PMC2649475, Online< <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2649475/>>

²⁷ Whiteside, Alan. "HIV/AIDS and development: failures of vision and imagination." International affairs 82.2 (2006): 327-343.

²⁸ Hutton, Vicki E., RoseAnne Misajon, and Francesca E. Collins. "Subjective wellbeing and 'felt' stigma when living with HIV." Quality of Life Research 22 (2013): 65-73.

²⁹ Infodemic is defined an excessive amount of information about a problem that is typically unreliable, spreads rapidly, and makes a solution more difficult to achieve.

cultural, religious practices for the origin and transmission of the virus, the African nations accused the Western nations, dubbing it a 'western disease', attributing it to widespread homosexuality in the West.³⁰ Just like the previous health emergencies began, the western world began to treat the virus as a "law and order" problem, rather than a complex public health issue, entailing social, economic consequences and responded by limiting the rights of individuals for example, restricting People Living with HIV (PLHIV) from entering or residing in their geography. The use of unrestrictive extra-legal model powers (ELM) allowed nations to go outside the law, legal mechanism to control the spread of pandemic, thereby justifying wider suspension of fundamental and human rights.

2.3 Competing priorities of the states

The slow global response to the threat of HIV during the initial phase was characterised by a startling contrast of both inaction and denial. The developed world's 'inaction' both at individual and organizational levels was fuelled by the fear of intrusion in domestic affairs, if they joined the global HIV eradication program.³¹ On the other hand, the response of the developing and underdeveloped world was characterised by 'denial'. These lesser developed states refused to admit to the existence of the new public health challenge, which was on account of two factors: first, the lack of resources for tackling the virus; and secondly, the fear of jeopardising their regional growth.³² This strong denial from these nations, especially Africans, was most keenly reflected during the International Conference on African AIDS in Brussels (1985), which was boycotted by fifteen delegate African nations,

³⁰ United Nations Development Programme. "The Challenge of Sustainable Development in South Africa: Unlocking People's Creativity." South Africa Human Development Report 2003 (2003). Print.

³¹ Biesma, R. G., et al. "The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control." Health Policy Plan 24.4 (2009): 239-52. Print. <www.ncbi.nlm.nih.gov/pubmed/19491291>.

³² Warren Ashley et al 'Global health initiative investments and health systems strengthening: a content analysis of global fund investments', National Library of Medicine, July 2013, Online. <www.ncbi.nlm.nih.gov/pmc/articles/PMC3750586/>

raising concerns and suspicion regarding the credible evidence of the African origin of the virus.³³

Another problem was the entailing economic consequence, as many of poorer nations in Africa, Asia, which were hardest hit by the HIV epidemic, were also faced with competing development and fiscal priorities. For instance, in April 2001, members of the African Union pledged to allocate approximately 15% of their annual budget to the healthcare sector but, by the end of 2016, only four countries – Ethiopia, Swaziland, Malawi, and Gambia – were able to meet the target on account of the fiscal inability of most of these nations to maintain sustainable long-term commitment to health programs, especially the one's targeting the HIV.³⁴

The complexity of these competing priorities required a coordinated response in terms of combining various resources, technical knowledge and political will of developed nations, which had to be in consonance and in proportion with the needs of the underdeveloped and the developing world. Such a response also demanded policymakers to reform the global governance model based on a common set of values. But the outcome of the initial fight against the virus reveals an insufficient, inconsistent response by the developing and the developed nations. To address the issue of competing priorities; to respond to the policy gaps the affluent states need political wisdom to generate sufficient legal, policy measures; further requiring pro-active actions to satisfy the global health governance needs and to bring a greater coherence to the holistic picture of global health. This can only be achieved by preparing a pandemic management mechanism which is open to social realities, and the humanitarian concern for other states, who may lack resources.

³³ Prins, Gwyn. "AIDS and global security." *International Affairs* 80.5 (2004): 931-52. Print.

³⁴ Downie, Richard. *Advancing Country Partnerships on HIV/AIDS*. 2017. Print.

This form of a response endorses a global strategy framework for tackling the epidemic, by reducing risk, vulnerability as well as global impact.

2.4 WHO's Global Response

The earliest medical reaction to the HIV/AIDS focussed primarily on the domestic research, development of vaccines and medication. The attempt to coordinate for a global policy response came at a slightly belated stage. The international community, after extensive deliberation, assigned the responsibility of coordinating the fight against the virus to the World Health Organization (WHO). This decision was recorded in the report of the first regional conference on AIDS; it was observed that: "there was a strong consensus that the WHO should take a stronger position of leadership and advocacy for national and international programmes for AIDS prevention and control." One of the first moves of the organisation was to convene a global dialogue in international forums, global conferences, attempted to elucidate many fallacies regarding the virus- its nature, its origins, and its methods of transmission, to spread global awareness. Then began the task of marshalling resources to create the approaches and tools required to combat not just the virus, but also to alleviate the social impact on the affected.

By the beginning of the 21st century, the HIV/AIDS international response was accelerated on account of the increasingly universal access to treatment. In June 2001, at the UN Special General Assembly Session on AIDS, delegates made commitments to formulate a global strategy for the purpose of reducing risk, impact, and vulnerability to HIV/AIDS. It was for the first time that the issue of HIV/AIDS-related stigma and discrimination took global centre-stage, and international consensus emerged about the need to improve the

coordination of health and welfare programmes across all countries affected³⁵. On the other hand, WHO's more localised strategies in the field of HIV, outlined in a plan titled as – The contribution of the World Health Organization to scale up Universal access to HIV/AIDS prevention³⁶, revolved around different strategies ranging from confidential testing, strengthening health sector, scaling up global coordination to reduce the impact of the virus. These strategies not only helped lesser developed states to scale up the virus prevention, care strategies but also strengthening their health system, at the same time assisting states to develop a broad system for testing and counselling, thereby providing a holistic array of services to the infected individuals.

2.5 Development of International Guidelines

After the formulation of a comprehensive framework by WHO for global coordination, urgent demands for global guidelines on HIV were raised; for providing coherent recommendations to sovereign governments, other multilateral agencies, and non-governmental organizations for protecting human rights in the context of the HIV/AIDS. In this backdrop the first global consultation was organized by the United Nations Centre for Human Rights (UNCHR) in July 1989 seeking cooperation of the WHO. The participating member nations were keen to formulate international guidelines for better compliance with human rights standards in terms of law, policy, or administrative practice. Although the first guidelines were drafted and passed much later but the participating members underlined the need to provide guidance to states regarding standardised and holistic guidelines.

³⁵ C Cabal, L., and P. Eba. "Learning from the Past: Confronting Legal, Social, and Structural Barriers to the HIV Response." *Health Hum Rights* 19.2 (2017): 113-15. Print. <www.ncbi.nlm.nih.gov/pubmed/29302168>.

³⁶ *Ibid*

The Office of the High Commissioner for Human Rights (OHCHR) along with United Nations Programme on AIDS (UNAIDS), in 1998, issued broad global guidelines on HIV/AIDS, which were meant to integrate standards of international human rights law into the virus response.³⁷ The twelve guidelines covered state's responsibility to promote public health, protection of rights of infected members and creating a favourable legislative framework for the protection of PLHIV. Pursuant to the formulation of these recommendations, states were persuaded to administer these guidelines to secure protection of right by implementing them and circumventing several coercive policies and practices.

2.6 Policy responses to the HIV Epidemic

While the global human rights system recognized and formulated guidelines for the prohibition against HIV-related discrimination by the end of the twentieth century, yet the pandemic response in several nations turned oblivious towards their moral, legal obligations of the global health equity movement. The evidence from the post pandemic legislative development reveals a more troubling trend, which is that once these emergency laws are set in motion, they can become permanent fixtures

In a given national context, the legal and policy environment has been identified as a determinant of health outcomes, shaping vulnerability to disease, behaviors of individuals, and the rollout of interventions, as well as participation in them. The debate on how best to utilize criminal law and human rights protections to shape behavior in a public health crisis has been fervent, not only in the context of HIV but also in the recent COVID-19 pandemic. The evidence and research find little support for the contention that punitive actions against the HIV infected, vulnerable or marginalised population in the epidemic could lead to any

³⁷ Ibid

positive outcomes. A number of previous research suggests that any form of criminalization on account of HIV non-disclosure, inadvertent transmission is significantly associated with processes of stigmatization that serve to reduce access to virus testing^{38 39}, in addition to several linkage to therapy and long-term engagement and cascade of care. Such penal action also contributes towards a syndemic⁴⁰ of stigma, amplifying barriers to care.

Nevertheless, as of 2022, almost 92 countries around the world continue to have laws that criminalise non-disclosure of HIV/AIDS and its inadvertent transmission.⁴¹ Apart from the application of punitive actions, there are other restrictive regulations in place in 48 nations, whereby the entry and residence of the infected foreigners is restricted.⁴² These curtailments and punitive measures, as a part of state's extra-legal model provides it with unrestrictive executive powers by way of which the sovereign could go outside the legal mechanism to control the spread of epidemic, thereby justifying wider suspension of fundamental and human rights of the general public at large.

The Global Commission on HIV and the Law observed that, 'the legal environment can play a powerful role in the well-being of people living with HIV and those vulnerable to HIV'.⁴³ For the 2022–2027 period, UNAIDS has also adopted a new strategy that specifically focussing on the removal of criminalizing laws. This strategy is in addition to its plans to expand efforts towards combatting stigma, gender-based violence, and human rights violations.⁴⁴ The

³⁸ Gostin LO, Monahan JT, Kaldor J, et al.. The legal determinants of health: harnessing the power of law for global health and sustainable development. *Lancet* 2019;393:1857–910. 10.1016/S0140-6736(19)30233-8, Online <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7159296/>>

³⁹ Mykhalovskiy E. The problem of "significant risk": Exploring the public health impact of criminalizing HIV non-disclosure. *Social Science & Medicine*. 2011;73(5):668–75. 10.1016/j.socscimed.2011.06.051

⁴⁰ Syndemics is a conceptual framework for explaining diseases or health disorders that emerge in communities and are aggravated by the social, economic, environmental, and political milieu in which they exist

⁴¹ UNAIDS. "2020 global AIDS update: seizing the moment." Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS (2020). Print.

³⁰ UNAIDS. "UNAIDS and UNDP call on 48* countries and territories to remove all HIV-related travel restrictions." 2019. Web.

<www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2019/june/20190627_hiv-related-travel-restrictions>.

⁴³ Global Commission on HIV and the Law HIV and the Law: Risks, Rights & Health. New York: United Nations Development Program, 2012. <HIVlawcommission.org/>

⁴⁴ UNAIDS. Global AIDS strategy 2021-2026: end inequalities. End AIDS 2021 <https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026>

United Nations Development Programme's Commission on HIV and the Law, which functions with the goal of assessing the progress of laws and public policies that impact PLHIV, released, in 2012, a report titled "HIV and Law: Risks, Rights, Health"⁴⁵, stressing on the importance of liberal state policies and legislations for the promotion of health and human rights.⁴⁶ It argued for emphasising the difference between the reality of both moral and legal rights, and demanded a motivated change that be needed in the legal systems of many countries if the basic human rights of HIV positive people are to be upheld and observed

"The legal environment can play a powerful role in the well-being of people living with HIV and those vulnerable to HIV. Good laws, fully resourced and rigorously enforced, can widen access to prevention and health care services, improve the quality of treatment, enhance social support for people affected by the epidemic, protect human rights that are vital to survival and save the public money"

The civil society groups also came together to adopt the Oslo Declaration on the criminalisation of HIV and called for the end of virus specific criminalisation and recommended actions in order to create a legal environment which could support safe disclosure and treatment of PLHIV, as an alternative to a punitive atmosphere to target virus prevention.⁴⁷ It was in this context that many member nations like Kenya, Malawi, Mongolia, Tajikistan, and Zimbabwe, conducted exhaustive assessments of their laws and public policies which affected the PLHIV, and consequently made amendments to existing laws and/ or formulated new laws since then, thereby reforming many discriminatory

⁴⁵ Ibid

⁴⁶ Ibid

⁴⁷ UNAIDS. "HIV criminalization — Human rights fact sheet series 2021." 2021. Web. <www.unaids.org/en/resources/documents/2021/01-hiv-human-rights-factsheet-criminalization>.

practices.⁴⁸ Although discriminatory legislations alone cannot be blamed for insufficient virus response, it is true that a favourable legislative atmosphere and framework can play a vital and powerful role in the lives of PLHIV and those vulnerable communities who occupy liminal spaces in society, such transgender and sex workers, by protecting human dignity, empowering them and providing a legal redressal against discrimination, harassment, and violence.

Though the UNAIDS recommendations provide essential guidance to states, international, non-governmental organizations, and civil society groups on the formulation of strategies for combating HIV, but it remains the duty of states – and organizations for that matter – to look after their implementation. The vast literature on international human rights law has provided a theoretical, as well as a legal framework based upon which the discourse on human rights in relation to the HIV/AIDS epidemic has been created. Thus, the legalistic approach should be premised upon a moral discourse and arises out of the desire for change. This approach considers the systemic violence offered to non-normative individuals; a violence which seems to be built into the operations of all traditional and conservative social networks and is manifested in different forms. Investigating the parameters of this systemic violence can help us trace how inequity is structured and legitimised and as to how the roots of such a form of violence lies within the community systems of social relations and cultural practices.

In some cases, we may find that, even in states with favourable legislations may lack requisite resources or the security to demand fulfilment of the rights of PLHIV. This situation can exist particularly in those states where the space for expressing dissent or difference has

⁴⁸ Davis, S. L. "Measuring the Impact of the Human Rights on Health in Global Health Financing." *Health Hum Rights* 17.2 (2015): 97-110. Print. <www.ncbi.nlm.nih.gov/pubmed/26766865>.

been shrinking, further restricting the ability of human rights organisations to advocate social and political change. But despite policy measures in place neither the discrimination against the PLHIV has ceased in the social sphere nor has their ability to seek redressal by virtue of the legislation improved on account of poverty and public shame⁴⁹. It leads to an inference that apart from legalistic measures, the state must ensure a holistic development of its institutions and to ensure requisite impetus to advocacy and community action groups which could reach out to the most vulnerable groups and individuals.

2.7 Integration of Human Rights

The impact of HIV epidemic on human rights underscores one pertinent aspect- that all human rights are interrelated and indivisible. Although other rights – such as the rights to life, privacy, and the prohibition against degrading treatment – have central importance in human-rights-based approaches, they do not provide for the right to dignity and to health equality as essential in relation to several health interventions. In this regard, the two set of rights that are at the frontline during the HIV epidemic are- (a) right to health by way of access to healthcare, (b) right to freedom of movement and residence, both being inextricably linked to each other, both being central to the present research. The following part of the chapter shall explore these set of rights in the context of the HIV epidemic.

2.7.1 Right to healthcare access

UNAIDS defines “right to health” as the right to the highest attainable standard of physical and mental health. It guarantees everyone a system of protection of health and the autonomy of decision-making vis a vis health, regardless of their status, religion, or

⁴⁹ Nair, Mohit, et al. "Refused and referred-persistent stigma and discrimination against people living with HIV/AIDS in Bihar: a qualitative study from India." *BMJ open* 9.11 (2019): e033790. Print.

geography.⁵⁰ Several references to this right can be traced in international treaties, United Nations declarations, and domestic legislations across the globe. The policy progress in this regard, over the last three decades also includes the UN Committee on Economic, Social and Cultural Rights, comment on the issue of 'right to health', the UN Declaration of commitment on HIV and UN's global guidelines on AIDS and human rights.

An exploration of history and of the international rights apparatus that existed before the Second World War would reveal that it largely believed domestic rights violations of citizens to be internal affairs. The ramifications of the war also exposed the vulnerability of individuals within a system that revealed lack of adequacy of protection of individual rights, freedom, and liberty. The most immediate legacies of the Second World War were the death, devastation, misery, and the negative impact on global health.⁵¹ The establishment of United Nations, which recognised the promotion of human rights and thereafter the WHO, which asserted 'enjoyment of the highest attainable standard of health' as one of the most important fundamental rights brought the issue of healthcare to the forefront.

The vast literature on health and human rights in the context of HIV/AIDS reveals that in the policy arena, earliest linkages between both these facets appeared due to the efforts of Jonathan Mann, the first Director of WHO's Global Programme on HIV/AIDS during the late 1980's, which largely focussed on the utilisation of legal mechanism to protect PLHIV from both social and institutional discrimination. This form of humanistic discourse was also founded on the tenets of the Universal Declaration of Human Rights (1948), which was seen at risk from states, who looked upon human rights as a hindrance to public health. In this regard the primary responsibility for upholding right to health of citizens falls upon individual

⁵⁰ HIV/AIDS, Joint United Nations Programme on. "Right to health." Right to health. (2017). Print.

⁵¹ Howard-Jones, Norman, and World Health Organization. International public health between the two World Wars: the organizational problems. World Health Organization, 1978. Print.

states but we find vast difference between states in terms of the possession of resources as well as political will and commitment to the underlying principles of social justice. This diversity in many ways leads to complex legal issues about the universality of right to health; policies of exclusion and the economics of inequality, may also pose difficulties for the implementation of a human rights-based approach to health delivery systems across the globe.

In the context of HIV, this right is especially important due to its profound impact on individuals and communities worldwide. The deficiency in access to healthcare services for migrant workers in foreign nations remains a pressing and pervasive issue, highlighting the vulnerabilities within the global labor landscape. The unique challenges confronted by the migrant population, such as language barriers, cultural differences, unfamiliarity with the healthcare system and limited access to healthcare resources, significantly hinder their ability to seek and receive adequate care for sexually transmitted disease (STD) like HIV. Stigmatization and in some cases fear of legal repercussions like loss of employment, consequent deportation may further deter migrants from seeking testing or treatment, exacerbating the spread of infections within both migrant communities and the broader native population. In many cases, the precarious nature of migrant employment, coupled with limited or no access to health insurance for STD's, leaves these individuals without the necessary means to address their medical needs.

Several reports have highlighted the limited availability of sexual healthcare and the resultant health challenges faced by migrant workers across various global regions, with a particular emphasis on the Middle East. Bolini and Siem contend that the health disparities experienced by migrants and ethnic groups in host countries can be attributed to their lower

entitlements.⁵² They observe that these individuals not only confront adverse working and living conditions, known determinants of poor health, but also encounter obstacles in accessing healthcare due to political, administrative, and cultural factors. Importantly, these barriers differ across societies and age groups, presenting challenges not necessarily encountered by the native population. In this regard, Tan introduces the concept of 'ethnic distance' to illustrate the cultural divergences between individuals, highlighting that when the cultural values of the home and host nations differ significantly, this ethnic distance becomes even more pronounced.⁵³

Therefore, right to health of migrant workers in host nations is a complex issue that warrants attention and scrutiny. While the host societies make significant economic strides, relying heavily on migrant labor, the healthcare access for this segment of the population is a matter of concern. Ensuring their right to health would require host nations to formulate comprehensive measures, including the removal of barriers to treatment access, the provision of culturally sensitive healthcare services, the implementation of policies that safeguard their physical well-being and employment. A rights-based approach is essential to uphold the dignity and health of immigrant workers, recognizing their integral role in the development of host societies.

2.7.2 Right to free cross-border movement

The right to freedom of movement can be traced in Article 1 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Civil and Political Rights and encompasses the right to move freely within a country, to cross an international border. The rationale behind the liberal approach towards free movement lies in its close ties

⁵² Bollini O & Siem H, "No Real Progress towards Equity: Health of Migrants and Ethnic minorities on the eve of the year 2000", Soc Sci, Med. Vol.41, No.6, 1995

⁵³ Tan.M, 'Migration and Risk', AIDS Action Issue, p2, July 1998

with individual autonomy with regard to professional opportunities and occupation, which are sometimes not evenly distributed across geographies.

The restriction on international movement related to HIV usually takes the form of an administrative direction or law that mandates foreigners to reveal their HIV-free status before entering the host country, involving either mandatory written declarations or blood testing without any appropriate consent, counselling, confidentiality, or even support service at times. Whereas the restriction on residence involves a process whereby foreigners are tested for the HIV periodically, thereafter isolated and deported in case, they are found infected. This form of exclusion has a significant impact on the blue-collar labour population,⁵⁴ who are otherwise at an extreme disadvantage in their home countries. Not only do these curtailments entail social, civil rights consequences but also invades into the economic rights of the foreign workforce. Those already working in the host nations are faced with threats of deportation, loss of employment, which may also incentivise workers to conceal their status, or to avoid contact with government authorities and healthcare staff, thereby working illegally, which isn't an uncommon feature in societies having sizeable migrant workforce.

HIV-related travel curtailments have also attracted consistent criticism from international organizations, which have termed these measures ineffective, that only go on to promote discrimination.⁵⁵ The World Health Organization termed the screening of international travellers as an ineffective cordoning off strategy and suggested that such screening would be wasteful, violative of right to privacy and health.⁵⁶ The UNHRC and the Joint Nations Programme on HIV/AIDS (UNAIDS) have unequivocally stated that 'any

⁵⁴ Gilmore, N., et al. "International travel and AIDS." *AIDS* 3 Suppl 1.1 (1989): S225-30. Print. <www.ncbi.nlm.nih.gov/pubmed/2514742>.

⁵⁵Ibid

⁵⁶ World Health Organization. Statement on screening of international travellers for infection with Human Immunodeficiency Virus . 1988: WHO/GPA/INF/88.3. Print.

restriction on this right of liberty of movement based on the positive HIV status alone cannot be justified by public health concern.⁵⁷

The global resistance to the restriction of movement of the PLHIV was first raised at the Joint United Nations Programme on HIV/AIDS (2004) and the International Organization for Migration Statement on HIV related travel restriction, which argued that conservative guidelines on HIV related travel did not have any public health justification. This observation was also based on the scientific progress in treatment that changed HIV/AIDS from a deathly disease to one that could be successfully managed, yet the policies of exclusion of several nations have remained unchanged.⁵⁸ While the persistent campaigns of these organisations to eliminate virus related entry bans, has resulted in relaxation of restrictions in many states, others have moved towards tightening of their travel norms.

An interesting insight into the statistic reveals that states, who have formulated restrictive policies for the entry and residence of PLHIV have the following four common features: small size of ethnic population, high proportion of foreign migrant workforce, relatively lower prevalence of virus and absence of domestic legal environment to protect infected individuals. Thus, states and societies, having considerable immigrant population may be faced with greater public opinions on issues like xenophobia in terms of decision making, particularly in the gulf region.

The first part of this chapter has revealed the utilization of extra-legal measures by many states, as a part of strategies to control contagious diseases. The lack of necessary information, ignorance and fear may have contributed towards the framing of early state policies of restriction on infected foreigners, who were considered as carriers of the HIV. But

⁵⁷ WHO, UNAIDS. "WHO, UNAIDS statement on HIV testing services: new opportunities and ongoing challenges." Geneva: WHO, UNAIDS(2017). Print.

⁵⁸ Ibid

important question confronts modern states at present- whether these restrictions have become obsolete, especially in the light of medical understanding that the world has gained in the last more than three decades? To answer the questions regarding the relevance and viability of these conservative policies, we must also investigate and relook at the history of pandemics and epidemics. The world today is much different from when the conservative health policies of limiting human movement were first introduced during the cholera epidemic, or even when the first HIV-related travel restrictions - were first put into force.

An important U.S study spanning over 16 years (2000-2016) and consisting of a sample size of 39,000 PLHIV found that prompt treatment along with good access to healthcare has contributed towards normal life-expectancy amongst this population.⁵⁹ The reduced bodily impact of the virus and the longer life expectancy due to the anti-retroviral treatment has led to some recent and steady changes across the globe, where travel bans have been largely replaced by growing attention on support, treatment, and health education for promoting behaviours, which have proven far more effective than cordoning off the borders. Apart from the successes in treatment, the modern age of globalisation and economic liberalisation has led to high intensity of movement for better opportunities, income generation, which has been an ordinary aspect of millions of lives today, especially of low-income nations, making it vital for host governments to utilize rational methods to protect public health, while opening their borders to meet its labour demands. Further, human resource supply for the fulfilment of the labour vacuum should not be the only motive behind allowing free movement, rather it should be carried out on moralistic notions as well.

⁵⁹ Marcus JL, Leyden WA, et al, 'Comparison of Overall and Comorbidity-Free Life Expectancy Between Insured Adults With and Without HIV Infection, 2000-2016. JAMA Netw Open. 2020 Jun 1;3(6):e207954. doi: 10.1001/jamanetworkopen.2020.7954. PMID: 32539152; PMCID: PMC7296391.

The vast history of human management of pandemics and epidemics reveals how extra-legal constitutional provisions⁶⁰ have been utilized by many states, further for making their case stronger they have consistently used open ended terms like ‘security of the state’, ‘national threat’, ‘imminent danger’, etc. to construct pandemic policies. Whether a pandemic has caused an extreme situation to act as per the extra-legal model is still questionable, as it is subject to severity of waves and various stages, thus, acting outside the law has continuously allows the state to suppress several fundamental rights including freedom of information, press, life and personal liberty and equality before law that has been proved critical during pandemic and other health crisis.

However, to create a balance between public health issues and human rights, the international law requires that restrictions may be invoked in pursuing goals of protecting public health but the same needs to be evidence based. The Committee on Economic, Social and Cultural Rights (CESCR) in its statement made in July 2020, has asked states of all income levels to comprehend their core priorities in case of health emergencies; re-assess their pandemic regulations, especially regarding criminal actions against and restrictions on movement against PLHIV considering scientific evidence.⁶¹

The need for pandemic preparedness in the form of pandemic treaties between nations has become increasingly apparent in the wake of global health crises such as the COVID-19 pandemic. The interconnectedness of the modern world demands a collective and proactive approach to address the rapid spread of infectious diseases. On 1st December 2021, a dialogue was initiated by 194 member states of World Health Organization for formulating

⁶⁰ ‘extra-legal model’ accepts that exceptional responses may sometimes be necessary to deal with crises, but insists that the natural tendency in such circumstances for courts and legislatures to accommodate executive demands – and thereby water down ‘normal’ standards and constitutional protections – should be fought by requiring the executive to act openly outside the normal legal order.

⁶¹ Sun, Nina. "Applying Siracusa: A call for a general comment on public health emergencies." *Health and human rights* 22.1 (2020): 387. Print.

specific conventions under the constitution of WHO to build up pandemic preparedness by way of a pandemic treaty, which is built by a spirit of collective solidarity⁶². By formalizing international cooperation mechanisms, the WHO's proposed pandemic treaty seeks to address the gaps exposed by recent pandemics, ultimately strengthening the collective ability of nations to manage and mitigate the impact of future global health crises.

By adopting lessons learned from the response to COVID-19, the treaty could establish mechanisms for rapid information exchange, early detection, and effective response strategies. In the context of HIV/AIDS it is imperative to enhance global cooperation and coordination in the fight against this enduring health crisis. Despite significant progress in the understanding and management of HIV/AIDS, the epidemic continues to affect millions of people worldwide, disproportionately impacting immigrant communities. An international treaty which addresses HIV would provide a unified framework for developed, developing and under-developed countries to collaborate on prevention, treatment, and research efforts. It could streamline the sharing of resources, technologies, and best practices, ensuring that the latest advancements in medical science reach all corners of the globe.

On a global scale, developed states like the United Arab Emirates should seize the present opportunity to explore possibilities of strengthening responses to pandemics. Joining the proposed treaty could facilitate the UAE's access to vital resources, information sharing, and collaborative research efforts, enhancing the nation's ability to respond effectively to pandemics. Additionally, its participation in the treaty also aligns with its own commitment to public health and could contribute to the development of a more resilient and interconnected global health infrastructure. This form of policy discourse shall lead to a

⁶² World Health Organization. Strengthening health emergency preparedness and response in the WHO South-East Asia Region building upon lessons learnt from COVID-19: World Health Organization. Regional Office for South-East Asia, 2022. Print.

consensus-based rights-based framework, which does not differentiate between citizen and non-citizens by advancing and universalising right to health and easing restrictions on cross-border movements of PLHIV.

Chapter 3: The Indian Migrant Workforce

The preceding chapter revealed the use of extra-legal mechanisms in domestic settings that have characterised pandemic response in the past, further exposing its influence in shaping the current pandemic policies across the world. This chapter delves into the investigation of migration and its health-related dimensions, by analysing the diversity of conditions that different sub-groups of Indian migrant's face in their home country.

The exploration of the vulnerabilities of the Indian workforce leads to a better understanding of its economic; social, and cultural structure surrounding them and the political priorities of the Indian state. The exploration of these diverse conditions would assist policymakers to identify changes and approaches. This chapter further analyses the inherent vulnerability the Indian labour population, their exposure to the HIV, access to resources and the health fundament of the Indian state to ascertain the underlying issues around health in the context of labour migration and the healthcare needs of the migrating workforce. .

3.1 Labour Welfare and Vulnerability

The concept of labour welfare that the Indian state claims to pursue, is one that is comprehensive and relates to the development of total personality, embracing physical, mental, and social psychological aspects of the lives of low skilled workers. The normative basis for protection of the rights of this segment of the population finds its roots in the Article 43 of the Indian constitution which states that the 'State shall endeavour to secure, by suitable legislation or economic organisation or in any other way, to all workers, agricultural, industrial, or otherwise, work, a living wage, conditions of work ensuring a decent standard of life and full enjoyment of leisure and social and cultural opportunities.' The government's

attention is also focused on promotion of welfare and providing social security to its labour force both in organised and unorganised sectors. The Indian government boasts of the legislative changes that it has brought over the years for the welfare of its labour population, yet the nation stands lower in terms of the protection of the rights of its workers and high incidence of vulnerable employment.⁶³

The larger system of class, economic and social inequities faced by the Indian labour population can be summed up by the conceptual framework of 'structural violence', which in many respects is distinct from direct or personal violence and is embedded into the fabric of India's society wherein unequal power tends to shape the unequal lives of individuals. It can also be regarded a way in which a social structure adversely impacts people by not providing; limiting or by barring people from receiving their basic needs and usually affects people on the bottom rung of society, leaving them more vulnerable to different risks and odds. Vulnerability as a concept is extremely complex, as it includes several characteristics of individuals and groups that exposes them to risk, suffering and restrict their ability to predict or recover from the harm. The concept is also complicated in the context of Indian low-skilled workers as it explores the intersection of several disciplines such as public health, social and economic positioning of the workers, as these disciplines have their own specific reasons for measuring and developing conceptual models of vulnerability.

Three set of constituents, and their interactions are primarily responsible for the marginalisation of the Indian labour population in the context of health and HIV- Firstly, the legislative policy environment; secondly the group membership based on sexuality, caste; and lastly, the unequal and asymmetric access to healthcare.

⁶³ International Trade Union Confederation. "The World's Worst Countries for Workers." 2019 ITUC Global Rights Index. 2019. Web. <www.ituc-csi.org/IMG/pdf/2019-06-ituc-global-rights-index-2019-report-en-2.pdf>.

3.2 Public and Legislative Policy

3.2.1 *Governing through the HIV/AIDS Epidemic*

India's response in terms of detection of the virus came at a belated stage (1986), i.e., almost three years after the beginning of an extensive tracking of the HIV in the United States. The tracking began with the evaluation of blood samples of high-risk individuals, i.e., female sex workers (FSW's) in the metropolitan cities of the country by Indian Council of Medical Research (ICMR), which used a covert mechanism of sample collection and testing.⁶⁴

The immediate reaction of the Indian government, much like that of other nations was that it looked at the virus as a 'foreign' disease from which common citizens would be spared. The very first detection, in 1986, of HIV antibodies in FSW's did little to dismiss the popular belief, as they were denigrated for importing the virus and were identified as a potential source of infection which could threaten public health. The emphasis was thus, placed upon high-risk population rather than high-risk behaviours, which significantly reflected in the initial policies relating to the virus prevention of both the state and the national government. During the early phases, lack of political liberalism, also led to misinformation, which was greatly responsible for the negative societal outlook, having profound social, interpersonal impact on People living with HIV (PLHIV) in India.⁶⁵

During the late 1980s, several legislative and policy measures were proposed by the Indian parliament to prevent the importation and transmission of the virus. In this regard, the state government of Goa, was the first to introduce a legislative action by way of Goa Public

⁶⁴ Ramachandran, Prema. "ICMR's tryst with HIV epidemic in India: 1986-1991." *The Indian Journal of Medical Research* 136.1 (2012): 13. Print.

⁶⁵ Northcott, Herbert C, and Linda Reutter. "Public opinion regarding AIDS policy: fear of contagion and attitude toward homosexual relationships." *Canadian Journal of Public Health= Revue Canadienne de Sante Publique* 82.2 (1991): 87-91. Print.

Health Amendment Act, 1988 which mandated compulsory testing of people suspected to be infected with the virus, those found infected were forced with isolation at government health facilities.⁶⁶

The Goa Act caused serious rights violation of citizens and was extensively criticized by human right groups such as Lawyer's Collective and Mumbai based People's Health organisation (the first NGOs in the country to build an HIV/AIDS awareness and prevention outreach programs). The amendment was challenged within the first few months of its introduction in the landmark case of *D'Souza v. State of Goa*,⁶⁷ which was amongst the first cases heard by the Indian courts against the state's discriminating policy action against the PLHIV. Dominic D'Souza, the petitioner, filed a writ petition before the bench of the Bombay High Court against his illegal detention, isolation in a Tuberculosis (TB) sanatorium in his home state of Goa after he was found infected with the virus. The state justified its action in the interest of public health and cited Section 53 of the 1987 Goa Public Health (Amendment) Act, which mandated isolation of PLHIV.

The Court while disregarding the contentions made by the petitioner, found that there was no ground for invalidating the source of the state government's power to detain an infected person, as it may pose a potential threat to public health. The Court observed (verbatim) –

“Isolation, undoubtedly, has several serious consequences. It is an invasion upon the liberty of a person. It can affect a person very adversely in many matters including economic. It can also lead to social ostracization. But in matters like this individual rights must be balanced the public interest. In fact, liberty of an individual and public

⁶⁶ D'Souza v. State of Goa. AIR 1990 Bom 355 at para 17

⁶⁷ Section 53(1)(vii) of the Goa, Daman, and Diu Public Health Act, 1985

health is not opposed to each other but are well in accord. Even if there is a conflict between the right of an individual and public interest, the former must yield to the latter.”

One very intriguing aspect of the judgment was the judicial expression of its inability to doubt the wisdom of the legislature, the Court further made no effort to cite any credible evidence, or any coherent investigation made by the state before amending the statute and the ruling was primarily based on surmises, speculation and lacked credible data to back its judgment, it further observing –

“This policy decision is taken by those who oversee advancing public health and who are equipped with the requisite know-how. We find ourselves too ill-equipped to doubt the correctness of the Legislative wisdom. Even if there is any doubt about its correctness, its benefit must go in favour of the policy maker.”

The decision also exhibited the indifference and disinterest of the judiciary to interfere with the legislative actions of the state, which infringed upon the fundamental rights guaranteed under the Indian constitution.⁶⁸ In continuance of the state’s preventive measure, the Government of India (GOI) introduced its first legislative bill- The AIDS Prevention Bill of 1989, which was uniquely notorious in providing unfettered powers to the government health authorities to infringe upon rights of citizens, similar to the Goa Act.⁶⁹ The draft Bill included provisions to require medical institutions both private and governmental to notify local health authorities regarding the presence of drug addicts, newly infected HIV patients in their care. The draft bill also empowered health authorities to forcibly test, and question individuals suspected to be at higher risk of infection, isolate positive cases; and to bring criminal

⁶⁸ Constitution of India 1950, Part III, Fundamental Rights: Article 14, 19 and 21

⁶⁹ The AIDS Prevention Bill of 1989, An Agenda for Joint Select Committee, Journal of the Indian Law Institute, Vol.;33, No. 1, January-March 1991); Published by: Indian Law Institute

penalties for the transmission of the virus, further, none of those found to be infected were guaranteed medical treatment. Not surprisingly, the bill received immense criticism for blaming and denying basic rights and, following several opposing petitions from civil society groups such as AIDS Bhedbhaav Virodhi Aandolan, it was finally withdrawn by the government.⁷⁰

3.2.2 Post National AIDS Control Organization (NACO)

In the face of both domestic and international pressure, the Indian government was forced to shift from its iron fist policy of isolation to more liberal integrationist approach, which aimed at bringing the infected population to the mainstream. In 1989, the Government of India formulated its first medium-term plan of controlling the virus, in collaboration with the World Health Organization, for setting-up an efficacious program management structure with a long-term goal of coordinating multispectral policies.⁷¹

Later, in the year 1992, the Ministry of Health and Family Welfare of GOI established National AIDS Control Organization (NACO) as a nodal organisation for formulation of policy and implementation of programs for prevention and control of HIV/AIDS in the country. This policy shift can be very clearly visualised in two very distinct phases, i.e., pre and post NACO phase, as the establishment understood the significance of the costly social and economic impact of the virus, felt the need to intensify, expand its welfare measures for the infected population, while working towards the prevention of transmission.

Implementing any national medical program in India poses a challenge due to its vast size, social diversity, and complexity. To extend their reach across various socio-economic backgrounds, targeted interventions supported by NACO, such as Project Pehchan, Avahan,

⁷⁰ Andolan, AIDS Bhedbhav Virodhi. "Less than Gay: A Citizens' report on the status of homosexuality in India." (No Title) (1991). Print.

⁷¹ Asthana, Sheena. "AIDS-related policies, legislation and programme implementation in India." Health Policy and Planning 11.2 (1996): 184-97. Print.

Sonagachi Project, Project Kavach, along with initiatives like HIV education through the Link Worker Scheme, Red Ribbon Express, and The Condom Social Marketing Programme, play innovative roles in financing and delivering healthcare services.⁷² These efforts are particularly focused on key affected groups and individuals at high risk of HIV transmission.

The coordinated measures of the state, along with the participation of civil society groups and provincial governments resulted in the slowing down of the epidemic in India, which is reflected in the decline of newer infection by almost 48 (forty-eight) percent and the virus-related deaths by 82 (eight two) percent between 2010-2020.⁷³ Even though India made remarkable progress in containing new infections but until recently, the country did not have any specific legislative framework for the protection of PLHIV, which could supplement the efforts of the state to provide reasonable living, working and health benefits to the infected population. While most western countries were quick in combating as well as protecting human rights by amending or introducing new legalisations, India's progress was rather slow, nonetheless it remains the only state in the South Asian region to introduce a progressive legislation for advancing the rights of PLHIV.

The HIV & AIDS (Prevention and Control) Act, 2017, was one of the first key steps in ending rampant discrimination against PLHIV in the country and has been able to set firm foundation for weeding out the prevalence of adverse conditions. The Act aimed at covering essential aspects pertaining to safe working environment, informed consent for tests and grievance redressal mechanism and further laid down a 'test and treat' policy by virtue of which every infected citizen was legally entitled to free treatment by the state and further

⁷² Palchaudhuri R, Niggl M, Palmer CS. Eliminating HIV & AIDS in India: A roadmap to zero new HIV infections, zero discrimination & zero AIDS-related deaths. *Indian J Med Res.* 2016 Dec;144(6):789-792. doi: 10.4103/ijmr.IJMR_1902_16. PMID: 28474612; PMCID: PMC5433268.

⁷³ National AIDS Control Organization & ICMR National Institute of Medical Statistics (2021). *India HIV Estimates 2020: Technical Brief.* New Delhi: NACO, Ministry of Health and Family Welfare, Government of India..

criminalised discrimination against PLHIV.⁷⁴ This form of a rights-based approach towards the treatment and rehabilitation of PLHIV' based entirely on the concept of dignity of human life and equality enshrined under the Indian constitution and the legalisation has certainly paved a path towards discouraging institutional discrimination against the infected individuals.

3.3. Group Membership of Caste and Gender

3.3.1 Challenges associated with caste-based inequity

The caste system, as a form of social stratification system has prevailed in India since last three millennia. India's backward classes number around 200 million or one-sixth of India's total population⁷⁵, most of whom have traditionally been engaged in menial work, which are considered sinful or impure by the rest of the religious communities in the country including the religious minorities of Muslims and Sikhs. Thus, caste hierarchy along with the theories of purity, culture and customs perpetuate backward caste's second-class status. Furthermore, entrepreneurial opportunities are extremely limited for this groups, as they lack both capital and collateral to secure loans. Their limited access to land and capital due to historic discrimination has resulted in greater level of poverty.

Despite constitutional and legal prohibition of untouchability and caste discrimination, the members of the community continue to suffer from discrimination, which has also led to caste-based inequity in health care utilization, especially in the rural India. The common forms of discriminatory pattern, behaviours in the healthcare setting involves- refusal to admit Dalits⁷⁶ and lower caste members to rural hospitals or grant of access to basic care at home

⁷⁴ See Section.4, 37 of the HIV, AIDS Prevention Act, 2017

⁷⁵ Keelery, Sandhya. "Dalits and Adivasis in India: Statistics and Facts." (2020). Web. <www.statista.com/topics/4946/dalits-and-advasis-in-india/#topicOverview>.

⁷⁶ Also previously termed as 'untouchables' is the lowest stratum of castes in India

by health care workers and treatment in violation of their rights to the highest attainable standard of health.⁷⁷

Such historical patterns of discrimination and lack of employment opportunities has led to circular domestic migration between native, largely rural locations with a low HIV prevalence to urban geography, with a higher virus prevalence.⁷⁸ This circular labour migrants within the country from rural to urban geography has also been looked upon as a bridge population, which is regarded as a potential population transmitting virus infection from a high-prevalence group to individuals who would otherwise be at lower risk.

In the wider context of research on migration, in comparison to the work on gender and irregular migrants, the backward caste as a vulnerable group has rarely been studied. There is a paucity of data about the caste-based migration from India to the United Arab Emirates. In this regard, an inference can be drawn from two studies which have attempted to explore the caste-based migration to the Emirates, from the high migration intensity geographies in India. The first being the background paper published by International Labour Organization, found that a staggering 92.2 percent of the migrating Indian women from two of country's southern states, i.e. Kerala, Andhra Pradesh belong to socially disadvantaged caste groups of Scheduled castes, scheduled tribes and other backward classes.⁷⁹ The second study by the Institute for Development and Communication, Chandigarh revealed that 50 percent and 78 percent of the migrating workers to the Emirates from the districts of Hoshiarpur and Jalandhar (Punjab, India) hail from the scheduled caste and Other backward classes.

⁷⁷ Humanitarian AIDS Relief Trust, India's inequality in healthcare: the caste divide; Published: January 28th, 2016, Online. <www.hart-uk.org/blog/indias-inequality-in-healthcare-the-caste-divide/>

⁷⁸ Sinha, Kounteya. "Mass economic migration: the greatest threat to HIV control in India." *BMJ* 346 (2013). Print.

⁷⁹ Kodoth, Praveena. "In the shadow of the state: Recruitment and migration of South Indian women as domestic workers to the Middle East." International Labour Organization: Geneva, Switzerland (2020). Print.

As people from these communities suffer from societal stratifications, social restrictions, they are further restricted from gaining access to high-quality healthcare, a problem that has been especially highlighted in the coronavirus pandemic. While the Indian state has implemented several national health programmes to ensure best healthcare access to these communities, there are still several shortcomings in implementation and until such issues remain unaddressed, the community remains at the margins and highly exposed to HIV, with limited access to treatment.

3.3.2 Challenges of Indian Women with HIV/AIDS

The status of women in a patriarchal society like India has put them at an extreme disadvantage and the additional impact of HIV has resulted in far reaching social, economic consequences for women. Further lack of access to education, employment, socio-economic conditions has also influenced their power equation. The increasing '*feminisation*' of the epidemic in the India is also attributable to the low status of women, lower participation in workforce and lack of economic independence, information, ability to have safer sex and limited abilities to exert knowledge about safe sexual practices. The gender inequality and poverty are responsible for the spread as well as the disproportionate impact of HIV and AIDS on women.⁸⁰ Bergerand & Luckmann while attempting to explain the issue of HIV from a feminist prism asserted that – 'it is a socially constructed disease and much of the response and attitudes towards HIV-infected individuals revolve around the pre-existing concept, paradigms and societal construction of those affected.'⁸¹ Therefore, the recognition of the inequality leads to the development of feminization of HIV, which points to the social features of women that puts them in a vulnerable position.

⁸⁰ Pradhan, Basanta K, and Ramamani Sundar. "Gender Impact of HIV and AIDS in India." (2006). Print.

⁸¹ Berger, Peter L, and Thomas Luckmann. *The social construction of reality: A treatise in the sociology of knowledge*. Anchor, 1967. Print.

India has the third largest population of PLHIV in the world and even though the overall rate of infections has declined in the last decade, the rate of newer infection among women is on a rise.⁸² Factors like child marriage, lower income and the large family sizes has traditionally contributed towards the low access to education amongst females in the country, which in turn affects their health literacy, i.e. the ability to obtain, process, and understand basic information and services needed to make appropriate health decisions.⁸³ Many aspects of health like health knowledge, health status, use of health facilities and safer sexual behaviour have been found to be closely related to literacy levels by many studies.⁸⁴

Now, if we explore the migratory pattern of this segment of the labour workforce, we find that overseas avenues of employment in the Emirates and higher wages attract low-skilled female workers to migrate. Female workers from India are preferred choice for the booming domestic service industry in the host nation, estimating more than 2,36,545 domestic workers comprising of 12.8 percent of the total low-skilled workforce and 42.4 percent of the total female workforce in the country.⁸⁵ The demand for paid home-based care has been driven by a combination of changes in demographic structures, the rise in levels of income in the host country along with the declining female participation in the low skilled jobs which has leading to significant participation of Indian women worker.⁸⁶

This segment of workers has been recognized as “overworked, underpaid, under-protected” and, indeed, on the whole, has not benefited from “the gradual expansion of mainstream social and labour policies that have characterized socio-economic development

⁸² Singh Muhindro, 'Human Rights and Plight of HIV-Women: A case in India', The Indian Journal of Political Science: Vol. 71, No. 2, June, 2010, p. 546, print

⁸³ Wallace L; North American Primary Care Research Group. Patients' health literacy skills: the missing demographic variable in primary care research. National Library of Medicine, 2006, Online. <www.ncbi.nlm.nih.gov/pmc/articles/PMC1466997/>

⁸⁴ Davis Terry C, Instruction manual, REALM sample kit Shreveport, LALSU Medical Center, 1501 Kings Highway:1-20

⁸⁵ Human Rights Watch, I Already Bought You: Abuse and Exploitation of Female Migrant Domestic Workers in the United Arab Emirates, 2014, Online. <www.hrw.org/report/2014/10/22/i-already-bought-you/abuse-and-exploitation-female-migrant-domestic-workers>

⁸⁶ The United Arab Emirates' National Report on the Implementation of the Beijing Declaration and Platform for Action; 2019, Online. w

since the Industrial Revolution.⁸⁷ They are often susceptible to exploitation, physical and sexual violence, requiring feminist lens to be directed towards exploring the gendered process of integration, adaptation and their social mobility within the host society.

3.3.3 Impact on the Gay and Bisexual Community

The gay and bisexual population, within the Indian workforce is very invisible, which can be inferred from the fact that there have not been any prior studies that have extensively explored the living or working conditions of self-identified gay and bisexual men in the country. The present-day Indian society is both conservative, masculine and when individuals cross their prescribed gender stereotypes or are unable to fulfil their gender or sexual roles, they are discriminated and stigmatised.

The United Nations General Assembly (UNGA) Special Session on HIV/AIDS Report estimates the sub-group population of MSM to be about 3.1 million, whereas UNAIDS report suggests that the number could vary between 5 (five)- 15 (fifteen) million.⁸⁸ This can, however, be a lower estimate on account of fewer disclosures and a considerably large population size of the country. The virus infection among men who have sex with men (MSM) has been on a considerable rise around the globe, particularly in the Asia Pacific region in the recent years.⁸⁹ This pattern and growth of infection is also reflected in India, with the current estimated virus prevalence among MSM at 7.3%, which is 20 times higher than among the general population.⁹⁰

⁸⁷ ILO, The employment, and conditions of domestic workers in private households, Document D. 11, 1970, p 63, print

⁸⁸ HIV and Men who have Sex with Men in Asia and the Pacific: UNAIDS Best Practice Collection, 2006, Online. data.unaids.org/publications/irc-pub07/jc901-msm-asiapacific_en.pdf

⁸⁹ Independent Evaluation of National AIDS Control Programme. Jaipur: Indian Institute of Health Management Research; 2007.

⁹⁰ UNAIDS Website, HIV programmes for MSM and transgendered people gradually being scaled up in India; Published: 17 May,2012, Online.

Because of cultural and legislative barriers, the community had to remain at the margins of the society, their sexual preferences and activities kept secret for the fear of legal prosecution under the Indian Penal Code.⁹¹ The non-disclosure of sexual identities has been a great deterrent in terms of access to health services, as most MSM community members, prefer not to test or seek medical intervention for sexual transmitted infections. Meanwhile, many Non-profit organisations working on HIV prevention amongst MSM, in the earlier years, had trouble in reaching out to individuals who were marginalised by their sexuality with information and other health, psychological care services, on account of governmental interference.⁹²

The vacuum of the state inaction was filled by the intervention of MSM community in the country, which utilised several tactics to raise its demands, through litigation, advocacy, even direct activism, by way of public marches, parades, and protests. It took the collective effort of several LGBTQ (Lesbian, gay, bisexual, and transgender, queer) organisations and a period of 17 years of judicial struggle for the community to realise its demand of decriminalising homosexual activity in the country. The advocates of LGBTQ rights have hailed the Indian Supreme Court's decision in Navtej Singh Johar's case⁹³ and its observation vis a vis critical linkage between non-discrimination and access to adequate healthcare, which could escalate the effectiveness of health care and lower stigma within the community members.

The judicial activism and legal reforms may not provide efficacious remedies for deep rooted repression faced by the MSM, yet constitutional guarantees and prohibition of

⁹¹ See Section 377 of Indian Penal Code, 1860 until 2018 criminalised bisexual relations.

⁹² Misra Geetanjali, 'Decriminalising homosexuality in India: Reproductive Health Matters', November 2009, Vol. 17, No. 34, Online. <papers.ssrn.com/sol3/papers.cfm?abstract_id=1543794>

⁹³ Navtej Singh Johar & Ors. v. Union of India; All India Reporter 2018, Supreme Court, WP (CRL) No. 76/2016

discriminatory practices represent a dynamic and powerful symbol of social change, which can create favourable environment for the community members in the future.

3.4 Inequality in Healthcare Access

Historically, India has been struggling with inequalities in its health sector, affecting the healthcare accessibility for its marginalised population such as its labour workforce, lower caste and below poverty line population (BPL).⁹⁴ The healthcare system in the country presents a spectrum of contrasting landscapes. On one end of the spectrum, are the privately regulated institutions that have been successfully delivering advanced medical care to the elites, mostly the urban population, while at the same time paving way for medical tourism, a sector which has been a consistent growth of 30% between 2015-2019.⁹⁵ At the other end of the spectrum, is a weak and under-developed public health infrastructure which has failed to incorporate the specific needs of the poor and the marginalised groups in its plans of action.

The Indian government has consistently pledged to guarantee Universal Health Coverage, to its citizens, i.e., to provide quality healthcare to all sections of the society, irrespective of their ability to afford the cost of treatment or medication. However, the government has selectively adopted public insurance model to universalise healthcare instead of enhancing its primary health care system.⁹⁶ As such, access to good quality public healthcare has remained fragmented and India and only 16 (sixteen) percent of the

⁹⁴ Yarlini Balarajan, et al, 'Health care and equity in India', *Lancet*. 2011 Feb 5 2011; 377(9764): 505–515,Online. <10.1016/S0140-6736(10)61894-6>

⁹⁵ Lamba Mandeep & Mohan Dipti, 'HVS Monday Musing: Medical Tourism in India', April 2021, Online. <www.hvs.com/article/9044-hvs-monday-musings-medical-tourism-in-india>

⁹⁶ Mohan P, Kumar R. Strengthening primary care in rural India: Lessons from Indian and global evidence and experience. *J Family Med Prim Care*. 2019 Jul;8(7):2169-2172. doi: 10.4103/jfmpc.jfmpc_426_19. PMID: 31463225; PMCID: PMC6691438.

population has access to free or partially free public healthcare,⁹⁷ whereas, the out of pocket expense of the population on health is over 65 (sixty five) percent, which is one of the highest in the world, even higher than lesser developed neighbouring countries like- Sri Lanka (38%) and Nepal (60%).⁹⁸ Thus, the increased health expenditure of lower income groups have further driven them towards poverty. The statistics in healthcare, clearly exhibit that India is still far away from achieving the universal health coverage. The uneven access to healthcare in India is characterized by (a) an under-developed health system (b) and the socio-economic divide vis a vis access to healthcare.

3.4.1 India's Healthcare System

Even though India's national health care system aspires to provide a comprehensive array of services to all and at no cost, it has been struggling to do so in practice. The importance of public health system does not need any explanation, as the current Coronavirus pandemic has sufficiently revealed the inadequate health infrastructure in the country and its inability to deal with any major health emergency.⁹⁹ The unfolding of the human tragedy exposed the deep-rooted challenges plaguing India's public health system after decades of neglect and underinvestment.

Year after year, India boasts of its economic and technical advancement, but conceals the global indicators, which reflect a troubling picture of country's healthcare system. For instance, India ranks lower in the number of hospital beds per thousand population among the lesser developed nations such as Chile (2.11), Bangladesh (.087) and Mexico (0.98).

⁹⁷ Kumar Ankit & Isabelle Jourmard, 'Organization for Economic Co-operation and Development: Improving Health Outcomes and health care in India'; Economics Department Paper No. 1184, Jan 2015, Online. [one.oecd.org/document/ECO/WKP\(2015\)2/En/pdf](https://one.oecd.org/document/ECO/WKP(2015)2/En/pdf)

⁹⁸ Bhatia Mrigesh & Singh D.P, Health Sector Allocation in India's Budget (2021–2022): A Trick or Treat?; The International Journal of Community and Social Development; Published May 24, 2021, Online. <journals.sagepub.com/doi/full/10.1177/25166026211017338>

⁹⁹ Nimavat N, Hasan MM, Charmode S, Mandala G, Parmar GR, Bhangu R, Khan I, Singh S, Agrawal A, Shah A, Sachdeva V. COVID-19 pandemic effects on the distribution of healthcare services in India: A systematic review. *World J Virol.* 2022 Jul 25;11(4):186-197. doi: 10.5501/wjv.v11.i4.186. PMID: 36159611; PMCID: PMC9372784.

Similarly, India's National Health Profile in 2017, indicated the under staffing of medical staff and recorded the presence of only one state allopathic doctor for every 10,189 people and one government run hospital for every 90,343 people¹⁰⁰. The collapsing public health system has led to a persistent negative attitude towards it amongst the lower and middle-income groups, which is constrained to avail services of expensive private healthcare.¹⁰¹

The evidence suggests that nations which have developed advance healthcare systems spend more than 10 (ten) percent of their Gross domestic product (GDP) on budgetary allocation to healthcare services, whereas India's spending in the healthcare is slightly more than 1 percent, which is amongst the lowest in the world.¹⁰² In its National Health Policy (2017) the government set a target of increasing healthcare spending to 2.5 percent (GDP) by the year 2025¹⁰³, but the marginal increase in the healthcare investment, in the last five years, casts serious aspersions on the intentions of the state, which in its own annual "Rural Health Statistics" has admitted the abysmal state of its three-tiered health centres which lack basic facilities and adequate personnel.¹⁰⁴

3.4.2 Socio-economic Barriers to Healthcare

While it cannot be doubted that India has made remarkable economic progress, particularly in terms of gross domestic product (GDP), which has quadrupled in the last three decades¹⁰⁵, but this progress has also been accompanied by growing disparities between the

¹⁰⁰UNDP, 'The next frontier Human development and the Anthropocene', New York: UNDP, accessed 17 December 2020, <<http://hdr.undp.org/sites/default/files/hdr2020.pdf>>

¹⁰¹ (Das J, Hammer J. Money for nothing: the dire straits of medical practice in Delhi, India. J Dev Econ, 2007, Online. <<ideas.repec.org/a/eee/deveco/v83y2007i1p1-36.html>>

¹⁰² OXFAM; Inequality Report 2021: India's Unequal Healthcare Story, Online.

¹⁰³ National Health Policy, 2017; Ministry of Health and Family Welfare, Online. <<main.mohfw.gov.in/sites/default/files/9147562941489753121.pdf>>

¹⁰⁴ Rural Health Statistics; Government of India Ministry of Health and Family Welfare Statistics Division- 2019-2020

¹⁰⁵ India: Gross domestic product (GDP) in current prices from 1986 to 2026; Statista, Online. <<www.statista.com/statistics/263771/gross-domestic-product-gdp-in-india/>>

rich and the poor. There is strong evidence to suggest that the income disparity between the different socioeconomic groups is associated with worse health outcomes.¹⁰⁶

Poor economic status is one of the dominant contributors (54%) to total health inequalities in India.¹⁰⁷ Penurious living condition, unsafe drinking water, lack of sanitation, use of biomass fuels, hazardous working conditions as a part of the livelihood among the marginal population group often increases their exposure to numerous health problems. The overall pattern of healthcare utilization in the country is found to vary linearly with the economic class, the stronger economic segment in the country were found to utilize healthcare at 4.8% while lower income population, used healthcare services only 1.63% of the time.¹⁰⁸

The Indian state, to reduce the income disparity and as a part of its policy of financial inclusion and social security has implemented several schemes to bridge economic inequalities.¹⁰⁹ At the same time the government has placed excessive reliance on the public insurance system by expanding the scope of government sponsored health insurance (GSHI) schemes in the last one decade. The most recent and one of country's largest insurance scheme being the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (Ayushman Bharat Prime Minister National Health Protection Scheme, ABNHP), which aims to upscale the previous state initiatives and to cover under its ambit all the underprivileged and lower income households.¹¹⁰ But the scheme has faced severe impediment in terms of its implementation, on account of lack of an existing health infrastructure, including fewer health workers,

¹⁰⁶ Joe William et al, Health Inequality in India: Evidence from NFHS 3, Economic and Political Weekly, Vol. 43, No. 31, Aug. 2008, Online. <www.epw.in/journal/2008/31/special-articles/health-inequality-india-evidence-nfhs-3.html>

¹⁰⁷ Ibid

¹⁰⁸ Ibid

¹⁰⁹ See MNREGA (Mahatma Gandhi National Rural Guarantee Scheme) and Pradhan Mantri Jan Dhan Jojana (Prime Minister's People's Wealth Scheme).

¹¹⁰ About Pradhan Mantri Jan Arogya Yojana (PM-JAY)", Online. <pmjay.gov.in>

inadequate funding, which is a meagre USD 856 (Eight hundred fifty six) million per year, for an estimated target population size of 100 million families, apart from other issues such as delay in reimbursement to the hospitals.¹¹¹ The failure of the country's public insurance model can also be gauged from the fact that merely 6.05 lakh people received treatment under the ABNHP scheme between March, 2020- May 2021, the period which saw highest number of hospital admissions, on account of Coronavirus infections and other related ailments.¹¹²

The government has finally responded to this challenge and the ongoing national and global criticism by undertaking an initiative to strengthen its primary, secondary and tertiary care services by allocating INR 5,156 (five thousand one hundred fifty-six) crore, in its Union budget for financial year 2022-23, for the newly announced ABNHP- Health Infrastructure scheme.¹¹³ The success of this scheme vis a vis addressing the gap in the health system would depend on how the components under the scheme would be implemented, yet the step seems to be too little too late.

The analysis of the vulnerability of a large part of the Indian labour population, reveals relatively higher exposure to the HIV, other forms of STI's and their restrictive capacity to access quality healthcare in their home country (K.Sudhakar,2009). The governmental intervention in terms of constitutional reforms and policy formulation, to a limited extent have been able to keep a check on the institutional discrimination against the marginalised population but its weak healthcare system, has thwarted its efforts to meet the growing challenges that the labour population faces.

¹¹¹ Ray Ranjana, Monash University 'COVID-19 exposes India's weak public healthcare': Published: East Asia Forum; 18th July 2020, Online. <www.eastasiaforum.org/2020/07/18/covid-19-exposes-indias-weak-public-healthcare/>

¹¹² Right to Information response; F.No-S-12012/14/2021/NHA, published: June16,2021: India Today Article; Under Ayush Bharat, huge disparities among states where covid patients availed scheme

¹¹³ Union Budget FY 2022-2023 - National Portal of India, Online.

Further, the high rate of unemployment (over 20%)¹¹⁴ in India and large-scale cross-border migration of workers has also emerged as a major threat to the cross-border health equity movement.¹¹⁵ The uneven nature of contemporary globalisation has led to intensified social, economic inequities between countries and international migration can be seen as a reflection of it. At the global level, policymaking on migration has usually revolved around the areas of immigration, trade, labour and rarely focussed on the healthcare of immigrant population. In this regard, the Indian government needs to adopt multi-sectorial approach, ranging from engagement of global organisations, easing consular access for citizens in the host nations, and forming bi-lateral healthcare agreements, if necessary. This form of a coordinated policy approach by the Indian state to address the health implications associated with modern migration of temporary workers will protect both the communities in the country of origin and destination.

On the other hand, the host nations also need to shoulder the healthcare needs of temporary Indian workers, by way of access to quality health services that includes health information, prevention, and primary care to labour migrants for contagious infection like the HIV, would not only benefit the Indian workers but also serve as an important public health measure. If migrants are unable to access treatment and therapy for the HIV, out of the fear of loss of employment, arrest, or deportation, they may be forced to remain untreated, or work illegally, which could undermine public health responses. Further, screening and tests for incoming workers would not only lead to additional financial burden on them but would also incentivise illegal migration. In the domestic settings when Indian labourers migrate across the border for work, they not only aim to achieve higher financial remuneration but

¹¹⁴ CMIE: Unemployment rate in India: 2022

¹¹⁵ Zimmerman C, Kiss L & Hossain Migration and Health: A Framework for 21st Century Policy-Making', 2011, Online. journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001034

also better health trajectories, which can only be attained through a migrant sensitive model of healthcare that explores health issues across various migrant typologies. This includes ensuring access to adequate social protection; insurance cover, health, safety; and other ancillary services that are based on human rights principles to make migration safe and healthy for all.

Chapter 4: Migration of the Indian workforce to the UAE

This chapter analyses the pattern of labour movement to the United Arab Emirates (UAE); contemporary transitions in country's labour market, and changes in state's approach towards its immigrant population, particularly Indian, whose participation has been steadily increasing in the domestic sector. This chapter has largely benefitted from Looney (1994)¹¹⁶, Kapiszewski (2001)¹¹⁷, Kamrava and Babar (2012)¹¹⁸, Hertog (2013)¹¹⁹, UAE government website, press releases and the digital media accounts. Most of these studies focus on immigration legislation, policies of UAE, largely focussing on describing contemporary issues like human rights abuse, health, safety, work environment and ethics

4.1 Transitions in the Labour Movement to the UAE

4.1.1 Pre-Federation: Reliance on the Middle Eastern Labour Force

Initial migration flows to the UAE has gone through transformation in two important phases: the oil booms respectively in 1950's to 1960's and 1970's to 1980s. The first phase occurred from 1950 to 1970, particularly during the first Gulf oil boom period when post-war economic development in the West fuelled oil production on a commercial scale.¹²⁰ Infrastructural developments in transport, health, education, and administration within Gulf

¹¹⁶ RE Looney Budgetary consequences of defense expenditures in Pakistan: Short-run impacts and long-run adjustments, Journal of Peace Research, Published- 1994, Online <
<https://journals.sagepub.com/doi/abs/10.1177/0022343394031001002>>

¹¹⁷ Kapiszewski Andrzej, Nationals and expatriates : population and labour dilemmas of the Gulf Cooperation Council States, Ithaca Press, Reading, Year 2001

¹¹⁸ Kamrava, Babar Zahra, Migrant Labour in the Persian Gulf , Georgetown University , Center for International and Regional Studies, School of Foreign Services in Qatar Series, 2012

¹¹⁹ Hertog Steffan, The Private Sector and Reform in the Gulf Cooperation Council Research Paper, Kuwait Programme on Development, Governance and Globalisation in the Gulf States, London School of Economic, 2013, Online<
https://eprints.lse.ac.uk/54398/1/Hertog_2013.pdf>

¹²⁰ AlShehabi, Omar, Histories of migration to the Gulf. In Transit states: Labour, migration, and citizenship in the Gulf, 3–38. London: Pluto Press, print

and particularly in UAE created economic opportunities that drew many migrants from Middle Eastern nations such as Palestine and Yemen¹²¹. UAE's migrant labourers constituted 85% of all migrant labour in the Gulf States during this period largely due its lucrative wages and adaptive immigration policy. The second oil boom increased the participation of South Asians, particularly Indians from the early 1970s to the mid-1980s. Emirati economy also benefitted from Indian labour force, as it was relatively cheaper, further their mixed ethnic and religious orientation was also less likely to create any form of social unrest or political risk, thereby making them a perfect match for UAE.¹²²

4.1.2 Post-Federation: Between 1970-1980

The labour demand pre-1970's was locally met by inflows, mainly from Arab region only, lesser reliance was placed on expatriate workers. By the early 1970s the total number of foreigners in the region was estimated at 800,000 which tripled to 2.76 million by 1975.¹²³ To meet labour demand in the construction, oil and service sectors, it preferred to rely on short-term foreign labour migration rather than training the local population. The post-1970 period was also marked by diversification of labour flows with a more significant presence of people from South Asian countries, especially India.

4.1.3 Post 1990: The impact of the Kuwait War

The Emirati Government had been extremely concerned with the disproportionate immigrant population, factors such as security, geo-political risks, and Iraqi invasion of Kuwait in 1990 further solidified the security concerns of the country. Thus, the immigration policy development of the country needs to be viewed in reference to the significant

¹²¹ Owen, Roger, *Migrant workers in the Gulf*. London: Minority Rights Group, Ithaca Press, 1985, print

¹²² Froilan T. Malit Jr, et al, *Labor Migration in the United Arab Emirates: Challenges and Responses*, Migration Policy Institute, September 2013, Online. <www.migrationpolicy.org/article/labor-migration-united-arab-emirates-challenges-and-responses>

¹²³ History of Federal Law No.14 for the year 204 on combating the Communicable Diseases, Legal 500, April 2020, Online.

presence of foreigners conceived as a 'possible risk to their security and sovereignty' by its government. This part of the chapter covers features of UAE immigration policy as it developed under various national and international conditions. The immigration policy saw an astonishing shift post Iraqi invasion of Kuwait and creating an extreme situation of caution for the country, resulting in deportation of two million Arab nationals, who were considered as threat to national security by the UAE government. The decline in the Arab migrant population in the country was matched by the steady increase of Asian migrants, mainly from India. At the same time, the rapid growth of the migrant population has been understood to cause trouble within the UAE since migrants bring with them their own cultures, norms, and lifestyle practices, all of which can conflict with local traditions, Arabic, and Islamic values.

4.1.4 Participation of female migrants in the Emirati labour market

In the 1970s, the United Arab Emirates (UAE) witnessed a significant shift in its labour market dynamics, characterized by the initial engagement of migrant women. This period marked a transformation in traditional gender roles, especially within domestic work and personal services, as women began assuming roles traditionally held by the male workers in the Emirati society. It is also noteworthy that there had been no significant impact of the transitions in migratory patterns, as detailed in the preceding paragraphs upon the female workforce, the source of which largely remained stable, that is, South Asia.

The relatively modest percentage of female migrant participation in the initial phase, particularly in 1975 and in subsequent years witnessed a discernible increase. In 1975, post-confederation, the engagement of the female migrant force was as low as 2.90 percent. This

figure underwent a significant change, reaching 10.48 percent by 1995.¹²⁴ As of 2022, their engagement in the Emirati labour market stands at 18.3 percent out of which more than two-third comprises of Indian workers, half of whom being engaged in the booming domestic service industry.¹²⁵

Abuses and labor exploitation in male-dominated sectors are generally well-documented and more visible, primarily because men often work in groups in the oil, construction and agricultural sector. In contrast, abuses against women migrant workers are less known, as they are more likely to occur at an earlier stage of the migration process or in less visible situations. These abuses encompass various forms, including demands for higher payments from agencies, frequent violations of physical integrity involving punishments, intimidations, ridicule, and humiliations, as well as instances of sexual harassment.¹²⁶ Those who successfully escape persecution often lack access to legal services and redress; many end up in irregular situations and face deportation when they resist returning to their employers under the sponsorship.

4.1.3 Participation of female

4.2 Contemporary Issues faced by Indian Labour Migrants

High levels of unemployment, underemployment, and low-wages in India are often cited as the primary reasons that propel large-scale migration from the region to UAE. Indian low-skilled, low-literate workers in the UAE have traditionally suffered from poor working conditions, absence of efficacious labour law and healthcare protection. Local English

¹²⁴ Sabban Rima, GENPROM Working Paper No. 10 Series on Women and Migration UAE: Migrant Women in the UAE, The case of female domestic workers by Rima Sabban Gender Promotion Programme, p.3, Ministry of Planning, Population Censuses 1986, 1997; Labour Report 2000, Ministry of Labour

¹²⁵ Ibid

¹²⁶ Women migrant workers in the UAE: Not quite in the portrait : NGO submission to 45th Session of the Committee on the Elimination of Discrimination of against Women, Online < https://www2.ohchr.org/english/bodies/cedaw/docs/ngos/MigrantForumAsia_UAE_45.pdf >

newspapers across Middle Eastern region, the international media have reported several labour issues, ranging from lower payment of wages in contravention to employment contract, withholding of passports and wages by employers¹²⁷. Consistent criticism has also been made by international organisations concerning the working, living conditions, human rights of immigrant workers in the host nation¹²⁸. Transition and development of the immigration policy and legislation needs to be viewed in different context, there are several domestic, international, ethnic, cultural, and religious factors shaping it.

4.2.1 The Emirati Immigration Policy

The Arab Gulf States have been longest surviving authoritarian regimes in the world since their foundation. Since the independence of Saudi Arabia in 1932, Kuwait in 1961, Oman in 1970; Qatar, Bahrain, and UAE in 1971; each of the AGS have been able to maintain hereditary monarchies in power. In the Emirati state, the Federal National Council is merely a consultative council. Overall, the citizens of the AGS are denied participation in democratic exercise and do not have any means to voice their political decisions through electoral process or parliamentary representation.¹²⁹

In the backdrop of conceived security risk from substantial immigrant population in the country, the immigration legislation and policies are also propounded under a particular social-cultural-religious backdrop. The ethnography of Emirates also promotes society and governments to establish wide disparity between citizens and migrants. This disparity is conventionally reflected in country's immigration process, i.e., its visa sponsorship process known as the Kafala and its medical screening process of resident and incoming foreign

¹²⁷ Harvard International Review, Middle East, and Africa, 'Taken Hostage in the UAE', July 2022, Online. hir.harvard.edu/taken-hostage-in-the-uae/

¹²⁸ Qadri, Mustafa, 'The UAE's Kafala system: Harmless or Human Trafficking? Part of Report: Dubai's role in facilitating corruption and global illicit financial flows, Carnegie Endowment for International Peace, 2020, Online. <www.jstor.org/stable/resrep26918.13>

¹²⁹ Matsuo M. et al, Asian Migrant Workers in the Arab Gulf States The Growing Foreign Population and Their Lives, Brill Academic Pub Publisher, 2019, print

workers. The following part of the chapter analyses the challenges faced by Indian workers on account of the exclusionary and partisan processes underlying immigration.

4.2.2 Legislative vacuum and the Kafala System

The traditional system of sponsorship of foreign labour in UAE has been governed by the Kafala system, which determines the relationship between employers and foreign workers. The system remains widespread in most of the Arab world and has contributed immensely towards migrant's precarity.¹³⁰ While, the policy provides a clear framework for employer-employee contractual relationship, it grants disproportionate powers to the employers, with absolutely no space for grievance redressal for the foreign workers. Many global organizations have criticized the system and compared it with the modern day slavery and maze of exploitation.¹³¹ Due to paucity of protective legislations, the Indian immigrants have been conventionally making complaints to the Indian consulate, ranging from non-compliance of employment contract, reduced wages, and non-issuance of renewal of employment contract, physical abuse, poor housing conditions and refusal to pay overtime allowance.¹³² Since the early 2000's, the Indian government has taken up these issues on behalf of its workers with the Emirati government, which began reacting to the criticism, and later changed its policy orientation. Although, the support in terms of legislation came at a belated stage (post-2015), yet UAE made several changes in its attitude for better outreach to its expatriate workforce.

¹³⁰ Abdoulaye Diop, et al, "Migration Policies across the GCC: Challenges in Reforming the Kafala," Migration to the Gulf: Policies in Sending and Receiving Countries (Cambridge: Gulf Research Centre, 2018):p.33, Online. gulfmigration.grc.net/media/pubs/book/grm2017book_chapter/Volume%20-%20Migration%20to%20Gulf%20-%20Chapter%203.pdf

¹³¹ Amnesty International, Official Website, "Unpaid and abandoned: the abuse of Mercury MENA workers," September 26, 2018, Online. www.amnesty.org/en/latest/research/2018/09/mercury-mena-abuses-qatar/.

¹³² Jadhav, Radehshyam, "Saudi Arabia tops Indian Gulf workers' victimisation list: MEA," The Hindu, July 17, 2019, Online. www.thehindubusinessline.com/news/saudi-arabia-tops-indian-gulf-workers-victimisation-list-mea/article28521417.ece

4.2.3 The Communicable Disease Law

The influx of huge immigrant population and transformation of the demography during the first ten years of formation of Emirati confederation led to perceived threat from communicable diseases, considered to be 'foreign'. To manage prevailing contagious diseases of the period, such as Cholera, Malaria, Plague etc., the Emirati state took the first legislative step by issuing Federal Law No. 27 of 1981 concerning the prevention of communicable diseases. The law laid down the domestic policy framework concerning testing, reporting, isolation, deportation of migrant workers found to be infected with the diseases, as mentioned in the schedule of the Act. By the time HIV/AIDS emerged on the global scene, UAE already had a policy framework to handle crisis arising out of contagious diseases. The virus was included in the scheduled list of diseases in Schedule D of the Act and since then been a permanent fixture of the federal legislation. Even after the amendment of the law in 2014, by way of Federal Law 14 of 2014, the list of diseases has remained unchanged, and the state has imposed same set of rules for testing, isolation, and deportation for all the diseases under the Act. This is contrary to the findings of preceding Chapter-2, which revealed that any policy or legislation concerning communicable diseases should be based on the assessment of the stage, severity of waves; and availability of alternative measures to manage them.

Today, HIV screening is part of the holistic health screening, a mandatory requirement for long-term work permits, conducted both in the countries of origin, the host nation, and has become an intrinsic part of the immigration process. Far from being eligible for consideration for protection, those migrants who test positive for HIV are either denied entry into the country, or alternatively, isolated, deported after their employment contracts are rescinded, without any treatment or provision of counselling and care. Indian workers suffer serious hardships under the deportation regime of the UAE. Resident migrants, who test

positive, are reported to the health authorities within 24 hours and are detained in jail like hospital cells, returned to their home country and receive a lifetime blanket ban on re-entry into the Emirates, without any appropriate system of referral.¹³³ A closer look at the policy would reveal that the state has turned oblivious to the humanitarian needs of its foreign workers, human rights obligations, including the principle of non-discrimination, right of migrants such as privacy, protection of the family. United Nations, Human rights and global organizations have maintained¹³⁴ that UAE's policy of testing and deportation of temporary workers is detrimental to public health and even wider workforce productivity.

4.2.4 Monarchical dominance and Civil Society Organisations

Many Islamic scholars in the Arab world have argued that the roots of civil society in the region could be traced to the Islamic values and religious scriptures, for instance injunctions to promote philanthropy, tribal precepts of collective responsibility and mutual aid were some of the features of the early Arab society.¹³⁵ The religious directives to perform 'zakat' and 'sadaqa' encouraging donation of a percentage of income to the poor had been the traditional norm in the region even at the time when there was no organised civil society in the UAE and other Arab Gulf countries.¹³⁶ In this backdrop, when the civil society organisations were first formed during the 1970's (post confederation), they mostly had philanthropic orientation.¹³⁷

¹³³ Reinl, James & Underwood, Mitya, Ministry of Health Stands By HIV Policy, The National Newspaper, p.1, May 12, 2009, Online. <http://www.thenational.ae/article/20090512/NATIONAL/705119804/1010/FRONTPAGE>

¹³⁴ UNAIDS, UNDP Joint Press Release, Still Not Welcome- HIV related travel restrictions, 2019, Online <https://www.unaids.org/sites/default/files/media_asset/hiv-related-travel-restrictions-explainer_en.pdf>

¹³⁵ Likić-Brborić Branka, Migration, Civil Society and Global Governance: Chapter – 3; Global migration governance, civil society, and the paradoxes of sustainability, 2019, ISBN13: 978-0-367-14726-6

¹³⁶ Jafar Badr, Strategic Philanthropy in the Arab world, Fiker Institute, Dubai, October 2022, Online. <www.fikerinstitute.org/publications/strategic-philanthropy-in-the-arab-world>

¹³⁷ Ibid

Today, the civil society in the UAE has expanded yet it faces several daunting challenges. Under the monarchical political domination, both the formation of civil society organisations (CSO's) and its functioning in the state are subject to governmental approval, tight scrutiny and regulation.¹³⁸ The United Nations Development Programme has consistently made appeals to the UAE to honour previous commitments towards political reforms, pluralism and human rights, eliminating legislative, administrative restrictions and to amend legislations regulating civil society to accord with international standards.¹³⁹ Closer look at the Emirati CSO's reflect a spectrum, consisting of associations of commerce, non-governmental organizations mostly funded by the monarchy, advisory bodies assisting the government, charity, religious, youth and women groups supported by local chiefdoms.¹⁴⁰ While most of country's CSO's have conventionally focussed on the upliftment of its citizen population, extending to relief at the world level, especially emergency relief, none of them have actively engaged with its large immigrant population or acted as a watchdog for their rights violations.

The federal government has made tall public claims, terming its civil society as robust, independent, functioning within a favourable legislative environment; being influenced by the teachings of Mahatma Gandhi.¹⁴¹ Yet many global indicators show a different picture, revealing abysmal state of civil advocacy in the state, ranking it lowest in terms civil society participation.¹⁴² The overall environment such as political backdrop, ethnocentric legislative

¹³⁸ UAE, Law No 12 of 2017, Regulating Civil Society Organization

¹³⁹ United Nations Development Programme, Publications, Fast Facts: Civil Society and Civic Engagement in the Arab States, July 2014, Online. <www.undp.org/arab-states/publications/fast-facts-civil-society-and-civic-engagement-arab-states>

¹⁴⁰ CIVICUS, Monitoring Civic Space, UAE civil society fears crackdown ahead of COP28, Online. <monitor.civicus.org/explore/uae-civil-society-fears-crackdown-ahead-cop28/>

¹⁴¹ Nasreen Abdullah, UAE built a civil society that passes Mahatma Gandhi test: Sheikh Nahya, Khaleej Times, 31st Jan 2023, Online. <www.khaleejtimes.com/uae/uae-built-a-civil-society-that-passes-mahatma-gandhi-test-sheikh-nahyan>

¹⁴² Human Progress, Civil Society Participation Index, 2022, Online. <www.humanprogress.org/dataset/civil-society-participation-index/rank-list/>

framework, and state-imposed scarcity of funding has led to lower efficiency of these organisations.

As migrants have conventionally lacked redressal opportunities, in such an atmosphere CSO's can promote safeguards to identify vulnerability amongst migrants; ensuring adequate access to law and justice; collective negotiations on behalf of immigrants; fostering inclusion; increasing co-operation with provincial and federal authorities. Therefore, there is an urgent need for the UAE government to consider changes, allowing the civil society to regain strength, allowing them to engage in new themes and ways of working, and reaching out to new constituencies of the migrant population.

4.3 Policy shift: The 'Migrant-Friendly Approach'

In this section of the chapter, we delve into the current phenomenon of the UAE's 'migrant-friendly approach.' Since the beginning of the new century, the nation has deliberately worked on reshaping its image, portraying itself as more tolerant and accommodating towards its immigrant community. It also examines the significance of this change in attitude, questioning whether it represents a meaningful shift or merely a superficial attempt at an image makeover. The specific context of UAE's immigration has gone through some progressive change with the effect of globalization and multitude of criticism by international non-governmental organizations, international human rights organizations, various academic and non-academic research institutions.

Nevertheless, during the late 2000s, there was a noticeable emergence of stylized expressions that highlighted a sense of tolerance, peace, and harmony, particularly emphasizing the cultural diversity within the UAE. Portraying the state as a symbol of diversity became a prevalent trend, evident in the adoption of migrant-friendly policies, official state

documents, and speeches by state officials.¹⁴³ This contemporary shift towards an inclusive society also entailed the active involvement of migrants in national events, media campaigns, and other communication channels sponsored by the state.

4.3.1 Emergence of the 'Migrant-Friendly' discourse in the UAE

The altered policy orientation can be seen in the official statements and speeches, policy orientation to incorporate migrant friendly attitude as an illustration of which can be consistently noticed in the continuous use of the phrase by the state in its official statements: *"The UAE is a country where people from nearly 200 nationalities work and live in peace and harmony."*

Abdul Rahman Mohammed Al Owais, former Minister of Culture, Youth and Community Development has been instrumental in highlighting this migrant friendly approach in Emirati immigrant policy by styling the official statements, communication reflecting the inclusion and diversity of migrant population in the country. In the same period, Anwar Gargash, who was a long-serving Minister of State for Foreign affairs, in an official speech at UN Human Rights Council's Universal Periodic Review in 2008, while explaining human rights condition of the UAE, stated: "A large part of the UAE's population is made up of culturally diverse foreign workers attracted by the positive employment opportunities and tolerant social environment in the country."¹⁴⁴ Similar assertions of diversity and plurality have become a popular expression in the context of the UAE's policies, especially concerning migrants, labour issues, economic development, and investment. Sheikh Mohamed bin Zayed Al Nahyan, the

¹⁴³ Horinuki K. Promoting Diversity, Branding the State: Migrant-Friendly Discourses in the United Arab Emirates. Vol.8. Springer, Singapore, 2019, Online. <link.springer.com/chapter/10.1007/978-981-13-6899-8_6>

¹⁴⁴ Office of United Nations Human Rights Commission, Press Release, Human Rights Council adopts outcomes of the Universal Periodic Review of Montenegro, United Arab Emirates and Liechtenstein, Published 7th June, 2013

crown prince of Abu Dhabi, stresses upon the importance of coexistence in the UAE communities: “At home, the UAE has a well-established track record of coexistence, as well as religious and cultural tolerance among its residents”¹⁴⁵. The recent initiative of the Emirati government to sanction Hindu temples and a Sikh Gurudwara in Dubai and Abu Dhabi¹⁴⁶ can also be seen as attempt to provide larger religious space to the Indian communities.

4.3.2 Reframing documents reflecting ‘Migrant-Friendly’ attitude

Migrant friendly attitude has also been expressly reflected in reframed immigration documents which regards migrants as essential workforce for economic growth and their role in building a diversified society. The Dubai Strategic Plan (2007) expressed the migrant population as a major contributor to the economic growth and industrial development in UAE. This has created a unique multicultural environment with rich opportunities for cultural interaction and cooperation¹⁴⁷.” The Abu Dhabi government’s Policy Agenda 2007–2008 as well as the Abu Dhabi Economic Vision 2030, also stress the role of migrants in future growth: ‘Expatriates have brought additional diversity and dynamism to the economy and to society’ and set a goal to attract more skilled migrant workers for future economic growth and diversification of the economy¹⁴⁸. The host nation uses this policy approach strategically to build its international reputation and showcase itself as a prosperous hub for immigrants.¹⁴⁹

¹⁴⁵ Ibid

¹⁴⁶ The Hindu, Newspaper, ‘Majestic Hindu temple opens in Dubai’, Source: Press Trust of India, 05th Oct 2022

¹⁴⁷ Abu Dhabi, Government of. 2007. Highlights Dubai strategic plan (2015).
Online. <<http://www.arabruleoflaw.org/compendium/Files/UAE/94.pdf>.>

¹⁴⁸ Abu Dhabi, Government of. 2008. The Abu Dhabi economic vision 2030.
Online. <www.ecouncil.ae/PublicationsEn/economic-vision-2030-full-versionEn.pdf.

¹⁴⁹ Lian, Fee Kwen, International Labour Migration in the Middle East, and Asia: Issues of Inclusion and Exclusion (Asia in Transition Book 8) 1st ed., Springer, 2019, print

4.3.2 Involvement of Migrants in National Events:

Historically, the host country had maintained a separatist policy approach towards immigrant population, with hardly any social integration efforts under the belief that Emiratis and migrants do not share same social and cultural ethos, accompanied by the fear of discontent amongst the citizenry population. Based on this underlined statement, migrants were generally excluded from everyday life and from interacting with local Emiratis community. With the advent of globalisation change, transformation of economy, the social and cultural understanding towards migrant population has also gone through some radical changes. The government has actively involved migrants in national events as community members and the government is now using these events to send a message to both Emiratis and migrants.

Since 2010, the Ministry of Labour, local government and private companies have officially held May Day or International Labour Day events to praise migrants' role in national development. On May Day events, ministers and officials express their gratitude towards foreign workers—mainly migrant labourers—and it can be said that it started a new trend in the UAE's labour policy, which saw legislative amendments post 2015.

Flag Day, a national event celebrated since 2013 as the anniversary of the accession of Sheikh Khalifa bin Zayed Al Nahyan as the UAE president; is also another example of attempted social and cultural inclusion of migrant populations in UAE. Both Emiratis and Non-Emirati residents have been asked to display the UAE flag in their homes, offices, schools, and public buildings to show their loyalty to the nation, primarily attempting to foster patriotism amongst the non-locals as well. On this day, there are many related events held both publicly and privately, and there are many video clips that are produced and uploaded to social media sites. The flag's colours of red, green, white, and black are frequently used as a unifying

symbol in national events and to visually develop and stimulate people's sense of belonging to the UAE as home. It is not difficult to understand that the government is mobilising migrant residents to Flag Day events to promote their sense of belonging to the host country¹⁵⁰.

The third illustration is the National Day that is symbolically organised to celebrate UAE's independence in 1971 and its progression as nation. Recent trends advocate active involvement of migrant population with Emiratis population in this event too. Sheikh Abdullah bin Zayed Al Nahyan, the minister of foreign affairs, stated on the occasion of the 43rd National Day (2014), "The UAE has become a destination for all with its tolerance and openness to the world's cultures and peoples, exchanging respect with respect and enjoying security and safety under the laws which respect freedom of difference and treat everyone fairly before the law, which is represented by the presence of 200 nationalities from different parts of the world enjoying stability and a decent life"¹⁵¹.

4.3.3 'Migrant-Friendly' Media Campaigns

Recent trends have shown measured attempts by the Emirati government to promote social stability, tolerance through national and social campaigns, for example, the Abu Dhabi Executive Council Communication Committee launched a television commercial campaign called 'al-youm _anā _Imārātī' (Today I Am an Emirati). This is a series of television campaigns to evoke testimonies of regard for the nation: the series features migrant residents (mostly South Asians) who describe the reasons for living in the UAE and their love the country¹⁵².

Another state funded media campaign called "Express Your Love for the UAE" was introduced on 45th anniversary of National Day (2015) by the Aqdar Initiative (Mubādalat

¹⁵⁰ Ibid

¹⁵¹ Wakalat Anba'a al Emarat. Abdullah bin Zayed statement on the occasion of the 43rd anniversary of UAE National Day, 1st December 2014, Online. <wam.ae/en/details/1395273298225>

¹⁵² Ibid

Aqdar) of the Khalifa Student Empowerment Program.¹⁵³ Its goal is to enable all members of the community (local and non-local) to express their love for the UAE and its leadership in their own unique way, and to document and publish these expressions. The Aqdar Initiative released a similar television commercial, 'Express Your Love for the UAE', in which four migrant residents who had lived in the UAE for a long time talked about how their affinity towards the host nation. An astonishing feature that could be gathered from these media campaigns is that all of them are also targeted towards the Emirati population, as these were broadcasted on local Arabic channels; and these campaigns have highlighted migrant labourers holding their place in shaping up economic and industrial development of UAE.

Introduction of immigrant friendly approach within the host society through changing the orientation towards migrant population, official speeches and media campaigns has two specific reasons. Firstly, the host state is deliberately inventing a new strategy for maintaining a good reputation globally by routinely emphasising on words such as 'diversity', 'tolerance' and 'coexistence', which are shaped by demographically imbalanced conditions, as features to promote itself as a liberal society, even though many migrant and labour issues still existed. As this is a new trend, it is still difficult to evaluate whether it will succeed or fail. Secondly, the state has made deliberate attempts to raise awareness and creating sensitisation towards both Emiratis and migrants. The state may also be apprehensive about any possible future conflicts between the citizenry and the non-citizen population, thus confidence-building measures between the two is important and the context of recent policy discussions, the government emphasises both coexistence and tolerance as core values in a demand that society respects Emirati culture and identity as well as other communities' identities.

¹⁵³ Barakat, Noorhan, Gulf News, 'An opportunity to express your love for UAE', June, 21,2016, p.1, Online. <gulfnews.com/uae/government/an-opportunity-to-express-love-for-uae-1.1849968>

4.3.4. Formation of the Ministry of Tolerance and Co-existence

The preceding part of the chapter has sufficiently displayed the changed attitude of the Emirati state towards the social inclusion of its immigration population. The state has been making consistent efforts to propagate the ideas of tolerance, celebrate cultural diversity, eradicate cultural, religious intolerance within its population, further, to reaffirm its commitment it has established the Ministry of Tolerance and Coexistence in 2016. The Ministry has placed greater emphasis on creating a liberal society, unity and proclaimed 2019 as 'The year of Tolerance' by formulating a framework including seven pillars that aim to cement the values of tolerance in the community, education, workplace, and culture.¹⁵⁴

An overview of Emirate's changed attitude towards social, cultural inclusion of its immigrant population, especially Indian, could be seen partly as a reaction to the criticism of several international, economic, and institutional forces; partly on account of its dedicated effort to project itself as an immigrant friendly destination. If one contextualises the region, i.e., Arab Gulf Countries, UAE has certainly taken a lead in transforming its approach which is more inclusionary, whereby opportunities of social, cultural exchange and religious freedom have been given to the Indian workforce. Another striking feature of the immigrant policy of UAE is represented through social awareness campaigns aimed towards sensitising its Emirati population and integrating its foreign population.

Today, migrants are recognised as vital part of the society and are often mentioned in official dialogues. Of course, this policy trend does not mean that migrant-related labour issues, uneven access to state sponsored services, disparity against non-citizens is going to be resolved. Most importantly its HIV screening programme under the Communicable disease

¹⁵⁴ UAE, Ministry of Economy Website, Our participation in government initiatives, 'Year of Tolerance', Online. www.moec.gov.ae/en/-/en/year-of-tolerance-1

law, embedded into the basic structure of its immigration policy, an issue which has led to precarious positioning of the Indian workers in the host state. The next part of the thesis shall explore the positioning of the Indian workers in the host state, the recent efforts of the federal government to conform its labour laws with international guidelines and further identify ability of the host state to provide social, health security cover to its Indian immigrant population.

Chapter 5: UAE's Social and Health Capability as a Host State

The fifth chapter of the thesis attempts to evaluate the positioning of the foreign labour population in the Emirati labour market, its future growth amid domestic economic growth. The chapter further analysis the potential of the United Arab Emirates (UAE) as a host state to create an equilibrium between its economic and public health interests while creating rights-based policy framework for the HIV infected labour migrants in view of its healthcare fundament and fiscal abilities.

The first part of the chapter explores the changes in the Emirati labour market, owing to its efforts to modernise into a diversified economy, entailing effects on the legal framework, especially in the sphere of labour law that have been initiated by the Emirati federal government. The second part of the chapter explores the need for the social growth of the foreign workers, plausible rationales behind policy action of the state to restrict the entry, residence of infected migrants and analysis of the health infrastructure and fiscal strength of the UAE to provide for a rights-based framework for its infected migrant population.

5.1 Characteristics of the Emirati Labour Market

The positioning of the nationals and the expatriate workers within the Emirati labour structure can be best explained through the segmented labour market theory,¹⁵⁵ which is premised on the assumption that the host state is in constant need of foreign workers and the local market is segmented through a division between employment opportunities for

¹⁵⁵ Grubanov-Boskovic & S., Natale, F., " Migration in a segmented labour market" EUR 28731, 2017, ISBN 978-92-79-71867-0, doi:10.2760/213154, JRC 107601.

citizens and foreigners. A close look at the nation's labour market would reveal that its nationals have traditionally been disproportionately represented in the public sector, while the immigrant population has been employed in the lesser regulated private sector. The wages of the foreign labour force were conventionally determined vis a vis the opportunity cost in their home countries and not by market forces in the host state.¹⁵⁶ The overall working conditions also favoured the citizen population, in terms of lesser working hours, defined salary structure, social security and pension benefits.¹⁵⁷ Many citizens also benefitted from the federal legislation that specifically forbade the expatriates and foreign companies to exclusively own business without a local partnership,¹⁵⁸ thus, making it one of the highest per capita income nations.¹⁵⁹

The exploration of the contemporary functioning of the Emirati economy and labour market would reveal several key issues that the nation faced by the turn of the twenty first century about the dwindling employment avenues for its nationals. The country's public sector found itself to be overstaffed and incapable of providing employment to its citizens. For the first time since the oil based economic boom, the state was struggling with involuntary unemployment.¹⁶⁰ While the private sector was growing at a moderate pace, yet several impediments such as lack of skills and the inadequacy of salary disincentivized citizen participation in this sector.¹⁶¹

¹⁵⁶ Al Awad, Mouawiya, "The Cost of Foreign Labour in the United Arab Emirates", Zayed University, Working Paper- U-WP-2010-001, July 2010, print

¹⁵⁷ Heard-Bey, Frauke. "The United Arab Emirates: Statehood and Nation-Building in a Traditional Society." *Middle East Journal* 59, no. 3 (2005): 357–75. <http://www.jstor.org/stable/4330153>

¹⁵⁸ UAE Federal Law No.8, 1983, Chapter -2, Article 10

¹⁵⁹ World Bank national accounts data, and OECD National Accounts data files; 2021.

Online. <[www://data.worldbank.org/indicator/NY.GDP.PCAP.CD?end=2020&locations=AE&start=1975&view=chart](http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?end=2020&locations=AE&start=1975&view=chart)>

¹⁶⁰ Richard Shediak & Hatem Samman "Meeting the Unemployment Challenge in the GCC The need for a Change", May 2010, Online. - efaidnbmnnnibpccjpcgiclfndmkaj/www.iqpc.com/media/8251/10415.pdf

¹⁶¹ Ahmed Al-Ali, Jasmin, "Emiratization in the Local Labor Force of the UAE: A Review of the Obstacles and Identification of Potential Strategies", Victoria University School of Management, Online. <www.anzam.org/wp-content/uploads/pdf-manager/2044_ALALI_JASIMAHMED.PDF>

This kind of overstaffing in public sector had just not been a challenge for Emirates but also for other Arab states which had similar economic and demographic characteristics. To respond to these challenges, the Emirati federal government made several reforms, investments in various education and skill development programs to address the underlying human capital deficit. It also managed to develop its education systems to match the skill-oriented employment opportunities for its nationals by creating higher education institutions, encouraging foreign universities to establish campuses and by granting scholarships to nationals to acquire overseas qualification.¹⁶² Apart from its policy focus on skill-based development, it also eased the employment access for citizens in the private sector. For instance, an employment reservation system was put in place by the federal government for citizens in commercial establishments having more than 50 (fifty) workers.¹⁶³ UAE's 'Projects of the 50' has also set out an ambitious target to invest 6.3 billion USD for creating 75,000 new jobs in the private sector by the year 2025.¹⁶⁴ The Emiritisation of labour market was also essential for social and political reasons, to prevent public resentment and to bridge the gap between the human capital needs of the private sector and the need to address unemployment of the citizenry. Thus, by creating preferable work conditions , imparting requisite skills , the Emirati state aspires to make transitions to the collective mindset away from the preference for public sector jobs. The efforts of the government to increase citizen participation in the private sector, attempts to transform its image globally has also led to several labour reforms that benefit the foreign population, explored in the later part of the chapter.

¹⁶² Ibid

¹⁶³ UAE Ministerial Decision No. 279 of 2022, Article – 2

¹⁶⁴ UAE Federal Government, First Set of Project of the 50, Nov 2021, Online. : <www://u.ae/en/about-the-uae/initiatives-of-the-next-50/projects-of-the-50/first-set-of-projects-of-the-50>

5.2 Economic Diversification of the UAE market

The Emirati economy is the second largest in the Middle East and like other states in the region, it has historically been sensitive to changes in the oil prices as its non-oil sectors have suffered from systemic weaknesses, such as lack of capital, innovation, technology, and knowledge.¹⁶⁵ Most of country's non-petroleum commercial activities also emanated from the oil sector since the 1970s.¹⁶⁶ The debate around economic diversification began during the mid-1980's, when the newly created Emirati federation was faced with its first economic recession, on account of dwindling oil prices.¹⁶⁷ The over-dependence of Emirates on its oil income was also demonstrated after oil price collapse in 2014, which halved the oil income for the state in 2015-2016 and decreased its per capita GDP by more than 11 (eleven) percent.¹⁶⁸ The sudden depression also served as a reminder to the state of its over-reliance on the oil-based resources and of the non-diversified structure of its economy in comparison to other developed non-Arab states.

To appropriately respond to this challenge, the federal government in 2014 formulated the UAE Vision 2021, which aimed to transform itself into a diversified economy that is skill and knowledge intensive to promote sustainable growth even after the depletion of short-lived oil resources. The richest states of Dubai and Abu Dhabi have gained immensely from the diversified changes, at the same time the economically deficient states in the Northern part of the country such as Ajman, Fujairah and Ras Al Khaimah have also received

¹⁶⁵ Schilirò, Daniele, "Diversification and development of the United Arab Emirates' economy", *Journal of Applied Economic Sciences*, Vol: VIII(2), August 2013, Online.

<www.researchgate.net/publication/256378376_Diversification_and_development_of_the_United_Arab_Emirates'_economy>

¹⁶⁶ Central Bank of United Arab Emirates "Central Bank Annual Report", 2015 Online.

<www.centralbank.ae/en/index.php?option=com_content&view=article&id=100&Itemid=329>

¹⁶⁷ Khandelwal, Padamja et al, "Economic Diversification in the GCC: The Past, the Present, and the Future", Institute for Capacity Development and Middle East and Central Asia Department, Ref: SDN/14/12, December 2014, Online.

<www.imf.org/external/pubs/ft/sdn/2014/sdn1412.pdf>

¹⁶⁸ Bank Audi, "The Challenge for further economic diversification amid the plunge in oil prices", UAE Economic Report, Jan 7 2016.

financial impetus from the federal government for the growth of its service and manufacturing sectors, which has further increased the labour demand in these regions.¹⁶⁹ As the seven Emirati states are distinctive in terms of their population, geography and fiscal resources, such diversification efforts have helped individual states to develop their regional economies by employing resources to make additional contributions to the national Gross Domestic Product (GDP).

With UAE's diversification and the consequent integration of its domestic economy with the global market led to flux of investment in various sectors such as tourism, manufacturing, health, and construction, which have greatly contributed towards the new employment opportunities for semi-skilled, non-skilled workers in the private sector that have been mostly filled by the foreign workers. Today, Emirates is a diversified economy, where the non-oil sectors form 72 percent of the total GDP¹⁷⁰ and the changes in the composition of employment has shown an increased demand for labour to drive its economic progress. Its labour engagement has steadily grown, the recent statistics released by the Emirati federal government reveals that the participation increased to 76.4 percent in 2021, as compared to the preceding year (75.7 percent) and the graph seems to be only moving upwards.¹⁷¹

5.3 Globalisation and Legal Reforms of the UAE Market

Economic diversification cannot materialize on its own without making the geographical borders more porous for business, therefore, globalisation can be regarded as an intrinsic part of economic diversification. Globalization, as a comprehensive term can be

¹⁶⁹ Annual Economic Report 2016. Ministry of Economy UAE, 2016, Annual Economic Report 2016, print

¹⁷⁰ Ibid

¹⁷¹ International Labour Organization, ILOSTAT Database, "UAE Labour Participation", June 2022, p.2, print

explained as set of social, economic, and political changes that equip the state to move businesses, investments both outwards and inwards. To attract foreign investments; create business-friendly environment, UAE made several recent shifts in its legislative framework. Between 2015-2018 alone, it made extensive amendments to its Companies Law, Labour Law, Arbitration and Bankruptcy law. In June 2021, the federal government even revamped its foreign investment laws by allowing 100 percent stake of foreign entities in UAE's commercial establishments.¹⁷² These reforms have helped UAE to become the sixteenth best country in the ease of doing business index in the 2019, top amongst all Arab states.¹⁷³

The Vision 2021 document of the state has also emphasized upon the need to shift from cultural, social, and political isolation towards a modern society.¹⁷⁴ This would require the state to make social investments for its workforce, which goes beyond the physical protection of foreign workers¹⁷⁵ but also their social and physical wellbeing.

The federal government introduced new UAE Federal Labour law with effect from February 2022, to modernise labour legislation and made changes by bringing significant protection against discrimination based on religion, race, class, ethnicity, protection against unequal treatment and pay at workplace.¹⁷⁶ The federal government through its Ministerial Resolution No. 318 of 2022 Concerning Bank Guarantees and Employees Protection Insurance Scheme directed employers to either purchase health insurance or to keep a bank guarantee for each of its foreign worker. Further, the state has introduced effective safety measures at workplace through Article 13 of the new labour law on the Regulation of Labour Relations

¹⁷² UAE Federal Decree Law 26/2020, Article 1

¹⁷³ UAE Ministry of Economy, Ease of Doing Business, Online. : <www.moec.gov.ae/en/-/ease-of-doingbusiness#:~:text=>

¹⁷⁴ UAE Vision 2021, UAE Government portal, "National Agenda 2021", 2014

¹⁷⁵ Hanieh, Adam. "States of Exclusion: Migrant Work in the Gulf Arab States." In *Just Work?: Migrant Workers' Struggles Today*, edited by Aziz Choudry and Mondli Hlatshwayo, p.41. Pluto Press, 2016., Online. doi.org/10.2307/j.ctt194xgtm.7.

¹⁷⁶ UAE Federal Law Number 33 of 2021

which mandates the employers to make appropriate arrangements for providing safe and hazard free environment to its workers.

In November 2020, the federal government introduced Federal Decree Law No. (15) of 2020 Amending provisions of the Federal Law No. (3) of 1987 to liberalise its legal and social environment. These measures included foreign worker's right to apply family and inheritance laws of their home countries, decriminalising alcohol consumption, and live-in relationships. While UAE rarely invokes Sharia laws but its presence within the Emirati legal system creates many ambiguities for expatriate workers and businesses. These amendments also reveal the weakening influence of Sharia laws in the country and exhibits the intention of the federal government to dilute religious laws, on account of its growing foreign population.

These measures by the Emirati state have different set of rationales. First, is the aspiration to boost its global image as a progressive state to attract foreign workers and investment. Second, its attempt to organise the private sector on account of the growing participation of citizens in it, and lastly its recognition of the increasing vulnerability of the expatriates at the workplace. The implementation of mandatory health insurance of workers, their safety and favourable labour legislation are highly advantageous, especially for Indian workers, who have conventionally faced systemic abuse at the hands of employers across Emirates. But an important question that poses the state at present is its ability and willingness to contribute towards the social protection, health security and holistic human development of its foreign workforce.

5.4 Social and Human Development of UAE's Foreign Workforce:

The recent attempts of the Emirati federation to globalise and diversify its economy has led to a growing demand for expatriate workers, which has also presented an array of

challenges, one of which is the social growth and human development of its large foreign worker population. Some of the changes in state's attitude have also extensively discussed in preceding Chapter 4 of this thesis. The successful foundation of the diversification and modernity of the country's economy can be assessed by the social, economic and health trajectories of its working population and the presence of a comprehensive welfare system that is a necessary foundation for a healthy and happy society in which every individual, whether citizen or expatriate can contribute to UAE's progress. The social growth of the population was recognised in the first developmental plans of the Emirati federation in the 1970's.¹⁷⁷ Even in the 1990's, social and human development remained a high priority for the state, combined with initiatives for the inclusion of Emirati women and expatriate workers for the creation of a favourable environment that empowers them to generate their full human potential.¹⁷⁸ Similarly, the cornerstone of the 2021 vision document also aims at improving the productivity of country's workforce.

While the state has displayed its intentions to support and protect its foreign workforce against health hazards, discrimination at workplace, other forms of non-contagious diseases through employer-sponsored insurance cover, yet it has desisted from making any attempts to review its Communicable disease law pertaining to travel restriction and residence of foreign workers infected with HIV.¹⁷⁹ The Emirati government has remained largely silent towards the demands, recommendations, and guidelines of global organisations on this issue. The core to these guidelines is the necessity to promote equality, promotion of public health, and the formulation of domestic policies to mitigate the impact on its

¹⁷⁷ Christopher M. Davidson, "The United Arab Emirates: A Study in Survival, May 2003, p.169, Online. <[www://hdl.handle.net/10023/13898](http://hdl.handle.net/10023/13898)>

¹⁷⁸ WAM "New avenues for UAE women", Abu Dhabi, Walkalat Anba Al- Imrat: UAE News Agency, 17th May 2001

¹⁷⁹ Federal law No. 14 of 2014, replaced by Federal Law No. 27 for the year 1981

population, while making sure that it does not clash with the freedom of movement, residence of its foreign workforce. Thus, the policy focus of UAE as a host state should aim at meeting its growing labour demand, at the same time maintaining low prevalence of the HIV.

The human rights bodies and global organisations have made persistent recommendations to the country to lift its virus-based restrictions and the debate revolving around the virus-based restrictive policies in the Emirates have been ongoing from the early 2000's. Although, no official statements have been made by the Federal government or its officials to uphold its policy action, but these measures can be justified on three predominant grounds: First is the perceived threat to public health and increased risk of virus exposure. The second being the ability of the health infrastructure of the host state to accommodate the healthcare demands from the infected foreign population. The third justification being economic, which regards mandatory HIV screening as a cost-effective method in comparison to the long-term fiscal commitment towards the treatment, therapy of foreign workers. The following part of the chapter analyses the rationales of these arguments and whether they still make a valid case for the Emirati government to continue the imposition of its restrictive policies.

5.5. Rationales behind mandatory testing:

5.5.1 Impact on Public Health

In the initial phase of the virus outbreak, when reliable HIV testing was made available to the public, a meeting of Directors of World Health Organization's Collaborating Centres was convened to discuss the recommendation to member states about the mandatory testing and certification of international travellers. The committee's concluding decision was against virus testing of travellers and immigrants, as it could not act as a deterrence for any future

growth of the virus, especially in those countries where it was already prevalent.¹⁸⁰ Interestingly, the committee also observed that such restrictions were unreasonable as per International Health Regulations (IHR), further substantiating that there was no support for testing in any global guidelines during this phase. World Health Organisations' Regional Office for Europe again reiterated this contention in 2002 and explicitly rejected the public health argument.¹⁸¹ Both these WHO recommendations have since then been used as a leading ground by civil society groups and global organisations in their campaign against virus-based restrictions on movement or residence of People living with HIV (PLHIV).

Time and again WHO's member nations have disregarded its advisories, while implementing their public health policies. Apart from the HIV related restrictions that have been imposed by 48 members states at present,¹⁸² its temporary recommendation against international travel restriction during the Ebola outbreak, H1N1 influenza were also ignored by many states.¹⁸³ While these recommendations are not enforceable under the international law, yet they are focussed to support the normative weight of WHO's authority in the sphere of global health governance, further, to prepare a basis of accountability. The organisation made some recent efforts to assure greater compliance, in October 2015, WHO's Director-General called for mechanisms which could fix accountability under IHR, including sanctions, yet these efforts of the organisation have not yielded any results.¹⁸⁴

¹⁸⁰ Leonard J. Nelson "International Travel Restrictions and the AIDS Epidemic" *The American Journal of International Law* Vol. 81, No. 1 (Jan., 1987)

¹⁸¹ Regional Committee for Europe, 52nd session. (2002). Fifty-second Regional Committee for Europe: Copenhagen, 16–19 September 2002: resolution: scaling up the response to HIV/AIDS in the European Region of WHO. World Health Organization. Regional Office for Europe. Online. <apps.who.int/iris/handle/10665/343856>

¹⁸² UNAIDS Press Release, 'UNAIDS and UNDP call on 48 countries and territories to remove all HIV-related travel restrictions, 27th June 2019

¹⁸³ World Health Organization (2009) No rationale for travel restrictions. World Health Organization. Online. <www.who.int/csr/disease/swineflu/guidance/public_health/travel_advice/en/>

¹⁸⁴ Tom Miles, States could be sanctioned for public health failings -WHO boss, October 20,2015, Reuters, p.1

While it is true that legislative and policy measures regarding travel and residence restrictions are subject to state sovereignty, but states should not turn oblivious to their moral duties and obligations towards international law and global rights framework. Unless there are no compelling, evidence-based reasoning for differential treatment of non-citizens, such restrictions should be avoided.¹⁸⁵ These non-scientific regulations mostly stem from infodemic¹⁸⁶ leading to politicized responsive policies, driven by elements of fear, prejudice, and taboos. The state action in terms of law and policy based on non-scientific considerations can entail ineffective results and may turn counterproductive, as it may create a false sense of security amongst citizens and dissuade them from safer behaviour. In shaping effective governance and public health outcomes, science, political commitment, and policy-making are intricately connected elements. Science serves as the foundation for evidence-based decision-making, providing insights into the causes and solutions to complex challenges. The synergy between these components is crucial, with political commitment translating scientific findings into actionable policies and strategies. This harmonious integration ensures that decisions are grounded in evidence, widely supported, and effectively executed, contributing to positive societal change. In this regard several changes can be formulated to transform the institutional setup of the host nation to enhance the quality of risk based decision making, which shall be discussed in the concluding part of this thesis.

5.5.2 Health infrastructure of the Emirati Federation

Emirates has been ranked as the twentieth most effective healthcare systems in the world in 2021.¹⁸⁷ It boasts of its comprehensive state sponsored health system, regulated

¹⁸⁵ Jeffrey V Lazarus et al, "HIV-related restrictions on entry, residence and stay in the WHO European Region: a survey", *Journal of International AIDS Society*, 2010,13:2, Online. online.library.wiley.com/doi/full/10.1186/1758-2652-13-2

¹⁸⁶ Infodemic has been defined by WHO as- too much information including false or misleading information in digital and physical environments during a disease outbreak. Online. www.who.int/health-topics/infodemic#tab=tab_1

¹⁸⁷ Avik Roy, "United Arab Emirates: #20 in the 2021 World Index of Healthcare Innovation", June, 25,2021, freopp.org/united-arab-emirates-freopp-world-index-of-healthcare-innovation-5ccc1512303ff#:~:text=Introduction,its%20low%20public%20spending%20growth_

both by the federal, provincial governments and its fast-growing private healthcare system which is constantly adding momentum to handle the increased demand on account of influx of foreign workforce. The government healthcare entities such as the Ministry of Health, Dubai Health Authority, Abu Dhabi Health Services Company, Health Authority of Abu Dhabi have partnered with foreign healthcare establishments and made quality health care more accessible to its population. The economic diversification, initiatives to attract foreign investment can be seen in the health sector as well. It was the first area in which the federal government allowed 100 percent foreign ownership, enabling it to garner foreign investment of 784 million USD between August 2016 and August 2021.¹⁸⁸

The Vision Document 2021 also made a commitment that the state “shall invest continually to build world-class healthcare infrastructure, expertise and services in order to fulfil citizens’ growing needs and expectations”¹⁸⁹ and further pledges to “advance nations’ health infrastructure to manage epidemics and pandemics”. The impact of these policy commitments was also reflected in the remarkable progress that the state made during the first phase of Covid 19 outbreak. The swift establishment of testing centres, usage of algorithms for identification and treatment of infected population, institutional isolation, successful reopening of economy and speedy research response to the newer variants of the virus are some of the successes of the country’s progressive healthcare. Both FREOPP World Index of Healthcare Innovation and Bloomberg's Covid Resilience have ranked UAE as one of the best performing nations in terms of managing the Covid-19 pandemic.¹⁹⁰¹⁹¹

¹⁸⁸ Jakob Kisser, Investment Opportunities in the UAE, 2021, Online. www.slg-strohallegalgroup.com/investment-opportunities-in-the-uae/

¹⁸⁹UAE government portal, About UAE, Vision 2021 & health, “Scope of Vision 2021 for health”, Updated 14th April 2022, Online. <u.ae/en/about-the-uae/strategies-initiatives-and-awards/strategies-plans-and-visions/strategies-plans-and-visions-untill-2021/vision-2021-and-health>

¹⁹⁰ Avik Roy, FREOPP World Index of Healthcare Innovation “Measuring the COVID-19 Policy Response Around the World”, April 5, 2021,

¹⁹¹ Sahim Salim, “UAE’s ranks top among 53 countries when it comes to Covid response and resilience”, Khaleej Times, 2nd Feb, 2022 Online. <www.khaleejtimes.com/coronavirus/covid-19-uae-is-worlds-best-place-to-be-in-pandemic-ranked-first-for-resilience>

The long-term vision of the state also exhibits the political will of the federal government to upgrade and expand its health infrastructure. While the 2021 document was still underway, the federal government has reaffirmed its commitment to the health sector in its recently launched Vision 2071 plan which strives to improve population access to healthcare, making the country as the topmost destination for medical tourism in the world by effecting affordable healthcare.¹⁹² Country's current health infrastructure also appears to be robust, the US based Medical Tourism Association has rated UAE as the best destination for medical tourism in the Arab region. Its two largest cities, Dubai and Abu Dhabi have been ranked as six and ninth best cities by Medical Tourism Index 2020-21, which is testament to the country's progressive healthcare infrastructure.¹⁹³ The inventive usage of artificial intelligence and robotics are some of the reformist projects that the state has presently undertaken. It is supported by immense fiscal and technological resources and has been constantly looking at other inspiring jurisdictions for creation of a legal framework for the healthcare sector; to adhere to the best practices of quality medical care. The efforts of the Emirati government to collaborate with foreign healthcare organisations has resulted in improvements in the health sector, yet it has desisted from partnering with international civil society groups and UN agencies in strengthening its response to sexually transmitted diseases, such as HIV, AIDS through exchange of global experience and coordination in planning and program implementation.

¹⁹²UAE Federal Govt, Press Release, Mohammed Bin Rashid Launches Five-Decade Government Plan UAE Centennial 2071, Nov 22, 2022, Online. <www://u.ae/en/about-the-uae/strategies-initiatives-and-awards/strategies-plans-and-visions/innovation-and-future-shaping/uae-centennial-2071>

¹⁹³ Global Medical Tourism Index issued by the International Health Care Research Center "UAE ranked top medical tourism destination in GCC", January 30, 2021, Online. <www.zawya.com/en/economy/uae-ranked-top-medical-tourism-destination-in-gcc-vyirmrk7>

The UNAIDS Data 2021 puts the total number of HIV infections in UAE at an extremely low figure of 461,¹⁹⁴ all of whom have been receiving state sponsored treatment. Since 2008, the Federal government has been discussing the promulgation of laws to prevent discrimination against infected nationals,¹⁹⁵ yet it has not brought any specific regulation in this regard. The intent of the government to protect PLHIV is missing in its legal framework, yet it has been able to safeguard the interests of its infected citizens by providing comprehensive array of services ranging from financial support, free treatment, therapy, counselling and right to complete retirement.¹⁹⁶ In this context, a notable disparity exists with regard to healthcare access and social protection between citizenry and immigrant population. Despite amendments in the labour laws of the UAE, many immigrants are left without adequate safeguards with respect to healthcare coverage for HIV. Limited access to legal representation and language barriers further exacerbate these challenges. The shortcomings in the legal framework contribute to a climate where the rights and well-being of immigrants may be compromised, hindering their ability to fully participate in and contribute to the society and economy of the host nation.

5.5.3 Economic Consequences of mandatory HIV screening

At the initial outbreak of the virus, mandatory testing of all cross-border travellers became a popular and convenient method utilised by most nations to protect public health at a time when very little was known of the virus and its bodily impact. Another key reason behind this policy action was the attempt of states to avoid excessive cost of treatment and healthcare, especially for its expatriate population.

¹⁹⁴ Ibid

¹⁹⁵ Mitya Underwood, FNC to consider law against HIV discrimination, The National News, Oct 24, 2008, Online. <www.thenationalnews.com/uae/health/fnc-to-consider-law-against-HIV-discrimination-1.497309>

¹⁹⁶ "United Arab Emirates – Global AIDS Response Progress Report", United Nation AIDS, 2012, p.21

This argument was plausible, especially in the backdrop of the weak health infrastructure and financial stress that UAE faced in the early 1980's. Until 1982, the entire population received free healthcare regardless of their nationality status.¹⁹⁷ In that year, the oil revenues decreased by approximately 18.4 percent and the domestic inflation rose to more than 7 percent, thereby creating a fiscal burden on the government.¹⁹⁸ The lack of coordination and investment characterised the country's health sector during this period. Even by the end of the decade, the government expenditure on healthcare as a percentage of the GDP amounted to a meagre 1 percent.¹⁹⁹ To address the growing economic strain, the government attempted to reduce public healthcare expenditure and suspended free health services to its foreign population except for emergency, child, and maternity care. It was in this setting that the first restrictions regarding entry and stay of infected expatriate workers were enforced by the Emirati government.

The present-day condition about health infrastructure of the Emirati federation reveals that it has become potent over the years. The pertinent questions that confront the state today is the financial consequences of the periodical and mandatory HIV testing of its large foreign workforce. The contemporary analysis reveals that the cost of periodical testing of foreign workers in the country exceedingly outweighs the cost of anti-retroviral treatment, as almost 90 percent of funds are utilised for virus screening and a meagre 3 percent for treatment, apart from the undocumented expenditure towards isolation, deportation of infected expatriates and indirect cost related to productivity loss.²⁰⁰ The economic

¹⁹⁷ Helem Chapin Metz, et al. "Persian Gulf States: A Country Study", 1993, Washington: GPO for the Library of Congress, Online. <[www://countrystudies.us/persian-gulf-states/83.htm](http://www.countrystudies.us/persian-gulf-states/83.htm)>

¹⁹⁸ Rizvi S.N , "From Tents to High Rise: Economic Development of the United Arab Emirates"; Oct 1993, Vol. 29, No. 4 p. 667

¹⁹⁹ Human Development Report, United Nations Development Programme, 1994 p.132.

²⁰⁰ "Position Paper on Mandatory HIV Testing in the Arab States", International Labour Organization- Regional Office for the Arab States, 19th December 2014

implications of testing are complex, there is very little evidence to suggest that the periodical screening is a cost-effective intervention.²⁰¹ Therefore, a comprehensive analysis of the existing policy and exploration of other alternatives, in the backdrop of economic, societal and health impact on the foreign labour population needs to be made by the UAE. This form of exploration would also assist the state to identify measures that would not only help it cut wasteful healthcare expenditure but also to employ necessary resources for creating a support-structure for infected foreign workers. This view is also supported by the International Labour organisation (ILO) which recommends that alternative policy measures should be evaluated by states that have imposed continuous travel restrictions on the movement of infected workers across borders.²⁰² The United Nations AIDS Gap report, 2014 also stresses on the assessment of the cost and societal effects of regulations concerning mandatory HIV testing and supports the access to HIV related health services by the foreign labour force.²⁰³

Even as UAE remains a low-prevalence country, with a relatively stable number of new HIV infections each year, minimal mortality, yet its federal government perceives it as a major threat on account of increasing growth of virus in the Middle Eastern region, which is among the top two regions in the world in terms of newer infections.²⁰⁴ Further, the state is concerned about the rapid changes in cultural values, increasing population of young adults, their changing sexual norms and increased leisure tourism in the country contributing to a heightened risk of HIV.²⁰⁵ The Arab Gulf nations have also lagged behind in achieving the 90-

²⁰¹ Medu, O., Lawal, A., Coyle, D. et al. Economic evaluation of HIV testing options for low-prevalence high-income countries: a systematic review. *Health Econ Rev* 11, 19 (2021). Online. doi.org/10.1186/s13561-021-00318-y

²⁰² Position Paper on Mandatory HIV Testing in the Arab States”, International Labour Organization- Regional Office for the Arab States, 19th December 2014, p.10

²⁰³ Ibid

²⁰⁴ Ghanem K.G, HIV and other sexually transmitted infection research in the Middle East and North Africa: promising progress? *Sex Transm Infect.* 2013; 89: iii1-4

²⁰⁵ Ibid

90-90 targets set by UNAIDS.²⁰⁶ This calls for important steps in the near future for strengthening virus response, scaling-up response to this growing epidemic, developing new national, regional strategies, increased political will in the regions to address the HIV epidemic.

The persistent efforts of the Emirati state to diversify itself into a modern, globalised economy shall continue in the coming years leading to a steady increase in the demand for expatriate labour. The policy actions of the Emirati federal government, ranging from amendments to its labour laws, modernisation of workplace, and compliance with international labour standards reflect its understanding of the challenges about the future demographic shift. The expatriate population should not be looked upon merely as a resource but also as an important driver for nation's growth.

The successful implementation of a human development policy and social growth of the foreign population in the UAE, needs to work together with industrialization, urbanization, and modernization. The future increase in the foreign labour participation would also create new demands in terms of healthcare services. In this context, even though the Emirati government has made the healthcare available through mandatory employer-based insurance schemes to its foreign workers, yet it has made no efforts to revisit its policy with respect to communicable diseases such as HIV, AIDS and there seems to be a huge divide in terms of public resource access between nationals and non-nationals.

Extending insurance cover for communicable diseases fosters a more inclusive and equitable healthcare system. In the case of HIV, a chronic condition that requires consistent medical management, comprehensive insurance can facilitate timely access to testing,

²⁰⁶ Saba H.F, 'Characterising the progress in HIV/AIDS research in the Middle East and North Africa. *Sex Transm Infect.* 2013; 89: iii5-iii9, Online. <doi.org/10.1136/sextrans-2012-050888>

treatment, and support services for affected migrant workers. The inclusive insurance coverage promotes early detection and effective management and would reduce stigma associated with certain communicable diseases. This form of a policy enactment which focusses on healthcare access rather than deportation recognizes the complexity of public health challenges and underscores the importance of a humane and evidence-based approach to state's immigration policy.

The analysis of rationales behind the restriction on movement and residence of infected foreign workers reveals that the same are premised on unfound and outdated grounds. Additionally, the policy focus on screening has led to disproportionate expenditure on periodic testing, which outweighs government spending on HIV related treatment and services, requiring fresh evaluation and exploration of an alternative policy at a time when the state is faced with more alarming public health challenges concerning non-contagious diseases creating economic implications and productivity loss.

Over past decade, the UAE has experienced a remarkable enhancement in its fiscal capacity. Economic reforms undertaken during this period have led to a significant increase in income and a notable reduction in reliance on the oil sector. This economic diversification has resulted in a more stable, steady, and secure financial foundation, providing the UAE with the resources needed to strengthen its health infrastructure. With a more robust financial position, the healthcare system is better equipped to support and advance public health initiatives.

This newfound financial strength positions the UAE favorably to consider alternative policies related to public healthcare access for its immigrant population, irrespective of their nationality status. By doing so, the country can position itself as a progressive, modern, and

labor-friendly destination. This approach aligns with global guidelines and the goals outlined in its Vision documents concerning health and epidemic management. Such a strategic shift not only enhances the overall well-being of the population but also contributes to the UAE's global standing as a forward-thinking and inclusive society.

Chapter 6 :Comparative assessment of UAE’s immigration law and policy

The Rapid increase of the migration flows from India to the UAE in the present times has no precedence. Both the flow of migration and its pattern have become more complex and diversified. Chapter-3 of the thesis has sufficiently demonstrated the inherent vulnerability of the migrating Indian workers. In such conditions, if the holistic social protection in the host nation is missing or otherwise suffer from discriminatory patterns, it has an adverse impact on the positioning of the Indian immigrants. While the preceding Chapter-4 and 5 have detailed several measures both in terms of changed attitude and legislative intent of the Emirati state to strengthen the social status, working environment of the Indian immigrant population, conforming to the broader global guidelines about labour welfare, but the state has resisted in applying the same standards in providing holistic health and social protection to the immigrant workforce.

The present chapter offers a backdrop for legislative action, policy for addressing the healthcare needs of Indian migrants, as a basis for efficacious response to HIV, in the context of cross-border migration. The contours of the policy and strategic landscape are presented, as a point of departure for ascertaining governance framework for Indian migrants. This chapter further provides summaries of international declarations, globally agreed framework relevant to health, migration, and HIV. It further explores the interaction between the international policy for migration and the national immigration, residency policy of the UAE.

6.1 International Migration Law and Policy

New international institutions were developed with diverse functions, ranging from operational support for migrants to monitoring compliance, and encouraging enforcement of

the new legal instruments. The International Labour Organization (ILO, established in 1919, specifically included in its mandate the 'protection of the interests of workers when employed in countries 'other than their own' because exploitative labour conditions were thought to constitute a threat to world peace. The United Nations High Commissioner for Refugees (UNHCR) was established by the General Assembly in 1950 to provide international protection for refugees, with the optimistic goal of completing its three-year mandate and then disbanding. In practice, its mandate has been progressively extended to cover not only refugees, but also internally displaced persons, stateless persons, and other groups in analogous circumstances. The International Organization for Migration (IOM) was established in 1951 in similar circumstances but with a different mandate, namely, to help European governments identify resettlement countries for 11 million people uprooted by the war, and other migrants, and arrange their transportation and integration in new homelands.

As with UNHCR, IOM's scope of activities has broadened significantly, making it the leading international agency to advance the understanding of migration issues, encourage social and economic development through migration, and uphold the human rights and wellbeing of migrants. It is an intergovernmental organisation outside the United Nations system, has a membership of 146 States. Along with these several other specialized bodies were also established concerning different aspects of international migration, for example, Human Rights Committee, and Migrant Workers Committee; these bodies play an extremely vital role in scrutinizing state action regarding migration and human rights abuse of migrant population.

International law contains a fairly detailed set of norms, principles, and rules relating to migration: a recent compendium of international migration law instruments, both hard and soft law but limited to universal instruments, labour law, nationality, statelessness,

trafficking, smuggling, international maritime law, state security, detention, international humanitarian law, refugee law, migration and development, diplomatic and consular protection, minorities and international trade law.²⁰⁷ Through this development we can deduce that there are frontiers of international migration law: first, the human rights, duties of persons involved in migration, as their specific rights and duties are elaborate in present-day human rights instruments; second the principles and standards deriving from State sovereignty, among which are the right to protect borders, confer nationality, safeguard national security, admit, expel non-nationals and combat activities that may adversely impact the state. The third pillar of international migration that is evolving over the years is law promoting cooperation and accommodation of uniform migration laws and policies to support the international movement of people. Any legal, political, and policy development of international migration law must be viewed in the context of these overreaching strands of international migration law.

6.1.1 Sources of International Migration Law and Policy

The sources of international migration law need to be recognised as per the development of international law in the context of migration. The international law of migration has gained its spirit and approach from the development of international law, as its subject matter has moved from state to individual, which also paved way for the development of International Migration Law. It has also gained substantiality from international treaty law and has developed in three layers at universal, regional, and bilateral levels. At the universal level, there is a vacuum for international treaties governing diverse aspects of migration, this level mostly relies upon internationally agreed principles of human rights and migration

²⁰⁷ Chetail, V. Sources of international migration law. In B. Opeskin, R. Perruchoud, & J. Redpath-Cross (Eds.), *Foundations of International Migration Law* (pp. 56-92). Cambridge, 2012 Cambridge University Press, print

through various United Nations declarations that have gained the sanction in the eye of law. There are few multilateral instruments that have gained force and sanction under international treaty law: the Convention relating to the Status of Refugees (1951), amended, and modified with its 1967 protocol; the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990) ('ICRMW'); the Protocol against the Smuggling of Migrants by Land, Sea, and Air.

A substantial portion of International Migration Law also derived from various human rights conventions developed over point of time. The Universal Declaration of Human Rights, 1948 has provided the foundational background for migration law. The major human rights treaties, such as the International Covenant on Civil and Political Rights (1966) ('ICCPR') and the International Covenant on Economic, Social and Cultural Rights (1966) ('ICESCR') are generally applicable to everyone, irrespective of nationality or statelessness. The ICCPR also enshrines tailored provisions that are particularly crucial for migrants, such as the right to leave any country and return to one's own country (art. 12) and due process guarantees on expulsion (art. 13). Among the specific human rights treaties, the International Convention on the Elimination of All Forms of Racial Discrimination (1965) is relevant to the highly passionate and xenophobic atmosphere that often surrounds migration. The Convention on the Rights of the Child (1989) provides guidelines for facilitating family reunification (art. 10) and ensuring the protection of refugee children (art. 22), while the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) and the International Convention for the Protection of All Persons from Enforced Disappearance (2006) prohibit States parties from returning a person to another State if there is a substantial

risk of torture or enforced disappearance²⁰⁸. Along with that the General Agreement on Trade in Services (1994) known as the 'GATS' also regulates a few areas of international migration laws and policy around the movement of persons for the supply of services, labour purposes, international transportation of labourers.

The universal legal framework governing migration thus consists of a wide range of multilateral treaties belonging to numerous branches of international law, including human rights law, refugee law, labour law, trade law, maritime and air law, criminal law, nationality law and consular law. The application of international instruments is subject to ratification, interpretation, and reservation instituted by the signatory state. Thus, a comparison between international migration law and national migration law and policy of the UAE must be analysed in the context of ratification, interpretation, and reservation moved by the UAE.

6.1.2 International Migration Law pertaining to People living with HIV:

International Migration Law has also been evolving in reference to the right to health of the migrant population and migrant labourers. The right to health has been recognized and established as a human right in all international human rights instruments. The "right of everyone to the enjoyment of the highest attainable standard of physical and mental health", as stated in Article 12(1)24 of the International Covenant on Economic, Social and Cultural Rights (ICESCR),²⁰⁹ is abbreviated as the "right to health". Several facets touching on the right to health and firmly related to its fulfilment are contained in the International Bill of Rights that is comprised of the UDHR (1948), the ICCPR (1966) and ICESCR (1966). They include the

²⁰⁸ Ibid

²⁰⁹ Article 12 must be read in conjunction with Article 2 of the International Covenant on Economic, Social and Cultural Rights. The latter states that each State party to the Covenant undertakes to take steps with a view to achieving progressively the full realization of the rights recognized in the Covenant by all appropriate means, including particularly the adoption of legislative measures. Nonetheless, the Committee on Economic Social and Cultural Rights General Comment No. 14 on Article 12 of the Covenant specifies that "progressive realization means that States Parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of Article 12"

rights to: food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition of torture, privacy, access to information, and the freedoms of association, assembly and movement.²¹⁰ Addressing migration health is a necessary precondition to full realization of the benefits of migration for those who migrate and for both countries of origin and destination.²¹¹ Good health is central to creating the capabilities that the poor need to escape from poverty. In other words, good health is not just an outcome of development – it is a way of achieving development. The right to health has a vital role to play in tackling poverty and achieving development – it lies at the heart of our struggle for a fairer, more humane world.²¹²

The Right to Health for the migrant population could also be traced from specific provisions of ILO and recommendations related to migrant workers specified in the previous part of the chapter 2 of the thesis. Article 23 and 24 of the Convention relating to the Status of Refugees 1951 also detail that the refugees also equally benefit from the subsequent development of international human rights law related to the right to health guaranteed under this convention and any other human rights conventions. Article 25(1) of the Universal Declaration of Human Rights 1948 affirms that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including” (but not limited to) “food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. The right to health recognized in Article 12 of the International Convention on Economic Social and Cultural Rights that the state has a

²¹⁰ B. C. A. Toebes, *The Right to Health as a Human Right in International Law*, Antwerp/Groningen/ Oxford, INTERSENTIA, 1999, p. 19, Online. <research.rug.nl/en/publications/the-right-to-health-as-a-human-right-in-international-law>

²¹¹ International Organization for Migration, *Mainstreaming Migration into Development Policy Agendas*, International Dialogue on Migration No. 8, IOM, 2005, Online. <publications.iom.int/books/international-dialogue-migration-no-8-mainstreaming-migration-development-policy-agendas>

²¹² Migration health is the health of those who migrate. See *Migration Health Report 2004*, IOM, 2004, p. 3

duty to eradicate all diseases and infirmity. The Convention against Torture and other Cruel Inhuman or Degrading Treatment or Punishment, 1984 also includes the migrant population who are subjected to cruel, inhuman, or degrading treatment or punishment based on their health and/or migration status, whether in a health care facility, detention centre, or other institution. T

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW)²¹³ provides for the right to equal treatment regarding access to social and health services for regular migrant workers and members of their family and nationals (Article 43 and 45 of ICRMW respectively). Further, there is Article 28 of the ICRMW that recognizes the right to emergency medical treatment for all migrant workers and members of their families regardless of whether their stay or employment is irregular. In recognizing only necessary emergency medical treatment, the Convention fails to guarantee access to preventive medical treatment, such as early diagnosis and medical follow-up as well as to palliative health services.²¹⁴ The Declaration on the Human Rights of Individuals Who are Not Nationals of the Country in which They Live²¹⁵ stipulates under Article 8, that aliens lawfully residing in the territory of a State shall also enjoy, in accordance with the national laws, rights such as the right to safe and healthy working conditions; the right to health protection, medical care, social security, social services, education, rest and leisure. Article 8 has been used to support the argumentation that human rights apply to non-nationals only as far as they are lawfully present. Nevertheless, Article 8 of the Declaration

²¹³ The Guide on Ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, International Steering Committee for the Campaign for Ratification of the Migrants Rights Convention, April 2009, Online. www.refworld.org/docid/4a09710a2.html

²¹⁴ Cholewinski R., Study on Obstacles to Effective Access of Irregular Migrants to Minimum Social Rights, Strasbourg, Council of Europe Publication, 2005, Online. www.coe.int/t/dg3/migration/arcHIVES/documentation/Legal_texts/5879-7-Effective%20access%20of%20irregular%20migrants%20to%20minimum%20social%20rights_en.pdf

²¹⁵ "Vulnerable Migrants have a Right to Health" in *Lancet*, 370, 2007, pp. 827-828.

cannot by-pass the interpretation of the ICESCR which affords economic and social rights to all persons regardless of legal status. Thus, it can be argued that the instruments confer the right to health not to merely citizens but also the non-citizen population.

The conception of the Right to Health becomes critically important with the migrant population being vulnerable and without any adequate legal support mechanisms. For example, with respect to the refusal to grant entry to migrants living with HIV, this may, in fact, be counterproductive to protecting public health. Given the nature of HIV infection, its significant presence in virtually every country in the world, the argument supporting the restriction on cross-border movement cannot prevent or slow down the spread of HIV within a country cannot be supported.²¹⁶ Arguably, a better public health solution would be to educate and advocate for ways to prevent the spread of the virus. Mandatory HIV tests simply force many carriers to hide their HIV status and with modern antiretroviral treatment, by keeping viral load at low levels. As mandatory testing can constitute a barrier to the access to health services, it contravenes the specific obligation of states not to limit or deny access to health services for all as provided for in international human rights instruments. Similarly, regarding avoiding economic strain on the host state, this arguably ignores the fact that infected migrants can work and are still an economic benefit to the state. This is especially true since improved medication has become cheaper, and life-expectancy has become longer. It is also noteworthy that in many instances the justification of avoiding excessive pressure on national health care resources is not used to impose blanket bans for persons with other medical conditions that require costly treatment. Both the afore-mentioned arguments have been elaborately discussed in the preceding Chapter-5. To conform with international human

²¹⁶ UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions, loc. cit. n. 58.

rights law, entry and residence restrictions based on health status should be applied on an individual basis, considering the real effect of excluding the applicant on public health grounds and the cost treatment would impose on the host state. Arguably, such restrictions on human rights would be objective and reasonable and would not be disproportionate and arbitrary as prohibited under the Siracusa Principles.²¹⁷

Similarly, the requirement to submit to virus screening infringes the principle of free and informed consent as a fundamental prerequisite and may leave the applicant without possibility of counselling or treatment. Furthermore, notwithstanding the discretion in terms of admitting infected migrants, discrimination based on health status or disability is contrary to international law not only if the aim is illegitimate or the means used are disproportionate, but also if a protected right or interest is affected. Particularly problematic is the situation of irregular migrants whose access to preventive, curative and palliative health services is often limited or denied. Legal obstacles to access to health services exist, for example, when health services providers are required by law to report to the authorities the presence of irregular migrants like in the case of the Emirates. Such requirement, therefore, must be eliminated so that national legislation may comply with international law.

Socio-economic conditions of migrants in the host country, including living and working conditions, physical and psycho-social environments, correlate directly to rates of long-term illness and chronic diseases. Familiarity with the culture and language of the host community is also a factor influencing migrating persons' health and utilization of health services. Cultural barriers include also different ways of viewing illness and the relationship

²¹⁷ Siracuse Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, observes that no limitation on the exercise of human rights shall be made unless provided for the national law of general application which is consistent with the Covenant and is in force at the time the limitation is applied.

between health care providers and patients.²¹⁸ Moreover, factors such as separation from family, as well as the social stigma of certain illnesses and the legal status of the person can negatively impact on a person's health status and result in increased risky behaviour.

Helping voluntary return²¹⁹ and reintegration of people living with HIV or with other health conditions requiring treatment and support may be particularly problematic if specific conditions are not met. Recently, a report on the conditions of migrants living with HIV in the Netherlands looked at various solutions and methods for sustainable return and reintegration and listed the following conditions as minimum ones: availability and easy access to ART in the home countries of migrant workers, sufficient income for meeting expenses towards treatment, care; supportive social network and can cope with possible stigma from society. The report concludes that such conditions can be assessed only by taking into consideration the individual's specific situation and the context in which the migrant would return.²²⁰ The report also suggests that any blanket restriction on the entry, stay of migrants would not only jeopardize their economic positioning but will also hurt the health status of the migrants.

6.2 UAE's Migration Law and Policy compared with International Migration Law

There are 35 million people living in the six-member countries of the Gulf Cooperation Council (GCC) (Saudi Arabia, Kuwait, Qatar, Oman, Bahrain, and the UAE); of which 17 million are migrants. According to Human Rights Watch (HRW) and the International Labour

²¹⁸ International Organization for Migration, Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments, International Migration Law Series No. 12, 2007, Online. publications.iom.int/books/international-migration-law-ndeg12-migration-and-right-health-review-european-community-law

²¹⁹ Voluntary return is the assisted or independent return to the country of origin, transit or another third country based on the free will of the returnee. Assisted voluntary returned (AVR) is the logistical and financial support to rejected asylum seekers, trafficked migrants, stranded students, qualified nationals, and other migrants unable or unwilling to remain in the host country. Glossary on Migration, loc. cit. n. 4. For an in depth discussion about what is voluntary return, see Health, Hope and Home? The possibilities and constraints of voluntary return for African rejected asylum seekers and irregular migrants living with HIV in the Netherlands, IOM, January 2009, at pp. 37-40.

²²⁰ J. Maiyo, et al, International Organization for Migration, 'Health, Hope and Home? The possibilities and constraints of voluntary return for African rejected asylum seekers and irregular migrants living with HIV in the Netherlands', 2009, Online. returnandreintegration.iom.int/en/resources/report/health-hope-and-home-possibilities-and-constraints-voluntary-return-african

Organization (ILO), migrant workers comprise about 95 percent of the UAE's workforce, and about half of its 4 million residents worked in the construction sector in Dubai or one of the other six emirates during the construction boom.²²¹ While the UAE has taken some several measures in terms of social integration of migrants and making the labour laws more robust, yet it is only a fraction of what is required. Such meaningful change will require effort from the UAE, but also from countries with the power to impose sanctions to stop human rights violations. Though the media has shed light on the plight of migrant workers, UAE's institutional restrictions hinder progress toward solutions, prohibiting researchers from documenting problems.

Systematic discrimination is exemplified by UAE's policies related to certain communicable diseases, for instance in 1998, the UAE screened the entire population for HIV/AIDS and deported all migrant workers, who tested positive.²²² There are several laws and regulations put in place to control the flow of foreigners entering and exiting the country's territory. Federal Law Number 6 of 1973²²³ as amended by Federal Law Number 13 of 1996 and Ministerial Decree Number 360 of 1997²²⁴ [the Immigration Law] holds the laws governing immigration regarding the entry, and residency of expatriates in the UAE. Additionally, UAE government passes several regulations about immigration under various ministerial decrees and orders, the most relevant of which, is Federal Law No. 14 of 2014 concerning state's communicable disease prevention law. The decrees have empowered the state to formulate policies for pre-arrival medical screening and mandatory periodical blood

²²¹ Human Rights Watch, Slow reform, 2010, Online. <<http://www.hrw.org/en/reports/2010/04/28/>>

²²² WHO, International Migration, Health, and Human Rights. Health and Human Rights Publication Series, Issue No. 4. World Health Organization (2003). Online. http://www.who.int/hhr/activities/en/intl_migration_hhr.pdf.

²²³ Federal Law No (6) for 1973 Concerning Immigration and Residence As amended By virtue of law 7 of 1985, Law 13 of 1996 And Federal Decree- Law No. 17 of 2017 1561466522.pdf (tlg.ae)

²²⁴ Executive Regulation of Entry and Residence of Foreigners Law and its Amendment, Government of UAE. RulesandRegulationsEnglish2.pdf (moi.gov.ae)

testing of foreign workers for the continuation of work permit and residency permit. The ILO has taken an unambiguous position in this regard by suggesting that mandatory virus testing of foreign workers violate their fundamental human rights and cannot be used as a tool for the prevention of the spread of HIV transmission or even for mitigating its impact. Furthermore, the organisation along with UNAIDS and International Organization for Migrants have been persistently campaigning for a framework that aims to dilute the provisions of mandatory medical screening of migrant workers for HIV.²²⁵

The availability of comprehensive retroviral treatment has also made it possible for infected workers to continue to live a normal life with the virus without any symptoms or without posing any threat of virus transmission. With proper support and care, the worker can continue to function and contribute to the workplace and the society. It is time for a global reawakening about HIV screening and differential treatment for people living with HIV.

The International migration law has evolved with the development of International human rights, comparative analysis in this chapter highlights huge gaps, inconsistencies between migration law and UAE's national policies concerning cross-border movement of HIV infected migrant workforce. While it is true that under international migration law, UAE may in its sovereign right impose restrictions on rights, in narrowly defined circumstances, if such restrictions are necessary to achieve overriding goals, such as public health, morality, public order and national security but the same needs to be least intrusive.

The preceding chapters of the thesis sufficiently revealed the attempts of the federal government to strengthen its labour laws, in addition, the Ministry of Labour has established offices in the Dubai and Abu Dhabi to facilitate the resolution of labour dispute cases. Further,

²²⁵ International Labour Organization ILO Regional Office for the Arab States; Position Paper on Mandatory HIV Testing in the Arab States, Online. www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/meetingdocument/wcms_330311.pdf

the state has also granted limited freedom to professional associations to raise work-related concerns, mandatory health insurance, lobbying with the government for redressal and to file grievances. These recent developments indicate a positive start but the gap between International Migration Law and UAE's communicable disease law Policy are far too big to be covered by small scale initiatives taken by the state.

A thorough analysis of UAE's HIV related immigration restrictions provides us with a holistic picture of the far-reaching negative impact of the ban, detention, and deportation of the infected workers. Firstly, it contributes to greater stigmatisation of foreign workers as carriers of diseases and their discrimination in the Emirati society. Secondly, the Indian workers that are restricted entry or deported on account of their HIV status may have limited access to healthcare in their home countries, which increases the likelihood of their disease becoming fatal. Finally, from a purely health care perspective, the inherently discriminatory practice of travel restriction and deportation may also obstruct the formulation of a proper national response to the virus. Because of future growth in the demand for foreign workers, several transformative efforts must be made by the federal government in terms of policy shift by ratification, implementation of international conventions on migrant workers, whereby, domestic laws recognize the right to health for international labour migrants, by removing barriers to accessing HIV related health services.

Chapter 7: Rights-Based framework for Labour Migrants

7.1 UAE's Labour and Migrant Law

While the Emirati government has taken some recent legalistic measures by making its labour laws more robust, paving way for a migrant friendly discourse, yet many facets of migrant health lack comprehensive policy intervention. The challenges concerning the holistic health security of Indian migrants cannot be addressed straightforwardly as it is highly dynamic. Further, this issue also intertwines with many social determinants which are not only linked to migrant's characteristics, for instance, their culture, age, and sexuality, but also with the background of the countries of origin, its idiosyncratic healthcare regime, and cultural values. Chapter 3 exposes the inherent vulnerability of the Indian migrant population, their large-scale exposure to HIV, limited access to quality healthcare in their home country, further revealing the cross-cutting nature of migration and health. In these domestic settings, migrating Indian workers not only aim for higher remuneration but also for better healthcare cover requiring a migrant sensitive healthcare system in the host nation that explores health issues across various migrant typologies.

While it is true that UAE has tried to enhance its healthcare infrastructure and been able to implement mandatory employer-based health insurance benefitting sizeable Indian population for non-contagious diseases, yet UAE's Communicable disease prevention law seems to create severe ramification on the social and economic state of HIV infected Indian workers. The state has continued to restrict its borders for infected migrants, strengthened its medical screening program fuelling more national resources, further expanded the scope of Communicable Disease law and made it more stringent over the period. A closer look at the cross-border restrictions would also reveal that most of such curtailments were

formalised at a time when there was a paucity of information with respect to the virus and its impact. Many neighbouring states with comparable demography such as Bahrain, Kuwait, Yemen, Saudi Arabia, also imposed similar restrictions on migrants by the mid 1980's.²²⁶ These restrictions have now become permanent fixtures in the immigration framework of these nations, as none of these Arab nations have lifted or reviewed cross border restrictions. But the case of Emirates needs to be evaluated on a different footing, as it has been publicly projecting itself to be distinct, forward-looking and has diluted many parts of the Sharia law for collective freedom of its migrant population.

The advocacy campaigns and arguments against HIV related travel restrictions over the last more than thirty years have mostly remained stable. Restriction on movement and overseas residence have turned out to be largely ineffective and discriminatory anachronism of a by-gone era. Yet a worldwide policy which adequately balances the interests of the state, and the rights of the foreign workers is complicated, considering how differently the virus has affected nations, requiring individual nations to formulate their own policies that are unique and may not be successful, if attempted by other states. The following part of the Chapter enumerates several recommendations and strategies which can assist the Emirati state to strengthen its HIV related healthcare interventions and social protection of infected Indian migrants.

7.2 UAE's Communicable Disease Law

UAE's Communicable Disease prevention law plays a decisive role in the sphere of public health, from ascertaining the jurisdiction and power of health agencies, to dominating

²²⁶ International Task Team on HIV-related Travel Restrictions, UNAIDS "Human Rights and Law Team Mapping National HIV-related restrictions on entry, stay and residence", 2019 Online. www.unaids.org/sites/default/files/media_asset/HIV-related-travel-restrictions-explainer_en.pdf

the social norms that shape individual behaviour. Despite its importance, the public health law of the Emirati state has largely remained static for its immigrant population and is further confronted with issues concerning transparency, trust, ethics, public participation, and distributive justice.

Historical overview of UAE's demography would reveal that the massive influx of foreign workers during the first ten years of formation of Emirati confederation and the perceived threat of communicable diseases led to the promulgation of UAE's Federal Law No. 27, 1981 which laid down policy standards for testing, disclosure, cross border movement, residence, isolation, and deportation of migrant workers. Thereafter, its successor, Federal Law No. 14 of 2014 not only expanded the scope of the former law but also made the ensuing penalties against violations more stringent. Both the erstwhile and the existing law have covered under their ambit almost all contagious diseases which have evolved or spread in the West Asian regions including the newly proliferated Covid 19 virus. The Act has outlined diseases from Schedule C to E and categorized them into three categories of highly severe, severe, and average severe.

The success of the Communicable disease law has been widely boasted by the Emirati state in its press statements and official website, presenting it as an example of epidemic management to the rest of the world. While it cannot be denied that the state has been able to curtail newer infections but its official numbers only account for the detection amongst its small citizen population. The false sense of achievement has also discouraged the state to make any revisions to its health law in tune with the scientific and healthcare advancement. Further, the 2014 Law faces a fundamental problem on account of lack of dynamism, it has covered almost all contagious diseases under different categories, yet it has laid down identical procedures for detection, prevention, isolation, and penalties. Chapter – 1 of the

thesis has demonstrated the need of public health policy to be evidence based, in this context, the Act has not given due regard to the transitioning of contagious diseases, modes of transmission, bodily risks, availability of treatment and applied a single set of standards, procedures to all communicable diseases leading to ineffectual targeting on account of the above-mentioned differential factors. For instance, the preceding Paragraph 4.2.3 has revealed the effective utilisation of the Law in managing the highly contagious Covid-19 pandemic, but the legislation may not be equally successful in implementing national HIV strategies.

The UAE's coercive legislations fails to recognize the principles of public health law like proportionality and least infringement. Nor are its statutory provisions in line with the normative human rights framework as discussed in Chapter 4. The preceding Chapter-5 of the thesis reveals the outdated premise upon which HIV related restriction under the Communicable Disease Law on residency and movement of foreign workers are based, frustrating the purpose of the state law. The arguments in favour of restrictions such as threat to public health, fiscal and healthcare strain have become outdated and obsolete. On the other hand, the UAE's economy gained momentum on account its diversification efforts in the last one decade, providing further impetus to the health infrastructure. This allows the country to explore alternative policies concerning the access to the public healthcare for contagious infections for its immigrant population, regardless of their nationality status, thereby presenting itself as a progressive, modern, labour friendly destination, further conforming to global guidelines.

The 2014 law, therefore, requires revision in terms of elimination of HIV from the Schedule D, which would bring uniformity about the healthcare access for non-citizen population. This form of revision will place ethical principles of public health into the statutory

framework relating to UAE's communicable diseases law to ensure that government efforts aimed at prevention do not lead to unnecessary abuse and violation of the rights of migrant workers.

7.3 Proposed Public Health Reforms for Indian PLHIV in UAE

7.3.1 Medical Screening Program

UAE's Ministry of Foreign Affairs on its official web portal has termed its overseas medical screening centres as the first line of community defence against communicable diseases. Its overseas programs have been in practice since 2011, prior to which health examination of incoming workers was conducted only upon arrival. This double-check mechanism has been targeted towards reducing the incidence of infectious diseases, perfectly fitting into the cordoning-off plans of the Emirati state. As per the new policy, Indian migrants applying for standard work visa and domestic work visa are needed to undertake mandatory medical screening at authorised facilities, mostly privately owned, at more than hundred different locations spread across India.

While it is true that many of the rationales behind HIV screening as explored in the preceding Chapter 5 are premised on obsolete, unscientific grounds yet an essential objective of the state relates to its endeavour to attract productive workforce which can effectively contribute towards national growth without putting excessive resource or fiscal burden on the host state, these apprehensions of the host state cannot be entirely dismissed. An important strategy to address these concerns could be found in the policy guidelines of UN's

International Organization for Migration for management of cross-border migration of HIV infected migrants.²²⁷

These guidelines have conventionally aimed to facilitate the formulation and execution of schemes that can individually, mutually benefit both country of origin and destination, further, necessitating a balance between migrant rights under global framework while recognizing the concerns of the host society. In this context, the pre-employment health screening can be utilised as a contributor for achieving better national health systems linkages and strengthening migrants' capacity to access healthcare. Such an attempt would require an overhaul of the existing programme, requiring multi-sectoral approach, partnership between governments along with the engagement of private healthcare sector and UN agencies.

Based on the evaluation and research conducted throughout the thesis, I recommend the following changes which the Emirati government can attempt to make in its overseas screening programmes more robust.

1. Development of procedures which allows information sharing of employment profiles of applicants with Foreign Affairs Ministry of UAE at the time of filing the work visa applications. Such a practice would assist the Ministry to ascertain the physical performance criteria of different occupations.
2. Creation of a new tripartite partnership between the Government of India's Ministry of Health & Family Welfare, UAE's approved private health screening facilities in India, and the Emirati federal government for extending services related to information sharing, health services including HAART, and health

²²⁷ HIV and International Labour Migration(ILO/IOM/UNAIDS joint statement) Aug. 1, 2008,Online. <www.ilo.org/global/topics/HIV-AIDS/publications/WCMS_127014/lang--en/index.htm>

counselling for PLHIV. The proposed overseas medical screening program should not only be used for detection of HIV infections amongst incoming workers but also for identifying viral load, determining the physical ability of individual worker to perform duties as per their prospective employment role. The information sharing about health status of the applicant workers should be done as per the rules of confidentiality.

3. Categorization of infected applicants based on their viral load, i.e., high, and low. Those detected with lower viral load can be advised to take obligatory anti-retroviral treatment (ART) in the host state until the expiry of the work visa or employment contract. Whereas applicants found with excessive viral load can be provided a recourse of seeking ART at central government aided or India's National AIDS Control Organization monitored health center until the load is suppressed, thereby giving an alternative to re-apply after receiving a certificate of fitness by government health centers.

This model of overseas health screening, therefore, not only resolves the apprehensions of the host state, but also acknowledges the health needs of infected migrant workers, encouraging them to seek therapy, thereby keeping them healthy and productive. Furthermore, such a program would also cater to the national healthcare commitments of the Emirati government and its respect towards Universal Health Coverage to guide the provision of migrant inclusive and sensitive healthcare accessible to Indian migrants.

7.3.2 Cross-border Healthcare Agreement

The preceding chapter reveals the persistent initiatives of UAE to project itself as a Westernized, modern Gulf nation, a popular destination for employment and investment. The forging of new trade relationships with other nations, especially India, its second largest trading partner has also augmented several ethical obligations for Emirates as a host state to improve treatment of its Indian workers which constitutes more than 27 percent of its total population.²²⁸

Although, the economic and trade bond between India and UAE dates to the pre-oil era but the emergence of Emirates as a major oil exporter has further strengthened their ties. India, the world's third-largest consumer of crude oil²²⁹, is home to a rapidly growing consumer market and labour pool that the oil-rich Gulf states including Emirates relies on for its economy. The trade volume between the two states has grown exponentially from USD 180 million in the 1970s to about 73 billion in 2021.²³⁰ Professional services, Information technology and education have become the top three sectors of India's foreign direct investment in UAE, which has seen a substantial increase in the recent years. The economic closeness of both nations is also reflected in their political and diplomatic proximity.

Emirates has acknowledged the fiscal potential of India and no longer looks at it merely as a source of labour but as an important partner for its future growth. This puts India, being the largest labour exporting nation to UAE in a position to better negotiate the demands, rights on behalf of its emigrant workers, especially when the host state does not

²²⁸ UAE Official Portal, Ministry of Cabinet Affairs, Statistics, "Population of UAE in 2020", UAE Stats, 2020, Online. <fsc.gov.ae/en-us/Pages/Statistics/Statistics-by-Subject.aspx?%3Fsubject=Demography%20and%20Social&folder=Demography%20and%20Social/Population/Population>

²²⁹ U.S. Energy Information Administration, International Energy Statistics, Total oil (petroleum and other liquids) consumption, "The 10 largest oil consumers and share of total world oil consumption in 2021", December 9, 2022, Online. www.eia.gov/tools/faqs/faq.php?id=709&t=6

²³⁰ Embassy of India, Abu Dhabi, United Arab Emirates, Bilateral Economic and Commercial Relations, "Brief on India-UAE Commercial Relations", November 2021, Online. <indembassyuae.gov.in/bilateral-eco-com-relation.php>

allow formation of trade unions. This position should be utilized by both nations to improve the conditions for its workers through Bilateral Health Agreements (BHA's), which can better target the healthcare, social and entailing economic needs of HIV infected Indian worker population.

There has been a continuing debate around the construction of a legal framework for cross-border health care, especially in the context of migrant labour force. It has gained more prominence in the recent past, as many European states have entered into Reciprocal Health Agreements with Non-EU nations for the purpose of granting access to equal healthcare to the nationals of signatory parties.²³¹ BHA's can be utilised by policy makers of both India and UAE to formulate guidelines for extending social protection to migrants and designing improved processes for healthcare support.

I have proposed a series of recommendations for a proposed BHA which can be formalised between both countries:

Recommendation 1: Establishment of regulations for determining applicable legislation by which such social security could be covered. Usually, migrant workers who work in the territory of a Party to the agreement should be subject solely to the legislation of that Party in accordance with the principle of *lex loci laboris*.²³²

Recommendation 2: Fresh engagement and collaboration of national social security institutions of UAE's Ministry of Community Development and Ministry of Health (through its National AIDS Program) to provide much needed systemic support, social security coverage, setting terms for admission and access to

²³¹ Govt of UK, Official Portal, Health and Social Care UK reciprocal healthcare agreements with non-EU countries: Online. <www.gov.uk/guidance/uk-reciprocal-healthcare-agreements-with-non-eu-countries>

²³² The principle states that a person employed in the territory of a Member State is subject to the legislation of that State .

anti-retroviral treatment (ART), psychological counselling at government health facilities to HIV infected Indian workers, their families at part with the citizen population.

The proposed bi-lateral agreement would require the strategic participation of labour exporting country, serving as an essential tool in terms of providing accurate information regarding the status of HIV infection, its progression, and the health status establishing the physical ability of the worker to perform duties as per their respective employment contracts. The accuracy of health-related information of infected workers and its effective sharing can further assist the host state to ensure continuity of care and better understanding for targeting improved health intervention for individual workers. This form of information sharing mechanism would also require India to remodel its existing HIV healthcare support system and formulate a supplemental infrastructure for physical screening, treatment, and counselling of workers at the time of departure.

Some measures that could help the low literate migrant workers are as follows:

1. Greater expansion of employer sponsored health insurance for Indian workers in the host state for HIV and other communicable diseases.
2. Simplification of the process of reimbursement and direct payment by insurers for Indian migrant workers
3. Participation of Indian workers in the healthcare centers of the federal and provincial government of the host state. The Emirati state should endeavour to adopt the guidelines outlined in the World Health Organisation's Global Code of Practice on the International Recruitment of Health Personnel and ensure that Indian healthcare workers possess identical legal rights, responsibilities as their domestically trained

counterparts, encompassing all aspects of employment, working conditions and retention strategies.²³³

4. Establishing institutions for regular assessment of the healthcare programs for Indian migrant workers in the host country.
5. Developing and interstate financing mechanism for rendering services ranging from treatment, counselling, and ancillary facilities.

The country of origin can take the responsibility of healthcare funding, alternatively seek the assistance of global financing programs for cost reduction.

7.4 Future Opportunities and Involvement of Civil Society Organizations

Chapter 1 of this thesis has explored the vast history of pandemics management, revealing the utilization of extra-legal constitutional provisions by many states. The recent Covid experience has also made it clear that International Health Regulations have turned out to be largely inadequate, requiring considerable strengthening and a paradigm shift in global pandemic governance, further fuelling the global debate revolving around an additional treaty for global pandemic response for advance readiness against pandemics including coordination with communities, underscoring the requirement for greater investments for global pandemic preparedness for health infrastructure, while respecting rights to build trust.

The proposal for an international treaty on pandemics was first discussed at the Paris Peace Forum in November 2020, and later in May 2021 by World Health Assembly.²³⁴ Such an instrument would provide an opportunity to address challenges facing both domestic and

²³³ Sixty-Third World Health Assembly, WHO Global Code of Practice on the International Recruitment of Health Personnel, 21 May 2010, Online < https://iris.who.int/bitstream/handle/10665/3090/A63_R16-en.pdf?sequence=1 >

²³⁴ World Health Organization. "World Health Assembly agrees to launch process to develop historic global accord on pandemic prevention, preparedness and response." 2021. Web. <www.who.int/news/item/01-12-2021-world-health-assembly-agrees-to-launch-process-to-develop-historic-global-accord-on-pandemic-prevention-preparedness-and-response>

international law pertaining to future and existing pandemics, epidemics for crafting a better health system, based on solidarity. The First working draft of WHO's proposed pandemic treaty stresses upon development of medical countermeasures, disclosure of data, enhanced coordination, financial mechanism, support for evidence-based policies, and entailing obligations to develop inclusive policies that recognize the needs of vulnerable groups.²³⁵ The proposed treaty provides necessary opportunity to develop human rights obligations to strengthen global health law, further overcoming human rights limitations.

An overview of international instruments would reveal that out of the seventy-one agreements which touch upon various facets of global health, only thirty-four are binding.²³⁶ To address this issue, the WHO and many of its member nations have also advocated for a stronger enforcement, through an accountability framework that includes transparency, monitoring through an independent oversight body under the proposed treaty which is legally binding under international law, violation of which may entail economic and diplomatic sanctions. These accountability measures would ensure the delivery of the instrument, and to provide the strongest protection to the most marginalised communities within member nations.

The Emirati policymakers should not be opposed to this treaty under the vague concerns of future ratifications, or conspiratorial fears, look at it as an opportunity to fix its structural policy shortfalls in terms of global coordination for pandemic management considering the high intensity of cross-border movement of its large worker population. Its engagement in the proposed treaty further allows UAE to supplement its existing domestic

²³⁵ World Health Organization. "Working draft, presented on the basis of progress achieved, for the consideration of the Intergovernmental Negotiating Body at its second meeting." 2022. Online. <apps.who.int/gb/inb/pdf_files/inb2/A_INB2_3-en.pdf>

²³⁶ Rouw, Anna, et al. "Assessing the Role of Treaties, Conventions, Institutions, and Other International Agreements in the Global COVID-19 Response." (2023). Web. <www.kff.org/global-health-policy/issue-brief/assessing-the-role-of-treaties-conventions-institutions-and-other-international-agreements-in-the-global-covid-19-response-implications-for-the-future/>.

communicable disease law, forge future partnerships and networking with international counterparts in managing existing, future pandemics along other relevant factors such as international organisations, civil society, private sector to fortify holistic social protection during health emergencies.

Since the very beginning of the HIV epidemic, civil society organisations (CSOs) have played a significant role in the response, both in terms of rendering services and advocacy. Even before United Nations and other international organisations recognized the complex issues associated with HIV, the CSOs within their limited means were able to address the broader range of issues without any auxiliary policy support. Thereafter, the period from the 1990's to early 2000 saw a significant development; growth of numerous social advocacy groups internationally, which spearheaded increased commitments at the global and regional levels towards the full realization of all human rights of PLHIV, including improved access to health services.²³⁷ Over the span of the last two decades, civil society advocacy has become fragmented into different movements focusing on the struggles of specific groups of PLHIV such as women, transgender, and children.

In spite the swell of civil action groups globally, there seems to be a policy and legislative vacuum in the Emirati state in terms of support for CSO's. United Nations Human Rights Council's Universal Periodic Review has highlighted the persistent targeting, increasing obstacles and hostile domestic environment faced by CSO's functioning independently in the UAE.²³⁸ The country's National Human Rights Institution's Chairman, in a statement marking International Human Rights Day in 2022 stressed upon providing larger space and increased

²³⁷ Parker, Richard. "Grassroots activism, civil society mobilization, and the politics of the global HIV/AIDS epidemic." *Brown J. World Aff.* 17 (2010): 21. Print.

²³⁸ CIVICUS, "United Arab Emirates at UN Human Rights Council: Adoption of Universal Periodic Review, 38th Session of Human Rights Council", 28th June, 2018; Online. <www.civicus.org/index.php/media-resources/news/united-nations/geneva/3246-adoption-of-the-upr-report-of-the-united-arab-emirates>

engagement with civil society to actively enhance, protect and promote human rights,²³⁹ which also infers the precarious situation of people's advocacy in the state.

Much of the recent academic literature has centred around challenges facing CSO's in fragile nations, in the context autocratic regimes, which inherently have a distaste for dissent, these organisations face different set of challenges. To analyse the functioning of CSO's within the Emirati state, it is essential to understand how state policies are promulgated by the more closed monarchical regime. Apart from state's oil economy, its ruling royal family has also influenced its civil society. Pursuant to the promulgation of 1974 law requiring all associations to be registered with the Ministry of Labour and Social Welfare,²⁴⁰ the royals at both the provincial and federal level started to monetarily fuel the CSO's, which ultimately outflanked even those organisations that were most determined to remain autonomous.²⁴¹ Further, the monarchy has setup umbrella organisations working in the sphere of civil society (Islamic, charity, cultural, media, education) which are directly or indirectly headed by the members of the royal family. This form of monarchical dominance may have also stemmed from the fears of possible challenges which an independent civil society could create by exposing state's developmental failures. CSO's operating in such conservative environment also lack unrestricted access to the vulnerable migrant populations and may lack clear information about their welfare and protection.

Considering the political environment, policy vacuum in the state, as explained in Para 4.2.4 it has become increasingly important to provide a larger space to CSO's which can articulate the concerns of disadvantaged groups, in doing so contribute to solving any future

²³⁹ WAM, "Human Rights Day 2022: Engage with civil society, says head of UAE's National Human Rights Institution", Gulf News; 9th December 2022, Online. <[gulfnews.com/uae/government/human-rights-day-2022-engage-with-civil-society-says-head-of-uaes-national-human-rights-institution-1.92606762](https://www.gulfnews.com/uae/government/human-rights-day-2022-engage-with-civil-society-says-head-of-uaes-national-human-rights-institution-1.92606762)>

²⁴⁰ UAE Federal Law No.6/1974,S.8

²⁴¹ Pollard, Stacey E. "The state and civil society in the Arab Middle East." Western Michigan University, 2014. Print.

social conflicts, compensate for policy failures, and incubate alternative organizational models. The experiences of CSOs in managing HIV epidemic globally may help UAE to generate new roles and competencies. Further, any future amendments in the Communicable disease law in the context of HIV leading to health, social protection of infected Indian migrant workers would also require the support of a vibrant civil society, enabling the state to fill certain gaps in healthcare, ancillary service to work closely with the Indian community and ensuring that the voice and different segments of the Indian worker populations are considered in the design of development programs. At the same time, the federal government should also provide the requisite space to CSO's to maintain their own identity and to strengthen their objectivity of being a watchdog, while ensuring meaningful intervention.

Conclusion

The incorporation of the above measures through legislative amendments, the establishment of new agreements, and engaging in multi-sectoral efforts represent methodical means that the UAE's federal government can employ. Additionally, fostering cooperation with international organizations, establishing national committees, and collaborating with Civil Society Organizations (CSOs) are essential strategies. These approaches aim to protect national interests while simultaneously adhering to global guidelines and recommendations regarding the rights of infected Indian workers in the country.

Implementing the suggested measures would not only contribute to creating a safer environment for the Indian worker population but could also serve as a catalyst for policy changes in other Arab nations. Many of these nations have imposed similar restrictions on the freedom of movement and residence of HIV-infected migrant populations. The proactive steps taken by the UAE government could set a positive precedent, influencing broader regional policies and fostering a more inclusive and rights-oriented approach towards infected migrant workers. In conclusion, any future actions undertaken by the government based on the above suggestions hold the potential to create a significant impact, not only within the UAE but also as a model for other Arab nations. By aligning policies with global standards and respecting the rights of infected workers, the UAE can contribute to broader positive changes in the treatment of migrant populations across the Arab world. This thesis aspires to be a valuable contribution to ongoing campaigns and advocacy efforts in the UAE and the larger Arab region.

Bibliography

Legislations

International Treaties

- Convention against Torture and other Cruel Inhuman or Degrading Treatment or Punishment (1984)
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
Convention relating to the Status of Refugees (1951)
General Agreement on Trade in Services, GATS (1994)
International Convention for the Protection of All Persons from Enforced Disappearance (2006)
International Convention on the Elimination of All Forms of Racial Discrimination (1965)
International Covenant on Civil and Political Rights (1966)
International Covenant on Economic, Social and Cultural Rights (1966)
International Covenant on Economic, Social and Cultural Rights (ICESCR)
The Convention on the Rights of the Child (1989)
Universal Declaration of Human Rights (1948)

United Arab Emirates

- Federal Law No. 14 of 2014
Federal Law No. 27, 1981
Federal Law Number 13 of 1996
Ministerial Decree Number 360 of 1997

India

- Constitution of India 1950, Part III, Fundamental Rights: Art. 14, 19 and 21
Indian Penal Code, 1860, S.377
The Goa, Daman, and Diu Public Health Act, 1985, S.53(1)(vii)
The HIV & AIDS (Prevention and Control) Act, 2017, S.4, 37

Jurisprudence

- D'Souza v. State of Goa. AIR 1990 Bom 355 at para 17
Navtej Singh Johar & Ors. v. Union of India; AIR 2018 SC 432, WP (CRL) No. 76/2016

Secondary Sources

Books

- Barry, John. *The Great Influenza: The epic story of the deadliest plague in history*. Viking Press, 2004. Print.
- Berger, Peter L, and Thomas Luckmann. *The social construction of reality: A treatise in the sociology of knowledge*. Anchor, 1967. Print.
- Castles, S., and M.J. Miller. *The Age of Migration: International Population Movements in the Modern World*. Palgrave Macmillan, 2009. Print.
- De Waal, Alex. *New pandemics, old politics: Two hundred years of war on disease and its alternatives*. John Wiley & Sons, 2021.
- Green, Monica H., and Carol Symes. *Pandemic disease in the medieval world: rethinking the black death*. Arc Humanities Press, 2015.
- Lian, Fee Kwen, *International Labour Migration in the Middle East, and Asia: Issues of Inclusion and Exclusion (Asia in Transition Book 8)* 1st ed., Springer, 2019, print
- Hanieh, Adam, Omar AlShehabi, and Abdulhadi Khalaf. *Transit states: Labour, migration, and citizenship in the Gulf*. Pluto Press, 2014.
- Horinuki, Koji. "Promoting diversity, branding the state: Migrant-friendly discourses in the United Arab Emirates." *International Labour Migration in the Middle East and Asia: Issues of Inclusion and Exclusion (2019)*: 97-114.
- Kamrava, Mehran, and Zahra Babar. *Migrant labor in the Persian Gulf*. New York: Columbia University Press, 2012.
- Killingray, David, and Howard Phillips, eds. *The spanish influenza pandemic of 1918-1919: new perspectives*. Routledge, 2003.
- Lian, Kwen Fee, Naomi Hosoda, and Masako Ishii, eds. *International labour migration in the Middle East and Asia: Issues of inclusion and exclusion*. Vol. 8. Springer Nature, 2019.
- Owen, Roger. "Migrant workers in the Gulf." *Middle East Review* 18.3 (1986): 24-27. Online

Journals and Articles

- Bhatia, Mrigesh, and DP Singh. "Health Sector Allocation in India's Budget (2021–2022): A Trick or Treat?" *The International Journal of Community and Social Development* 3.2 (2021): 177-80. Print.
- Biesma, R. G., et al. "The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control." *Health Policy Plan* 24.4 (2009): 239-52. Print. <www.ncbi.nlm.nih.gov/pubmed/19491291>.
- Cabal, L., and P. Eba. "Learning from the Past: Confronting Legal, Social, and Structural Barriers to the HIV Response." *Health Hum Rights* 19.2 (2017): 113-15. Print. <www.ncbi.nlm.nih.gov/pubmed/29302168>.
- Callen, Mr Tim, et al. *Economic diversification in the GCC: Past, present, and future*. International Monetary Fund, 2014. Print.
- Chancel, Lucas, et al. *World inequality report 2022*. Harvard University Press, 2022. Print.
- Chetail, Vincent. "International migration law." OUP Oxford 2014. Web. <papers.ssrn.com/sol3/papers.cfm?abstract_id=2174892>

- Chetail, Vincent. "Sources of international migration law." *Foundations of international migration law* (2012): 56-92. Print.
- Chetail, Vincent. "The transnational movement of persons under general international law- Mapping the customary law foundations of international migration law." *Research handbook on international law and migration* (2014): 1-72. Print
- Cohen.S,Myron, et al 'Prevention of HIV-1 Infection with Early Antiretroviral Therapy', *The New England Journal of Medicine*, Aug 11, 2011, DOI: 10.1056/NEJMoa1105243
- COVID-19 exposes India's weak public healthcare. *East Asia Forum*. 2020. Print.
- Davis, S. L. "Measuring the Impact of the Human Rights on Health in Global Health Financing." *Health Hum Rights* 17.2 (2015): 97-110. Print. <www.ncbi.nlm.nih.gov/pubmed/26766865>.
- Diop, Abdoulaye, Trevor Johnston, and Kien Trung Le. "Migration Policies across the Gcc: challenges in Reforming the Kafala." *Migration to the Gulf: Policies in sending and receiving countries* (2018): 33-60. Print.
- Downie, Richard. *Advancing Country Partnerships on HIV/AIDS*. 2017. Print.
- Embassy of India. "Indian Community in UAE." 2022. Web. <www.indembassyuae.gov.in/indian-com-in-uae.php>.
- Emiratisation in the local labor force of the UAE: a review of the obstacles and identification of potential strategies. *Proceedings of the 20th Australian New Zealand Academy of Management Conference on "Management: Pragmatism, Philosophy, Priorities"*. 2006. Print.
- Ferejohn, John, and Pasquale Pasquino. "The law of the exception: A typology of emergency powers." *International Journal of Constitutional Law* 2.2 (2004): 210-39. Print.
- Gaur, Seema, and Prem C Saxena. "Indian migrant workers in Lebanon and their access to health care." *Asian and Pacific migration journal* 13.1 (2004): 127-36. Print.
- Gilmore, N., et al. "International travel and AIDS." *AIDS* 3 Suppl 1.1 (1989): S225-30. Print. <www.ncbi.nlm.nih.gov/pubmed/2514742>.
- Hanieh, Adam. "States of exclusion: Migrant work in the Gulf Arab States." (2016). Print.
- Howard-Jones, Norman, and World Health Organization. *International public health between the two World Wars: the organizational problems*. World Health Organization, 1978. Print.
- Hutton, Vicki E, RoseAnne Misajon, and Francesca E Collins. "Subjective wellbeing and 'felt'stigma when living with HIV." *Quality of Life Research* 22 (2013): 65-73. Print.
- Joe, William, Udaya S Mishra, and Kannan Navaneetham. "Health inequality in India: evidence from NFHS 3." *Economic and Political Weekly* (2008): 41-47. Print.
- Joulaei, Hassan, Sowgol Shooshtarian, and Mostafa Dianatinasab. "Is UNAIDS 90-90-90 target a Dream or a Reality for Middle East and North Africa Region on Ending the AIDS Epidemic? A Review Study." *AIDS reviews* 20.2 (2018). Print.
- Joumard, Isabelle, and Ankit Kumar. "Improving health outcomes and health care in India." (2015). Print.
- Kapiszewski, Andrzej. "Arab versus Asian migrant workers in the GCC countries." *South Asian migration to Gulf countries: History, policies, development* 23 (2006): 46-70. Print.
- Kavanagh, Matthew M, et al. "Law, criminalisation and HIV in the world: have countries that criminalise achieved more or less successful pandemic response?" *BMJ Global Health* 6.8 (2021): e006315. Print.

- Keelery, Sandhya. "Dalits and Adivasis in India: Statistics and Facts." (2020). Web. <www.statista.com/topics/4946/dalits-and-adivasis-in-india/#topicOverview>.
- Kodoth, Praveena. "In the shadow of the state: Recruitment and migration of South Indian women as domestic workers to the Middle East." International Labour Organization: Geneva, Switzerland (2020). Print.
- Lamba, Mandeep, and Dipti Mohan. "HVS Monday Musings: Medical Tourism in India." (2021). Web. <www.hvs.com/article/9044-hvs-monday-musings-medical-tourism-in-india>.
- Global Commission on HIV and the Law. HIV and the Law: Risks, Rights, and Health: United Nations Development Programme, 2012. Print.
- Lazarus, J. V., et al. "HIV-related restrictions on entry, residence and stay in the WHO European Region: a survey." *J Int AIDS Soc* 13 (2010): 2. Print. <www.ncbi.nlm.nih.gov/pubmed/20205784>.
- Pranee, Liamputtong, *Researching the Vulnerable: A Guide to sensitive Research Methods*, Published Sage Publications Limited, 2006, print Loney, T., et al. "An analysis of the health status of the United Arab Emirates: the 'Big 4' public health issues." *Glob Health Action* 6.1 (2013): 20100. Print. <www.ncbi.nlm.nih.gov/pubmed/23394856>.
- Malit Jr, F, and Ali Al Youha. "Labor migration in the United Arab Emirates: Challenges and responses. Migration Policy Institute." 2013. Print
- Marcus JL, Leyden WA, et al, 'Comparison of Overall and Comorbidity-Free Life Expectancy Between Insured Adults With and Without HIV Infection, 2000-2016. *JAMA Netw Open*. 2020 Jun 1;3(6):e207954. doi: 10.1001/jamanetworkopen.2020.7954. PMID: 32539152; PMCID: PMC7296391
- Medu, O., et al. "Economic evaluation of HIV testing options for low-prevalence high-income countries: a systematic review." *Health Econ Rev* 11.1 (2021): 19. Print. <www.ncbi.nlm.nih.gov/pubmed/34100138>.
- Misra, G. "Decriminalising homosexuality in India." *Reprod Health Matters* 17.34 (2009): 20-8. Print. <www.ncbi.nlm.nih.gov/pubmed/19962634>.
- Mommers, C, et al. "Health Hope and Home? The possibilities and constraints of voluntary return for African rejected asylum seekers and irregular migrants living with HIV in the Netherlands." (2009). Print.
- Nair, M., et al. "Refused and referred-persistent stigma and discrimination against people living with HIV/AIDS in Bihar: a qualitative study from India." *BMJ Open* 9.11 (2019): e033790. Print. <www.ncbi.nlm.nih.gov/pubmed/31772110>.
- Nelson, L. J. "International travel restrictions and the AIDS epidemic." *Am J Int Law* 81.1 (1987): 230-6. Print. <www.ncbi.nlm.nih.gov/pubmed/11649887>.
- Northcott, Herbert C, and Linda Reutter. "Public opinion regarding AIDS policy: fear of contagion and attitude toward homosexual relationships." *Canadian Journal of Public Health= Revue Canadienne de Sante Publique* 82.2 (1991): 87-91. Print.
- Parker, Richard. "Grassroots activism, civil society mobilization, and the politics of the global HIV/AIDS epidemic." *Brown J. World Aff.* 17 (2010): 21. Print.
- Prins, Gwyn. "AIDS and global security." *International Affairs* 80.5 (2004): 931-52. Print.
- Qadri, Mustafa. "The UAE's Kafala System: Harmless or Human Trafficking?" *Dubai's role in facilitating corruption and global illicit financial flows* (2020): 79-84. Print.
- Rakotonarivo, Andonirina. "ILO global estimates on international migrant workers: results and methodology." (2021). Print.
- Rizvi, SN Asad. "From tents to high rise: economic development of the United Arab Emirates." *Middle Eastern Studies* 29.4 (1993): 664-78. Print.

- Robalino, David A, Carol Jenkins, and Karim El Maroufi. The risks and macroeconomic impact of HIV/AIDS in the Middle East and North Africa: Why waiting to intervene can be costly. Vol. 26: World Bank Publications, 2002. Print.
- Roos, David. "Social distancing and quarantine were used in Medieval Times to fight the Black Death." *History* 25 (2020). Print.
- Rouw, Anna, et al. "Assessing the Role of Treaties, Conventions, Institutions, and Other International Agreements in the Global COVID-19 Response:." (2023). Web. <www.kff.org/global-health-policy/issue-brief/assessing-the-role-of-treaties-conventions-institutions-and-other-international-agreements-in-the-global-covid-19-response-implications-for-the-future/>.
- Roy, Avik. "United Arab Emirates: #20 in the 2021 World Index of Healthcare Innovation." (2021). Web. <freopp.org/united-arab-emirates-freopp-world-index-of-healthcare-innovation-5ccc1512303f>.
- Sabban Rima, GENPROM Working Paper No. 10 Series on Women and Migration UAE: Migrant Women in the UAE, The case of female domestic workers by Rima Sabban Gender Promotion Programme, p.3, Ministry of Planning, Population Censuses 1986, 1997; Labour Report 2000, Ministry of Labour Schiliro, Daniele. "Diversification and development of the United Arab Emirates' Economy." *Journal of Applied Economic Sciences (JAES)* 8.24 (2013): 228-39. Print.
- Shakiba, E., et al. "Epidemiological features of HIV/AIDS in the Middle East and North Africa from 1990 to 2017." *Int J STD AIDS* 32.3 (2021): 257-65. Print. <www.ncbi.nlm.nih.gov/pubmed/33525959>.
- Shediac, Richard, and Hatem Samman. "Meeting the Employment Challenge in the GCC The Need for a Holistic Strategy." Print.
- Singh, L Muhindro. "Human Rights and Plight of HIV Women: A case in India." *The Indian Journal of Political Science* (2010): 535-46. Print.
- Sinha, K. "Mass economic migration: the greatest threat to HIV control in India." *BMJ* 346 (2013): f474. Print. <www.ncbi.nlm.nih.gov/pubmed/23360892>.
- Sinha, Pravin. "Bridging inequalities for decent work in South Asia." *International Journal of Labour Research* 9.1/2 (2019): 235-52. Print.
- Toebe, Brigit. "The right to health as a human right in international law." *Refugee Survey Quarterly* 20.3 (2001). Print.
- UNAIDS. "2020 global AIDS update: seizing the moment." Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS (2020). Print.
- United Nations Development Programme. "The Challenge of Sustainable Development in South Africa: Unlocking People's Creativity." *South Africa Human Development Report 2003* (2003). Print. <sustainabledevelopment.un.org/content/documents/849south_africa_2003_en.pdf>.
- Wallace, Lorraine. "Patients' health literacy skills: the missing demographic variable in primary care research." *Annals Family Med*, 2006. Print.
- Warren, A. E., et al. "Global health initiative investments and health systems strengthening: a content analysis of global fund investments." *Global Health* 9.1 (2013): 30. Print. <www.ncbi.nlm.nih.gov/pubmed/23889824>.
- Watch, Human Rights. "I Already Bought You". Abuse and Exploitation of Female Migrant Domestic Workers in the United Arab Emirates. Human Rights Watch, 2014. Print.
- Whiteside, Alan. "HIV/AIDS and development: failures of vision and imagination." *International affairs* 82.2 (2006): 327-43. Print.

- Women migrant workers in the UAE: Not quite in the portrait : NGO submission to 45th Session of the Committee on the Elimination of Discrimination of against Women, Online <https://www2.ohchr.org/english/bodies/cedaw/docs/ngos/MigrantForumAsia_UAE_45.pdf>
- World Health Organization. "Past pandemics." (2010). Web. <[www.who.int/europe/newsroom/fact-sheets/item/evaluation-of-the-response-to-pandemic-\(h1n1\)-2009-in-the-european-region](http://www.who.int/europe/newsroom/fact-sheets/item/evaluation-of-the-response-to-pandemic-(h1n1)-2009-in-the-european-region)>.
- Zimmerman, C., L. Kiss, and M. Hossain. "Migration and health: a framework for 21st century policy-making." *PLoS Med* 8.5 (2011): e1001034. Print. <www.ncbi.nlm.nih.gov/pubmed/21629681>