Mediated Health: Interrogating Health-Promotion Campaign Messages for Filipino Household Service Workers in Hong Kong

Jan Michael Alexandre C. Bernadas

While the consequences of international labor migration on the health of temporary and low-skilled workers have gained programmatic attention, these are often overlooked in health media scholarship. Using both a structural critique of health promotion (Nettleton & Bunton, 1995) and a culture-centered approach (Dutta, 2007), this article takes a closer look at the health campaign messages circulated by the Hong Kong Special Administrative Region (HKSAR) which are directed at Filipino household service workers (FHSWs). Specifically, this article focuses on influenza- and avian influenza-related messages found in pamphlets, posters, and fact sheets. Textual analysis reveals four problematic assumptions made in these materials. First, health promotion campaign messages reinforce the taken-for-granted value of vaccination. Second, they assume that FHSWs have sufficient access to quality food and rest. Third, they assume that FHSWs have the resources to avail of the prescribed prevention services. Fourth, health-promotion campaign messages assume that FHSWs have adequate access to health care services. Instead of promoting an inclusive public health agenda, they may have further marginalized FHSWs in HKSAR.

***Keywords**: mediated health communication, Filipino household service workers*

Against the backdrop of a structural critique of health promotion (Nettleton & Bunton, 1995) and a culture-centered approach (Dutta, 2007), this article interrogates the assumptions underlying influenza- and avian influenza-related health promotion campaign messages targeting Filipino household service workers (FHSWs) in the Hong Kong Special Administrative Region (HKSAR). The research problem that it attempts to address is: How effective are the influenza- and avian influenza-related health promotion campaign messages for FHSWs? To date, this is the only article to problematize health communication for FHSWs, and its implication to migration health advocacy in both the Philippines and HKSAR cannot be overstressed.

Four salient aspects of this article need to be mentioned. First, it puts a premium on health over the cultural (e.g., Liebelt, 2011), political (e.g., Ong & Cabañes, 2011), economic (e.g., Alcid, 2003), and social (e.g., San Juan, 1998) dimensions of Filipino migration. It must be noted, however, that health is difficult, if not impossible, to detach from its context

(Airhihenbuwa, Makinwa, & Obregon, 2000; Dutta-Bergman, 2004). Second, this article theorizes media as a mechanism for influencing the health of migrants. While policy makers have documented the unfavorable effects of migration on health (Calderon, Rijks, & Agunias, 2012; CARAM Asia, 2006), they are still unable to articulate the processes behind the the relationship of media and health—a challenge that health communication theory is willing to confront head on. Third, it reduces the atheoretical scholarship that has haunted health communication for more than two decades (Kim, Park, Yoo, & Shen, 2010). Fourth, it focuses more on "small media" (Beaudoin, 2007) instead of TV, newspaper, radio, and the Internet as health information sources, providing a more reflexive characterization of the day-to-day experiences of FHSWs.

Organized in three parts, this article begins with a history of Filipino FHSWs in HKSAR. Particular emphasis is given to the health dimension of migration. The second part focuses on health promotion and marginalization using a structural critique and a culture-centered approach. It also discusses selected health promotion campaigns that target FHSWs. The third part analyzes five specific influenza and avian influenza-related printed materials.

Understanding the Health of Migrants

Although the international labor migration of Filipinos started officially in the 1900s, it actually began as early as 1565 (Alcid, 2003). Described temporally in waves (Gonzalez, 1998), international labor migration, particularly its contractual and feminized dimensions, has increased from 134,642 in 1987 (Tornea & Habana, 1989) to 1,051,600 (Republic of the Philippines National Statistics Office, 2012). Across receiving countries, HKSAR has the biggest number of FHSWs (Bindra, 2012). From 1975 to 2009, for example, there was a steady increase in the population of Filipino women contracted as household service workers in HKSAR (Lycklama a Nijeholt, 1994; Philippine Overseas Employment Administration [POEA], 2004; Wee & Sim, 2005). Table 1 shows the percentage per ethnicity of labor migrants classified as having "*elementary* occupations" [emphasis added] as of 2011 (The Government of Hong Kong Special Administrative Region [HKSAR] Census and Statistics Department, 2012). Indonesian and Filipino household service workers constitute the largest percentage of labor migrants in HKSAR (p. 73). Recently, the number of FHSWs in HKSAR has been estimated at 164,628 (Mandap, 2014). Their population is not expected to decline soon. Although not as significant as that of their Filipino or Indonesian counterparts, Thai, Nepalese, and Indian household service workers have also figured in the landscape of international labor

migration in HKSAR. They are also joined by a small number of women from Pakistan, Japan, and Korea.

Table 1. Proportion of Asian labor migrants classified as "elementary occupations" against total working population according to ethnicity as of 2011. (The Government of HKSAR Census and Statistics Department, 2012).

Ethnicity	%
Indonesian	99.6
Filipino	96.9
Indian	42.9
Pakistani	14.9
Nepalese	46.6
Japanese	1.8
Thai	67.5
Korean	2.5
Other Asian	40.9

The complex relationship between FHSWs and HKSAR started in the late 1960s and early 1970s when expatriates and local residents were allowed, respectively, to bring in and hire FHSWs (Tam, 1999). Downturns in the Philippine economy in the two decades that followed attracted FHSWs to seek employment in HKSAR (Constable, 2007). Aside from its proximity to the Philippines, its emphasis on economic opportunities and human rights has made HKSAR as one of the most popular destinations for FHSWs (Gwartney, Lawson, & Hall, 2012; St John's Cathedral HIV Education Centre, 2006). On the other hand, the continuous demand for FHSWs is an offshoot of the increasing number of dual-career Hong Kong families that force mothers to look for non-family members to provide care for their children (Tam, 1999). In other words, the history of migration of FHSWs in HKSAR can be explained partly by HKSAR's proximity and the fluctuating market dynamics in both the Philippines and HKSAR (International Organization for Migration, 2012).

The most theoretically interesting—but one of the more unfortunate outcomes of this relationship—is the disenfranchisement of FHSWs (Parreñas, 2001) in HKSAR. FHSWs are in a structurally disadvantaged position in terms of class, gender, and ethnicity (Lowe, 2007). In its May 27, 2013 poll, the Public Opinion Programme (2013) reported that attitude toward Filipinos, in contrast to eleven other nationalities, was the most unfavorable. An environment of prejudice is likewise sustained by local media, with few exceptions (e.g., Lo, 2013 August 5). A letter to the editor

of *South China Morning Post* from a former director of immigration even states that:

> under existing immigration policy, foreign domestic helpers are not admitted for settlement. They are admitted into Hong Kong to perform domestic work for a specified period. They have to return to their home country upon completion of termination of their contracts. They are not eligible for unconditional stay after seven years residence in Hong Kong. Change of employment to take up non-domestic work in Hong Kong is not allowed . . . . (Chan 1996 as cited in Lowe, 2000, p. 209)

With this context, this article problematizes the outcomes of being a "second tier of migrant workers in the economic bloc of postindustrial nations" (Parreñas, 2001, p. 247). As minorities, migrants have to struggle against social exclusion (Shaw, Dorling & Smith, 1999; Iyer, Devasahayam, & Yeoh, 2004), distance from family members and other sources of social support (Parreñas, 2001), and job insecurity (United Nations Development Programme [UNDP], 2009). The influence of migration on health is exacerbated by poor working conditions (Malhotra et al., 2013) and living arrangements (Mission for Migrant Filipino Workers [MFMW] Limited, 2013) and inadequate access to health information and care (Calderon, Rijks, & Agunias, 2012; Human Rights Watch, 2010; Shuval, 2005).

In HKSAR, the Centre for Health Protection (CHP) is one source of health information for FSHWs. Established in June 2004 under the Department of Health, the CHP is responsible for disease prevention and control in HKSAR (Chan, 2013 May). With its mission and vision of inclusive engagement in controlling and preventing diseases, the CHP circulates health promotion campaign messages in Hindi, Nepali, Urdu, Thai, Bahasa Indonesia, and Tagalog. To date, it has 120 health promotion campaign messages for communicable infection topics and thirty for hygiene-related topics, using posters, pamphlets, and factsheets. While they are not systematically distributed, CHP's printed materials first become available to FHSWs upon their arrival at HKSAR International Airport (CARAM Asia, 2006) and are also distributed through non-government organizations working with household service workers. Aside from the printed copies, CHP also has their health campaigns in its official website, specifically in the "other languages" menu system.

In its non-Chinese and non-English health promotion campaign messages, the CHP focuses on eleven communicable diseases and two

hygiene-related topics. Most of these messages are in Bahasa Indonesia (n=21) followed by Hindi (n=20), Nepali (n=20), Urdu (n=20), Thai (n=19), and Tagalog (n=19). As a result of an ongoing threat of influenza and its variations, the CHP has intensified its health-promotion campaign through messages that range from maintaining a healthy lifestyle to getting vaccinated. In its fight against influenza and avian influenza, the CHP has also circulated health promotion campaign messages in Tagalog (n=5).

Since being hit by Severe Acute Respiratory Syndrome (SARS) in 2003, HKSAR has become vulnerable to avian influenza and its H5N1 and H7N9 variations (CHP, 2013). What happens to Filipinos in general and FHSWs in particular during communicable disease epidemics? Where do they get preventive and curative health information? How are their healthcare and information needs addressed in the public health program of their destination countries? For example, the *Sun* (2003) reported that a number of FHSWs were hospitalized at the height of SARS. In addition, because of SARS, a number of employers restricted the number of days off of FHSWs and brought upon the termination of their FHSWs' contracts (Tubongbanua, Pascual, de Guzman, Geolamin, & Cabantac, 2003). Until now, the literature on media and diaspora has failed to address these puzzles.

Conceptualizing Marginalization in Health Promotion

Health promotion refers to "the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions" (World Health Organization [WHO], 2013, page number). As a process, health promotion could be an outcome and an agent of marginalization, that is, it could create a "condition of inaccess [sic] to health resources, to the organizations which implement the distribution of health resources and to those policy platforms which determine allocation of these resources" (Dutta, 2008, p. 151). Marginalization in health promotion cannot be understood by using only one critique or approach. Sensitive to this limitation, this article engages both a culture-centered approach and structural critique of health promotion to expose the manifestations of marginalization in health promotion campaign messages for FHSWs in HKSAR.

The culture-centered approach claims that "the ways in which we communicate about issues of health in mainstream discourse further contributes to marginalization by reinforcing certain dominant messages about the marginalized communities and by restricting the resources available to them" (Dutta, 2008, p. 149). To date, this approach has informed research on health promotion campaign messages for family planning (Dutta & Basnyat, 2008) and HIV/AIDS (Acharya & Dutta, 2012; Bassu & Dutta,

2009). To examine the environment wherein these messages circulate, this article draws support from a structural critique of health promotion which, in contrast with surveillance and consumption, problematizes the objective of persuading people to engage in healthy lifestyle without taking into account the environment in which meanings of health are constructed and acted upon (Nettleton & Bunton, 1995). While the aforementioned approach and critique to be used in this article come from two distinctive disciplines—the former from communication and the latter from sociology—they both share a theoretical distaste for the biomedical model and the burden of responsibility placed on the individual over his or her health.

The biomedical model, as explained by Lupton (2003), refers to interpretations of health based on principles of medicine and the medical profession that are characterized as objective (Dutta, 2008). It structures illness as simply "caused by the malfunctioning of a specific bodily part, and that part in question needs to be treated so that the illness may be removed" (Dutta, 2008, p. 119). According to Sharf and Vanderford (2003), it "uses objective language to present traditional, biomedical information about organic, verifiable, measurable signs of disease as conveyed in the authoritative voices of physicians and other health providers, evidenced by clinical signs, laboratory tests, imaging, and other technologies" (p. 11). Not until almost half a century ago, in the context of patient-provider relationship, did social science start to question the dominance of the biomedical model (Lupton, 2003). The culture-centered approach points to the extent to which the quality of doctor-patient communication can influence the decision-making of patients from marginalized groups. Among sex worker patients, for example, the effectiveness of HIV/AIDS communication to motivate the use of pre-exposure prophylaxis heavily depend on their experiences with doctors (Dutta, 2013).

The culture-centered approach also exposes previously unchallenged assumptions about biomedicine and their implication on an individual's access to healthcare and information. First, biomedicine emphasizes the superiority of healthcare professionals and their technology over other sources, which are deemed unscientific (Dutta-Bergman, 2004). Second, it fails to recognize the structural reasons as to why people do not adhere to prescriptions (Jamil & Dutta, 2013). Using a culture-centered approach to critique the Radio Communication Project (RPC) in Nepal, Dutta and Basnyat (2008) found that health promotion campaign messages labeled traditional family planning as inferior to modern contraceptives and encouraged mothers to practice condom use. On the other hand, the Sonagachi HIV/AIDS Intervention Programme and the New Light's HIV/AIDS Project were relatively successful, for they focused on removing structural barriers encountered by commercial

sex workers in India (Basu & Dutta, 2009). One of the very few studies about the health of FHSWs in their countries of destination revealed that FHSWs in HKSAR were unable to avail of cervical smear test because of limited time (Holroyd, Taylor-Piliae, & Twinn, 2003).

In terms of a structural critique of health promotion, biomedicine, as a model, is also problematic because campaign messages "have the effect of pathologizing health problems within the selected social groups and, at the same time, affirming the health beliefs and behaviors of structurally advantaged social groups" (Nettleton & Bunton, 1995, p. 51). At the top of the hierarchy of the materially advantaged group, health-care professionals and their scientific interpretations are internalized to be universally good. Even more problematic is the way the biomedical model perpetuates itself "as the only viable option and as the only point of access to truth in the realm of health and illness" (Dutta, 2008, p. 123). It refuses to recognize that people could trust complementary/ alternative medicine practitioners as much as, if not more than, they trust medical doctors. For example, Dutta-Bergman (2004) found that Santalis in India consults homeopathic doctors and the Ojha (i.e., spiritual healer) more frequently than professionals from hospitals, dispensaries, or nursing homes. In coping with their illnesses abroad, FHSWs likewise engage in health practices learned from the *manghihilot* (i.e., traditional healer in the Philippines) (Sobritchea, Quesada, Subingsubing, & Action for Health Initiatives, 2010).

Beyond the biomedical model, the emphasis on individual responsibility regarding health is also a concern. From a culture-centered approach, health promotion campaign messages are designed to push individuals to change their practices or behavior (Dutta, 2008). Being healthy becomes an individual choice, that is, a person is solely accountable for his or her own health. As pointed out by Lahelma (2005), however, health inequity cannot be attributed to lifestyle alone but must be understood as socially enacted. Attributing health to individual responsibility is problematic because it does not take into account how access to food, shelter, and other basic health resources or lack thereof affects compliance to prescriptions in health promotion campaign messages. Placing the burden on individuals to engage in healthy behavior without regard for other factors (i.e., cultural, structural, and community) (Dutta, 2010, 2011; Dutta-Bergman, 2005) justifies the absence of governmental accountability regarding health. Drawing on the culture-centered approach, Acharya and Dutta (2012) critiqued HIV/AIDS communication and found that health promotion campaign messages had limited success in reducing the risk of infection despite continuous efforts at increasing awareness. Even among developed countries, Lahelma (2005) also maintained that "the poorer the social position, the poorer the health" (p.

86). In the case of women from a tribal population in India, Acharya & Dutta (2012) found that recommendations such as abstinence and monogamy for HIV/AIDS prevention were structurally difficult, if not impossible.

The practice of blaming individuals for their health conditions while completely disregarding their socio-economic position, place, socio-demographic characteristics, or social networks (Kontos, Bennett & Viswanath, 2007) is also considered problematic using a structural critique, for health promotion can only become successful when it also begins to address the political and economic structures that prevent people from living healthy lives (Nettleton & Bunton, 1995). Indeed, in his concluding comment, Parish (1995) echoed the sentiment of former WHO Director General Mahler: "Health is indivisible . . . . The domain of personal health over which the individual has direct control is very small when compared to the influence of culture, economy, and environment" (p. 23).

Locating the Marginalization of Migrants in Health Promotion

Instead of promoting public health among those classified as having "elementary occupations," (HKSAR Census and Statistics Department, 2012, p. 73), the CHP and its health promotion campaign messages have marginalized FSHWs from basic resources (Dutta, 2012). To illustrate: a poster related to influenza prevention (Figure 1) circulated in three Southeast Asian languages recommends that target audiences should make healthy living a habit. The problems with this poster are two-fold. First, tip number 4, translated as "Observe good ventilation," assumes that all FSHWs have direct control of the ventilation in their homes. Second, tip number 6, translated as "Keep a healthy lifestyle," assumes that all FSHWs have access to quality food and adequate rest and sleep. In order to adopt healthy lifestyles, people must first be able to fulfill their food and shelter needs (UNDP, 2009). If quality shelter and food are required to prevent influenza, then these must be available to FSHWs. However, not all FHSWs have access to these (Lowe, 2007). Although some were fortunate to share well-ventilated rooms with children of their employers, other FSHWs slept on kitchen or bathroom floors or even along hallways (Constable, 2004). Along with the problem of poor shelter, Sobritchea et al. (2010) also noted that some FHSWs did not have personal sleeping quarters. And even if FHSWs had private rooms, these rooms had no proper ventilation, which became a problem particularly during summer (Constable, 2004, pp. 135-136)

The living conditions of FHSWs, particularly of those who stay in inhabitable rooms, must not be taken for granted. The claim that "these are just isolated cases" is the culprit for justifying the inaction of both the Philippine and HKSAR governments in guaranteeing access to basic health

Figure 1. Influenza prevention-related poster circulated in Bahasa Indonesia, Thai, and Tagalog from the CHP Department of Health (2011)..

Figure 2. Influenza-related health promotion material circulated in Tagalog from the CHP Department of Health (2006)..

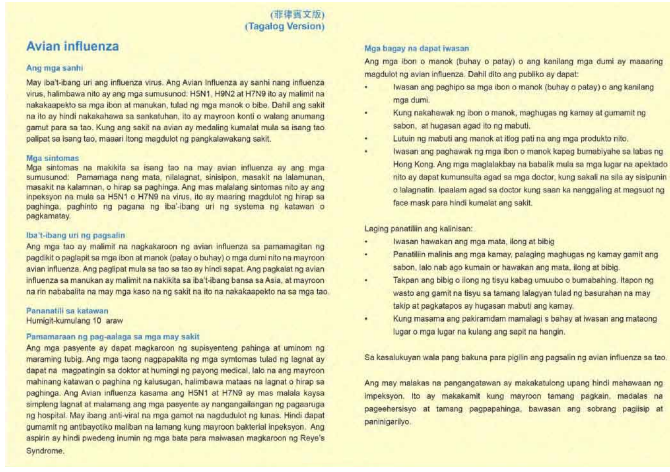


Figure 3. Influenza prevention-related pamphlet circulated in Tagalog with translation from the CHP Department of Health, (n.d.)..

needs among populations regardless of gender, ethnicity, and class.

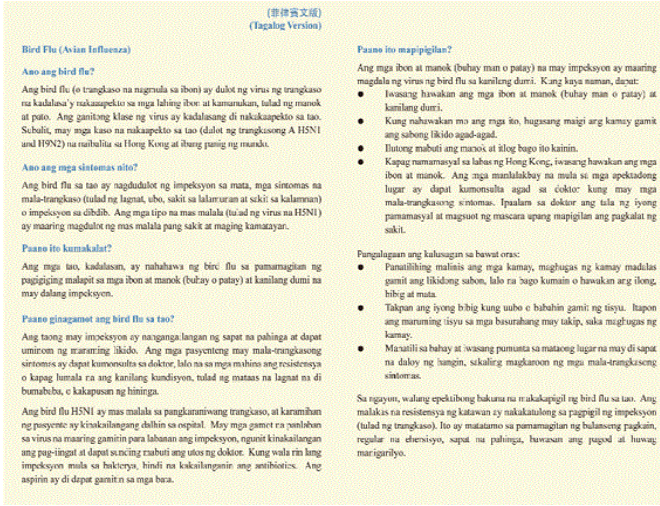
Another CHP poster (Figure 2) also advocates for a healthy lifestyle and good hygiene among foreign domestic helpers, but as Dutta-Bergman (2004) explained, health-promotion communication messages must take into account the marginalized groups' access to healthy food. For some FHSWs, having enough food to eat was a serious problem (Lowe, 2007). In her fieldwork, Constable (2007) learned that some FHSWs were given "overripe fruit and leftovers that no one else wanted" (p. 107) and that for FHSWs who were Muslims, their employers' preference for pork prevented them from eating sufficient amount of food every mealtime (Constable, 2007).

Basic health needs extend to preventive services. Preventive services refer to health promotion that provides information and resources that help avoid threats to health (Dutta, 2008). Of interest to this article is the prescription found in influenza- and avian influenza-related health-promotion campaign messages reminding FHSWs to get vaccinated or to visit a health-care professional for additional information. In the following poster's fourth paragraph (Figure 3), the Department of Health of HKSAR recommends vaccination as an effective way for FHSWs to reduce the risk of getting influenza and to minimize its complications. This message is problematic on two accounts. First, by operating within the biomedical perspective, this poster assumes that vaccination is accepted among FHSWs. Second, even if vaccination is culturally accepted, FHSWs are severely constrained by material and working conditions to go to private clinics or even public hospitals.

Despite the almost abandoned debate between biomedical and social constructionist perspectives (Sharf & Vanderford, 2003), the poster also completely disregards the cultural meanings (Lupton, 1994) of health in general and of vaccination in particular (Olufowote, 2011) for FHSWs. It assumes that FHSWs' view of health is the same as the one held by medical professionals, and thus, they are not expected to oppose vaccination.

Driven by their objective of behavior change, health promotion campaign messages seldom succeed because of a resistance from minorities whose definitions of health, which are tied to tradition, remain unchanged even with the changes in their physical context. With its underlying assumption that vaccination is unquestionably good, this third poster has participated in the marginalization of FHSWs and their possible opposing meanings to the relative merit of the prescription.

Aside from vaccination, the prescription on how to prevent avian influenza is also in pamphlet form (Figure 4). The fourth bullet point under the fifth heading, translated as "Avoid touching chickens and birds when



(非律宾文版)
(Tagalog Version)

Bird Flu (Avian Influenza)

Ano ang bird flu?

Ang bird flu (o trangkaso na nagmula sa ibon) ay dulot ng virus ng trangkaso na kadalasa'y nakaaapekto sa mga lahing ibon at kamanukan, tulad ng manok at pato. Ang ganitong klase ng virus ay kadalasang di nakakaapekto sa tao. Subalit, may mga kaso na nakaaapekto sa tao. Subalit, may mga kaso na naibalita sa Hong Kong at ibang panig ng mundo.

Ano ang mga sintomas nito?

Ang bird flu sa tao ay nagdudulot ng impeksyon sa mata, mga sintomas na mala-trangkaso (tulad ng lagnat, ubo, sakit sa lalamunan at sakit sa kalamnan) o impeksyon sa dibdib. Ang mga tipo na mas malala (tulad ng virus na H5N1) ay maaring magdulot ng mas malala pang sakit at maging kamatayan.

Paano ito kumakalat?

Ang mga tao, kadalasan, ay nahahawa ng birc flu sa pamamagitan ng pagigiging malapit sa mga ibon at manok (buEay o patay) at kanilang dumi na may dalang impeksyon.

Paano ginagamot ang bird flu sa tao?

Ang taong may impeksyon ay nangangalangan ng sapat na pahinga at dapat uminom ng maraming likido. Ang mga pasyenteng may mala-trangkasong sirtomas ay dapat kumonsulta sa doktor, lalo na sa mga mahina ang resistensya o kapag lumala ra ang kanilang kundisyon, tulad ng mataas na lagnat na di bumababa, o kakapusan ng hininga.

Ang bird flu H5N1 ay mas malala sa pangkaraniwang trangkaso, at karamihan ng pasyente ay kinakailangang dalhin sa ospital. May mga gamot na panlaban sa virus na maaring gamitin para labanan ang impeksyon, ngunit kinakailangan ang pag-iingat at dapat sunding mabuti ang utos ng doktor. Kung wala rin lang impeksyon mula sa bakterya, hindi na kakailanganin ang antibiotics. Ang aspirin ay di dapat gamitin sa mga bata.

Paano ito mapipigilan?

Ang mga ibon at manok (buhay man o patay) na may impeksyon ay maaring magdala ng virus ng bird flu sa kanilang dumi. Kang kuya naman, dapat:

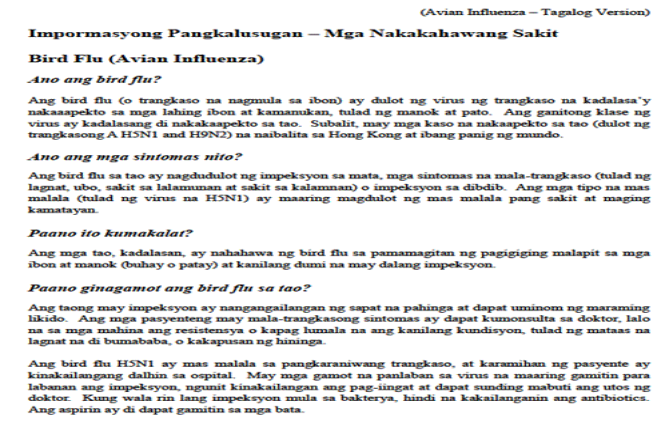
- Iwasang hawakan ang mga ibon at manok (buhay man o patay) at kanilang dumi.
- Kung nahawakan mo ang mga ito, hugasang maigi arg kamay gamit ang sabong likido agad-agad.
- Ilutong mabuti ang manok at itlog bago ito kainin.
- Kapag namamasyal sa labas ng Hong Kong, iwasang hawakan ang mga ibon at manok. Ang mga manlalakbay na mula sa mga apektadong lugar ay dapat kumonsulta agad sa doktor kung may mga mala-trangkasong sintomas. Ipaalam sa doktor ang tala ng iyong pamamasyal at magsuot ng mascara upang mapigilan ang pagkalat ng sakit.

Pangalagaan ang kalusugan sa bawat oras:

- Panatilihing malinis ang mga kamay, maghugas ng kamay madalas gamit ang likidong sabon, lalo na bago kumain o hawakan arg ilong, bibig at mata.
- Takpan ang iyong bibig kung ubo e babahin gamit ng tisyu. Itapon ang maruming tisyu sa mga basurahang may takip, saka maghugas ng kamay.
- Manatili sa bahay at iwasang pumunta sa mataong lugar na may di sapat na daloy ng hangin, sakaling magkaroon ng mga mala-trangkasong sintomas.

Sa ngayon, walang epektibong bakuna na makakapigil ng bird flu sa tao. Ang malakas na resistensya ng katawan ay nakakatulong sa pagpigil ng impeksyon (tulad ng trangkaso). Ito ay matatamo sa pamamagitan ng bulanseng pagkain, regular na ehersisyo, sapat na pahinga, buwasan ang pagod at huwag mariigarilyo.

Figure 4. An avian influenza prevention-related pamphlet circulated in Tagalog from the CHP Department of Health (2011)..



(Avian Influenza – Tagalog Version)

Impormasyong Pangkalusugan – Mga Nakakahawang Sakit

Bird Flu (Avian Influenza)

Ano ang bird flu?

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Figure 5. A fact sheet about avian influenza circulated in Tagalog from the CHP (2010)..

traveling outside Hong Kong. Travelers from affected places must consult a doctor immediately upon experience of influenza-like symptoms. Inform a doctor of your travel history and wear mask to avoid spread of disease," explicitly encourages FHSWs to visit their doctors in order to help prevent avian influenza. This prescription is problematic on two levels.

First, it assumes that FHSWs have direct control over their time at work. Using focus group discussions (FGDs) and interviews to understand the working conditions in HKSAR, Sobritchea et al. (2010) found that some FHSWs had to deal with unreasonable work hours. A participant shared her experience of not having enough rest time at work: "You go to the toilet not because you have to urinate but so you could have little rest. You sit down and lean back and close your eyes, and in that way you get rid of some of your

drowsiness" (p. 55). Moreover, some FHSWs complained about unreasonable workload. Aside from working almost twelve hours a day without overtime pay (Constable, 2004), some FHSWs were even brought to the houses of the relatives of their employers to provide additional household work. Having this kind of working condition prevents FHSWs not only from accessing health information on local media channels but also from seeing a doctor to seek health information (CARAM Asia, 2006).

Second, and even more importantly, FHSWs hesitate to consult doctors because of their fear of losing their jobs (CARAM Asia, 2006). The mere act of seeing a doctor, even if they were found to be free from avian influenza or any illness for that matter, might send the wrong signals to their employer. In an FGD, a FHSW shared that "there have been many instances when an employer will say, after the domestic worker has gone to the doctor two or three times, 'Okay, I think that it's better that you return to the Philippines and rest'" (Sobritchea et al., 2010, p. 80). The fear of having their employment contracts terminated results in their refusal to seek medical attention even during emergency situations. The context in which FHSWs construct their meanings of health, in contrast to that of professional migrants or under-skilled locals, is indeed inflected by their working conditions and living arrangements. As Dutta (2008) argued, "members of marginalized…" (p. 178) because, to begin with, the determination of FHSWs to seek medical attention is largely tied to work and influenced by their employers' decisions.

The capacity of influenza- and avian influenza-related health promotion campaign messages to marginalize their intended receivers also extends to the use of healthcare infrastructures (Carballo, 2007). Healthcare infrastructures refer to "the array of services for detecting and treating illnesses and the variety of treatment options which are typically available to patients and communities" (Dutta, 2008, p. 179). In contrast with other health promotion campaign messages presented in this article, a fact sheet for communicable diseases, for avian influenza in particular (Figure 5), focuses already on the instant an FHSW gets infected. The fourth heading presents various measures to cure avian influenza, and the second sentence under this heading emphasizes that an infected migrant should immediately see a doctor.

Although some FHSWs provided positive feedback regarding the quality of medical services in HKSAR (Sobritchea et al., 2010), others also shared their unfavorable experiences regarding discrimination by healthcare professionals (Sobritchea et al., 2010), some of it owing to the language barrier (CARAM Asia, 2006). These issues were compounded by brief consultation and long waiting periods. For example, an FHSW confided that

"when you go for a checkup, sometimes it takes months before your next one. The doctor will say, 'It's not yet that serious.' But you feel in your body that something is wrong" (Sobritchea et al., 2010, p. 63), and these kinds of situation lead women "to seek care late and when they do have problems, they have much worse outcomes than other women in the host population" (Carballo, 2007, p. 2).

Looking at these five health promotion campaign messages using a structural critique and a culture-centered approach, it is clear that the influenza- and avian influenza-related health promotion campaign messages for FHSWs have not only been ineffective but have also led to the marginalization of FHSWs. First, these health promotion campaign messages take for granted that FHSWs will immediately subscribe to vaccination. Second, they assume that FHSWs have sufficient access to quality food and rest. Third, they assume that FHSWs have the resources to avail of the prescribed preventive services. Finally, these health promotion campaign messages assume that FHSWs have adequate access to healthcare services.

In conclusion, while not all FHSWs are deprived of quality food, shelter, and rest, as well as adequate access to health information and care, the experiences of those who have been deprived, regardless of representativeness, should not be taken for granted. Health promotion campaign messages, must not escape the attention of the critics of media because, instead of promoting health, these messages could be counterproductive, thereby overburdening FHSWs physically, emotionally, and financially. Most importantly, these campaign messages tend to reduce the accountability of employers, recruitment agencies, and governments of HKSAR, and the Philippines in promoting the health of FHSWs.

Calls to action in migrant health programs and policies need to be outlined. This article could serve as a formative basis for improving health promotion campaign messages for FHSWs. A good health promotion campaign should first identify FHSW attitudes toward health and the barriers that the campaign is likely to encounter. Problem identification should begin by collaborating with FHSWs or at least with non-government organizations working for migrants. Moreover, health promotion campaign messages for FHSWs should also include employers as primary audience.

Beyond its immediate research context, the findings of this study could be taken as a reminder for the Philippine government to give more attention to informing FHSWs of their health rights in their countries of destination. In this endeavor, the government should be supported by health communication scholars who could provide incisive analyses of how seemingly well-meaning health promotion initiatives perpetuate the systemic but subtle violence that ethnicity and class inflict upon foreign workers. Although necessary, a

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JAN MICHAEL ALEXANDRE C. BERNADAS is a UGC graduate student scholar of media and communication. He is interested in interpersonal health communication of patients diagnosed with non-communicable illness and health information seeking behavior of Filipino household service workers. Aside from research, Jan also engages in organizational training and development (corresponding author: jbernadas2-c@my.cityu.edu.hk).