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LABOUR MIGRATION, GENDER, AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS



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WHEN CROSSING BORDERS: Recognising the Sexual and Reproductive Health and Rights of Women Migrant Workers

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1. International Organisation for Migration (IOM). World migration report 2010. Geneva: IOM; 2011.
2. United Nations Department of Economic and Social Affairs (UN DESA), Population Division. The age and sex of migrants 2011 wall chart. New York: UN DESA; 2012.
3. In the past decade, the issue of climate-change-induced migration has produced what the IOM calls “environmental migrants,” or persons who, for compelling reasons of sudden or progressive change in the environment that adversely affects their lives or living conditions, are obliged to leave their habitual homes, or choose to do so, either temporarily or permanently, and who move either within their country or abroad.
4. UN DESA. International migration report 2002. New York: United Nations; 2002.
5. United Nations. Universal Declaration of Human Rights. [cited 2012 July 17]. Available from: www.un.org/en/documents/udhr/index.shtml
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Migration and population mobility has become a permanent facet of a rapidly globalising world, and the Asia-Pacific region is no exception. In 2010, Asia accounted for 27.5 million international migrants, representing close to 13% of the total global figure of 214 million. Women constituted 48% or almost half of that figure.¹ On the other hand, the Pacific region had approximately six million international migrants in 2010, of which 51.3% were women.²

Migration (see Definitions) results from the interactions between political, social, economic, cultural, and environmental factors. It encompasses various forms of movement of people, and is characterised by duration, reason and form. It includes migration of refugees, displaced persons, economic migrants, environmental migrants,^{3,4} and persons moving for other purposes, including family reunification.⁴ Distinctions are commonly drawn among migrants according to whether their movement is classified as forced or voluntary, internal or international, temporary or permanent, or economic or non-economic.⁵

For purposes of this editorial, the focus will be on international women migrant workers, specifically those who work within temporary contractual arrangements.

Economic migration, or migration for employment, has dominated the movement of people in Asia and the Pacific region. For example, the Philippines has an estimated total of 4.4 million contract workers deployed abroad.⁶ Latest figures from Indonesia estimate a total of 4 million migrant workers, of which 75% are women.⁷ Thailand has an estimated 3.14 million migrants coming from Burma, Cambodia

and Laos, half of which are unregistered. Malaysia had 1.8 million registered migrant workers in 2010, with Indonesians accounting for half of the total figures. Undocumented migrant workers may equal the number of documented workers employed in Malaysia, although this is hard to verify.⁸ In the Pacific, New Zealand recruits temporary workers from Kiribati, Samoa, Tonga, Tuvalu and Vanuatu for periods of up to seven or nine months. The scheme, which was launched in 2007, entails deployment of up to 5,000 seasonal workers in the horticulture and viticulture industries.⁹ In the case of women migrant workers, nurses from Fiji have migrated to rim countries and secondarily to the Middle East.⁹

Labour migration flows and trends are influenced by gender dynamics in the countries of origin and destination. While migration can provide new opportunities to improve women's lives and change oppressive gender relations, it can also perpetuate and entrench traditional roles and inequalities and expose women to new vulnerabilities as the result of precarious legal status, exclusion and isolation.¹⁰ Vulnerabilities are severe and acute among women migrants in unsupervised and unregulated sectors—such as domestic work—and include violence, exploitation, abuse and labour rights violations.

Gender issues permeate all aspects of migration, including health. For women migrant workers, sexual and reproductive health and rights (SRHR) are key domains where gender and migration intersect. SRHR of women migrant workers are subject to regulation by both countries of origin and destination. These regulations begin even before their deployment, with the requirement of medical

screening for various conditions and diseases, including pregnancy, HIV and other sexually transmitted infections (STIs). Approximately 60 governments have established pre-departure and post-arrival medical screening of migrant workers. On the other hand, not all countries have done the same for providing health and rights information and education to migrants. Pre-departure training and seminars, which have become mandatory for countries like Cambodia, Indonesia and the Philippines, sometimes include topics on reproductive health and HIV and AIDS, but these depend largely on who is conducting these seminars.

Once women workers are in the country of employment, labour and immigration policies further curtail their SRHR. Many women experience restrictions in their freedom of movement, especially when employers confiscate their passports and identity documents. Countries like Singapore, Malaysia, Taiwan and almost all of the Gulf Cooperation Council (GCC) countries require pregnancy and HIV testing, either on a yearly basis or upon renewal of contracts. Those who get pregnant or acquire a sexually transmitted infection, such as HIV, could be imprisoned or deported. Marriage and childbirth are prohibited and there are restrictions when it comes to women migrant workers accessing abortion or contraceptives. These policies do not consider that women migrant workers travel with their sexual histories and sexual and reproductive health (SRH) notions and practices.¹⁰

Migrant workers, especially those classified as temporary and belonging to semi-skilled or 'unskilled' categories, often have limited access to health services and information. They fall through the cracks of the health system, both of their countries of origin and destination.¹⁰ They face multiple barriers in accessing SRH services, including: language barriers and the lack of translation services in health facilities; lack of familiarity with the health system; high cost of services, especially if these are not covered by insurance (particularly as health insurance packages, even if they are provided, offer basic coverage and they do not cover SRH services); bias or discrimination against non-nationals by health care providers; the lack of sanctions

against employers who deny health insurance or services to their workers; and lack of knowledge about SRHR. In addition, female migrant workers have to deal with the negative attitude of employers towards ill or pregnant workers and with fear of termination from the job due to illness and pregnancy.

Currently, there are no sustainable pre-departure, post-arrival and reintegration programmes in the region that address SRHR of women migrant workers. While there have been attempts to integrate SRHR in the pre-departure curriculum in a number of origin countries, these are not sustained or reinforced in most countries where women go to work and live for extended periods of time once they are employed abroad. For example, very few women migrant workers receive comprehensive SRHR information during the pre-departure seminars in the Philippines. Such information is provided only by a few NGOs. Once they move to other countries to work, they have even less or no access to SRHR information, as part of a more sustained onsite intervention programme.

There are unique efforts by NGOs to address SRH of women migrant workers, such as the Women's Exchange programme by the Migrants Assistance Programme (MAP) Foundation in Thailand, which enables Burmese women to have access to SRHR information provided mainly by trained peer educators and organisers. In Hong Kong, the St. John's Cathedral HIV Education Centre conducts outreach activities, such as HIV and AIDS awareness-raising for foreign domestic workers. These efforts mainly involve CSOs and NGOs who often see health issues, including SRHR, as part of the overall rights and entitlements of migrant workers. Yet most of these efforts are independently supported and are often carried out as 'projects,' and not as long-term programmes.

In the ASEAN region, there are a number of policy frameworks on migration and health that have been developed and agreed upon by countries, such as the 2007 Association of Southeast Asian Nations (ASEAN) Declaration on the Protection of the Rights of Migrant Workers and the 2011 ASEAN Declaration on HIV and AIDS. ASEAN has also convened

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11. Conel J, Negin J. Migration, mobility and HIV: A rapid assessment of risks and vulnerabilities in the Pacific. United Nations Development Programme (UNDP) and Secretariat of the Pacific Community (SPC); 2010.

a number of high-level dialogues involving member governments, international agencies and civil society to develop recommendations to address health and HIV risks and vulnerabilities of migrant workers. In the Pacific, a Regional Strategy on HIV and Other STIs (2009-2013) includes migrant and mobile populations as one of the key populations that need to be addressed. However, targeted and tailored prevention programmes that address the specific vulnerabilities and risks of migrants and mobile populations still need to be developed.¹¹ These policies also need to go beyond HIV towards addressing full SRHR.

Other international agreements that most countries in the Asia-Pacific region are signatories to include the International Conference on Population and Development (ICPD) Programme of Action (PoA) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). It should be noted though that while ICPD has the most comprehensive coverage of SRHR commitments and has an entire separate section on migration, it actually does not provide specific recommendations to address SRHR of women migrant workers. Meanwhile, the Committee on the Elimination of Discrimination against Women came up with General Recommendation No. 26 during its 42nd session in 2008, which included specific mention of

...origin and destination countries must ensure the provision of comprehensive SRH services and education at all phases of the migration cycle and facilitate the establishment of linkages and referral networks with migrant-friendly SRH service providers...women migrant workers must be empowered to make choices and decisions that affirm their bodily integrity and sexuality, and protect them from potential SRH risks and vulnerabilities.

the health of women migrant workers. The Recommendation urges countries of origin to “deliver or facilitate free or affordable gender- and rights-based pre-departure information and training programmes,” which include “information on general and reproductive health, including HIV and AIDS prevention.”

The movement of people implies the movement of sexual desires, beliefs, expressions and acts. SRHR in the context of migration requires multi-faceted, and multi-sectoral approaches throughout the migration continuum. However, the politicised nature of migration and the conflicts arising from immigration policies, public health and human rights, present real challenges. Many destination countries remain unwilling to recognise the human rights of migrant workers, including SRHR. The imposition of mandatory HIV and pregnancy testing, for instance, is seen universally as violative of a person’s right to privacy and bodily integrity. However, immigration policies impose this requirement for workers behind the guise of public health. Despite repeated calls from health and migrants’ rights organisations, many countries have not acted to concretely address the disharmony and incoherence of such policies.

In 2013, the forthcoming 46th session of the Commission on Population and Development (CPD) will focus on the theme, “New Trends in Migration: Demographic Aspects.” In the same year, the second High-level Dialogue on International Migration and Development will be held. These two global events provide unique opportunities to once again advocate for inclusion of SRHR of migrant workers in the political agenda of countries. Thus, it is crucial for advocates to know the processes leading to the High-Level Dialogue, engage in national, regional and global process, and undertake crucial interventions to advance the SRHR agenda in the migration and development discourse.

Another milestone to track is the ICPD Beyond 2014 Review, which has a key objective to facilitate the integration of the population and development agenda into the UN development agenda beyond 2015. Sectoral, national and

regional consultations have been held to assess the implementation of the ICDP Programme of Action. The results of the review will feed into the UN Secretary General's report, which will be presented in the 2014 Session of the CPD. Another review being done is that of the 2015 Millennium Development Goals (MDGs), which is also envisaged to provide the inputs for the post-2015 development agenda.

In order to ensure SRHR of women migrant workers, origin and destination countries must ensure the provision of comprehensive SRH services and education at all phases of the migration cycle and facilitate the establishment of linkages and referral networks with migrant-friendly SRH service providers. There is a need to increase and improve data generation on

SRHR issues of women migrant workers, as evidence and basis in the development of relevant and appropriate SRHR policies and programmes. Punitive policies should be reviewed and repealed, such as the conduct of compulsory testing and deportation of women migrant workers on account of pregnancy or HIV status. Lastly, women migrant workers must be empowered to make choices and decisions that affirm their sexual and reproductive rights, and protect them from potential SRH risks and vulnerabilities. To achieve this, governments from origin and destination countries must work together with civil society and other stakeholders in creating an environment that will enable women migrant workers to make life choices and exercise their sexual and reproductive rights.

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SEXUAL AND REPRODUCTIVE RIGHTS ARE MIGRANTS' RIGHTS: Contesting Policies for Low-Skilled Migrants in Southeast Asia

Increasing interdependence of goods and labour markets in an unbalanced global economy is spurring migration flows across the world. Southeast Asia is also evolving into a global and regional migration hub for incoming, outgoing and transiting migrants who most often are employed in manual jobs with little legal and social protection.

Spurred by intra-regional economic and demographic gaps, an increasing number of low-

skilled workers are crossing borders along two main circuits, from Southeast Asian countries to the Middle East and the Gulf States, and across Southeast and East Asian countries.

Despite the specific features of the two circuits, the policy approach to manage these, often undocumented, migration flows is similar in that States aim to discourage them except when strictly controlled. Reluctant to integrate low-skilled migrants on nationalist grounds, but

Notes and References

1. Marriage migration, such as in Taiwan, is not the focus of this brief article. However, inconsistencies with labour migration policies can be noted in that migrants' sexuality and reproduction is appreciated in this case since it serves the social reproduction purposes of the nation (see www.ari.nus.edu.sg/docs/wps/wps12_174.pdf)
2. www.rsis.edu.sg/nts/HTML-Newsletter/alert/NTS-alert-feb-1001.html

willing to utilise their labour to foster economic growth, governments in the region have opted to promote contract migration of a temporary nature.

A two-tier system has been established, where autonomous migration is only envisioned, and at times encouraged with visa facilitations and immigration incentives, for professionals and business persons.

Likewise, when there is discussion of free flow of labour in the context of regional integration frameworks, such as the Greater Mekong Sub-region (GMS) Regional Cooperation or the Association of Southeast Asian Nations (ASEAN) Economic Community (AEC), it applies to tourists, students and highly skilled labour. Such policy attempts often fail to make provision for the larger transnational flow of low-skilled migrants.

As part of the effort to closely regulate all details of low skilled migrants' employment and stay in the host countries, migration policies have also dealt with migrants' sexuality and reproduction. In particular, migrants' bodies and their sexual and reproductive behaviours have become the objects of regional, bilateral

If...we want to re-humanise low-skilled migrants, we ought to challenge such contract arrangements and the dual system differentiating them from high-skilled migrants. We ought to start advocating for independent and permanent migration options as well for low-skilled workers. Such fundamental shift is essential to enable the reinstatement of migrants' agency and the fulfilment of their sexual and reproductive health and human rights.

and national policies focusing on three issues: (i) management of contract migration, (ii) HIV and AIDS prevention, and (iii) human trafficking. While all these policies express a preoccupation with sexually active low-skilled migrants in terms of their possible impact on societal structures and public welfare, the discourses articulated by each of them to express this concern and the measures employed to control the expected consequences are different.

In contract labour arrangements, low-skilled migrants are reduced to asexual beings.¹ High-skilled workers are given opportunities to settle with their families, but low-skilled workers are only accepted in contract arrangements as 'single.' When married, they cannot migrate under the same contract programme with family members and there are no provisions for family reunion in the land of destination. Spouses have to apply separately with no guarantee of being placed in the same location. In the host country, low-skilled migrants are not expected to become engaged or get married with locals. Even between migrant workers, few legal venues exist for formal marital relations.

Female migrants have to undergo pregnancy tests, and if found pregnant before departure, they are excluded from the programme. If pregnancy occurs during their stay, they are repatriated. When they manage to remain in the country and join the many undocumented workers, their children may not be recognised by both their country of origin and their destination country, and are at risk of becoming stateless. In Thailand, the number of stateless children is estimated at 1 million, mostly children of Burmese migrant workers.²

If migrants' reproduction is the concern of migration policy, sexuality is the focus of HIV and AIDS prevention programmes. There, migrants are portrayed as a source of disease whose risky sexual behaviour needs to be controlled. Even if a rhetoric of vulnerability is most often used, migrants as a group are targeted for their supposedly risky behaviours, with too little attention for the systemic socio-economic and gender factors conducive to such behaviour.

Notwithstanding evidence that migrants often contract HIV in the host country, they are viewed as the 'culprits' and singled out among the many other mobile groups. HIV testing is mandatory to enroll in the programme and, as in the case of Singapore, repeated at regular intervals during their stay—a requirement that does not apply to high-skilled migrants. Few prevention and control programmes focus on tourists, business persons and foreign students, even if their total numbers are often larger and their sexual behaviour not necessarily safer than those of low-skilled migrants. This heightened public health attention in turn reinforces the stereotype that migrants are a conduit for the spreading of disease in the host country.

If not sanitised, sexuality is prone to being criminalised. Anti-trafficking laws and programmes, with their strong bias towards trafficking for sexual purposes and their lesser attention for trafficking in non-prostitution sectors, are blurring the lines between smuggling, prostitution and labour exploitation. Too often, the scope of trafficking efforts is expanded to cover migrant sex workers. The latter's classification as 'trafficked victims' not only denies their agency, but also has policy implications, since the solution for this category is to 'rescue' and repatriate them, rather than ensuring safe and non-exploitative work conditions. The trafficking discourse reinforces calls for harsh security and control measures to protect the victims, rather than the easing of cross-border travel and more hospitable migration policies for low-skilled workers. This is despite arguments that such conditions would actually contribute to reduce trafficking opportunities.³

These various discourses reflect the reality of societies unprepared to accept low-skilled migrants, viewing them as detrimental to the nation-building process and the preservation of dominant culture. In an effort to prevent

integration, their reproduction and sexuality is controlled. Low-skilled migrant workers undergo a dehumanisation process as 'migrant stock,' wherein they are disallowed to manifest their sexual and reproductive needs and enjoy their sexual and reproductive rights.

According to gender and hetero-normative stereotypes, female migrants are targeted in their reproductive, as well as their sexual capacity. On the other hand, male migrants mostly come into the picture in relation to 'risky' sexuality issues, and other sexualities are simply ignored.

Interestingly, not many have raised objections to such situations. Contract labour arrangements are often also perceived as safer migration by a majority of migrant rights' organisations, and a preoccupation with sexually transmitted infections and AIDS dominate the agenda of sexual and reproductive health (SRH) organisations.

The voices of alternative groups challenging the trafficking paradigm, such as the Empower Foundation in Thailand,⁴ are still too weak to be heard. With few exceptions, foremost the Solidarity for Migrant Workers in Singapore,⁵ emerging human rights advocacy attempts centre on selected elements, such as against mandatory HIV testing, in isolation from other SRHR components and with little questioning of the discriminatory ideology behind this.

If, however, we want to re-humanise low-skilled migrants, we ought to challenge such contract arrangements and the dual system differentiating them from high-skilled migrants. We ought to start advocating for independent and permanent migration options for low-skilled workers. Such fundamental shift is essential to enable the reinstatement of migrants' agency, and the fulfilment of their sexual and reproductive health, and the respect of their human rights.

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4. www.empowerfoundation.org/index_en.html
5. www.home.org.sg/downloads/UPR_Report_011110.pdf

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Disclaimer

The views expressed here are those of the author and do not represent the organisations she is associated or has been associated with.

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TRANSNATIONAL MIGRATION IN SOUTHEAST ASIA AND THE GENDER ROLES OF LEFT-BEHIND FATHERS

- 1 A full version of this article, 'Long-distance fathers, left-behind fathers and returnee fathers: Changing identities and practices among fathers in Indonesia and the Philippines,' will be published in Inhorn M, Chavkin W, Navarro JA, editors. *Globalised fatherhoods*. New York: Berghahn.
- 2 Chantavich S. *Female labour migration in South East Asia: Change and continuity*. Bangkok: Asian Research Centre for Migration; 2001.
- 3 'Father-carer' is an abbreviated phrase that describes fathers who have reported themselves as their children's primary caregivers during their migrant spouse's absence. It does not imply that fathers outside of this study do not perform care work or that they are the only caregivers. Generally, Indonesian, Filipino and Vietnamese men are not expected to assume the primary caregiver's role when their wives are present.
- 4 CHAMPSEA is a mixed-method study investigating the impacts of parental migration on child's health and wellbeing in Southeast Asia. The quantitative data is derived from surveys conducted in 2008 with some 1,000 Indonesian (East and West Java), Filipino (Laguna and Bulacan) and Vietnamese (Hai Duong and Thai Binh) households with at least a child who is aged either 3 to 5 (young child) or 9 to 11 (older child). Further interviews with around 50 Indonesian (East Java), Filipino (Laguna) and Vietnamese (Thai Binh) carers from the same pool of households were conducted between 2009 and 2012. For a more comprehensive explanation of the research institutions, research methodology and ethical concerns, refer to: Graham E, Jordan L, Yeoh BSA, Lam T, Asis M, Sukamdi. *Transnational families and the family nexus: Perspectives of Indonesian and Filipino children left behind by migrant parent(s)*. *Environment and Planning*. 2012; 44(4): 793-815. See also: Jordan L, Graham E. *Resilience and well-being among children of migrant parents in South-East Asia*. *Child Development*. 2012; 83(5): 1672-1688.

Introduction. The feminisation of labour migration in Southeast Asia, resulting from the rising demand for domestic and care workers in gender-segmented global labour markets, is reformulating householding strategies in sending countries in the region. While women-as-mothers rewrite their roles (but often not their identities) as productive migrant workers who now contribute to their children's wellbeing through financial remittances and 'long-distance mothering,' fathers' traditional roles are also being reworked.

While some studies indicate that left-behind men do take over the migrant mothers' task of nurturing and assume more caregiving roles during the women's absence,² more specific evidence is needed on the caregiving practices of left-behind men and the ensuing impact on their gender roles. This article

As more Southeast Asian mothers migrate for work, gender ideologies around parenthood remain resilient but flexible at the Southernmost end of the care chain. When care cannot be further purchased from elsewhere or where help is simply unavailable, fathers step up to do what is necessary.

provides a snapshot of the previously neglected fathering practices and care provisioning in the Filipino, Indonesian and Vietnamese 'mother-migrant, father-carer'³ households within the CHAMPSEA⁴ study.

Fathering Practices in 'Mother-Migrant, Father-Carer' Households. Mothers continue to be the main carers for children from non-migrant Filipino, Indonesian and Vietnamese households. When mothers become the overseas breadwinner, children's care arrangements featured a more visible proportion of non-parental carers (mainly grandmothers but also other close relatives), although the majority—particularly in Vietnam—were cared for by their fathers. These father-carers, especially Filipinos, were more likely to be caring for an older rather than a younger child when mothers migrate, while Indonesian father-carers tend to spend the most time caring for their children.⁵

Compared to left-behind mother-carers, left-behind father-carers generally spent fewer hours in carework. This is possibly because father-carers were also more likely to be engaged in waged employment outside the home even though they were their children's primary carers.

In contrast, when fathers migrate, mother-carers engaging in outside employment were a minority, except in Vietnam. With the exception of Vietnam again, Indonesian and Filipino father-carers received more help and support from other relatives, especially in baby-sitting, as compared to mother-carers. Overall, the father-

carer figure that emerges from the CHAMPSEA study is one who is engaged in remunerative labour (e.g., farming/agricultural work for Indonesian, driving for Filipino and elementary occupations for Vietnamese father-carers), alongside taking primary responsibility for the care of his children, while receiving support from others in discharging care duties. Through the interviews, CHAMPSEA father-carers were found to be involved in physical aspects of caring (i.e., earning money, sending children to school and others), as well as the intimate aspects of carework, such as cooking, feeding and bathing in relation to their children.

While left-behind father-carers in this study emphasised their adaptability and versatility in assuming the mothering roles vacated by their wives while retaining their identities as fathers, they did not assume carer roles easily as many had not participated actively in caregiving before their wives' migration. Some father-carers confessed to experiencing anxiety, stress and even health problems during their wives' absence.⁶

Left-behind fathers with adolescent daughters felt particularly uncomfortable and awkward when their daughters started menstruating. Others also lamented the longer hours spent in home-confinement, having sacrificed leisure activities and the freedom to spend an evening out with friends. On the whole, father-carers took on their caring duties quite positively and were happy to narrate a story of 'victory' over the odds, as they strived to provide both emotional and physical care, and be both 'father' and 'mother' to their children.⁷

Conclusion. As more Southeast Asian mothers migrate for work, gender ideologies around parenthood remain resilient but flexible at the Southernmost end of the care chain. When care cannot be further purchased from elsewhere or where help is simply unavailable, fathers step up

to do what is necessary. Despite fathers making up the majority of primary caregivers, there is a substantial proportion of 'other mothers,' such as grandmothers and aunts who assume the caregiving role, thus freeing fathers to continue with paid employment.

Nonetheless, the preferred parenting model for CHAMPSEA respondents was to either have both parents present to share in the caregiving work, or have gender-normative arrangements where fathers work abroad while mothers stayed behind.

Generally, left-behind father-carers in this study appeared to have coped well with the changes in gender roles during their wives' absence over the years, and at different life stages. Father-carers particularly expressed a sense of pride when they could claim that they have 'overcome the odds' in ensuring that their children were doing well under their charge.

Given the encouraging performance of CHAMPSEA's left-behind father-carers, more can—and should—be done to help them better juggle their roles as waged earners and primary caregivers. There should first be a provision of such considerations for left-behind father-carers within available employment opportunities.

Community organisations should also be sensitised to the needs of fathers and include them in relevant programmes. Father-carers' efforts at caregiving should be affirmed and eventually normalised, and supported at the level of policy formulation with regard to migration and development, as well as in practical ways through strengthening support networks for fathers in caring roles. By having more support for fathers, the society can then push for reaching greater gender equality in the sharing of household tasks and responsibilities.

Notes and References

- 5 The survey mainly focused on the material aspects of caregiving by taking into account who does the carework, which is divided into tasks, such as housework, babysitting and picking-up children. The types of caregiving that father-carers were actually engaged in emerged during the interviews.
- 6 Based on respondents' answers to the Self Reporting Questionnaire (SRQ20), a larger proportion of left-behind father-carers, compared to left-behind mother-carers, felt physical stress. Conversely, a higher percentage of left-behind mother-carers experience greater mental stress than their male counterparts.
- 7 For further discussions on the gendered aspects of caregiving in the Vietnamese context, refer to: Hoang LA, Yeoh B.S.A. Breadwinning wives and 'left-behind' husbands: Men and masculinities in the Vietnamese transnational family. *Gender and Society*. 2011; 25(6): 717-739. See also: Hoang LA, Yeoh BSA, Wattie AM. Transnational labour migration and the politics of care in the Southeast Asian family. *Geoforum*. 2012; 43(4): 733-740.

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MONITORING REGIONAL AND COUNTRY ACTIVITIES

SOUTHEAST ASIA: SRHR for Women Migrants in the Greater Mekong Sub-Region

Migrant workers, especially women migrants in Southeast Asia, often lack access to comprehensive information on sexual and reproductive health and rights (SRHR). They often receive very little practical knowledge before they go overseas, and in some cases, are simply encouraged to practice abstinence only. Women migrants' SRHR are often violated; for example, many governments have policies that require migrant women to undergo pregnancy and mandatory HIV testing as a consideration for entry or deportation. Migrant workers are also often denied access to sexual and reproductive health (SRH) services in countries of destination.

This situation contradicts international commitments made by Southeast Asian countries—all of whom are signatories to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC). They have also made commitments on SRHR at the International Conference on Population and Development (ICPD).

...one of the biggest challenges will entail building relations with often difficult to access ASEAN decision makers. Efforts will also include building space for a voice focused on SRHR of migrant women among CSOs with similar values from related sectors...

To address these challenges and to strengthen the SRHR of migrants, joint advocacy efforts of strong and active networks at national and regional levels are important. To this end, a regional workshop, "Review of the Greater Mekong Sub-region (GMS) Countries' Existing Reproductive Health Legislations, Policies, and Services for Women and Women Migrant Workers," was organised in Phnom Penh, Cambodia in September 2012 by Raks Thai Foundation in cooperation with CARAM Cambodia, and with the support of Rockefeller Foundation and the Asia Pacific Alliance (APA). This workshop provided a forum to discuss issues surrounding SRHR of women migrants and to explore potential advocacy opportunities.

Civil society organisations (CSOs) from six countries in the Greater Mekong Sub-region—Cambodia, China, Lao PDR, Myanmar, Thailand and Vietnam—came together to share and discuss their respective country contexts, and gaps in existing reproductive legislations, policies and services for women migrant workers. A number of key recommendations were formulated as a result of intense discussions, which should be taken within a broader human rights framework. Such a framework recognises the equality of all persons, including migrant workers, and their equal protection in the law in ASEAN member states.

The recommendations place a strong emphasis on the enablement of access to full, comprehensive and quality SRH services for all migrants and mobile populations, and especially women migrants, in countries of origin and

destination. This includes unrestricted access to full family planning and contraceptive services with a variety of contraceptive methods; STI and HIV prevention-related services, information, counselling, and treatment; and comprehensive sexuality education for youth. Migrant women, especially, need full information on SRHR; access to safe abortion services; access to maternal health services and antenatal care; and prevention services, such as cervical cancer vaccines and screening for cervical and breast cancers.

The promotion of better awareness and understanding of all government agencies, especially labour, police and legal departments, is essential to eliminate and address stigma and discrimination often experienced by migrants and mobile populations, and to increase recognition of their rights. The promotion of awareness is also crucial to achieve the elimination of gender inequality, including gender-based violence, another serious issue.

With the opening of ASEAN borders in 2015 due to the establishment of the ASEAN Economic Community, it is crucial that these issues get addressed through a cross-border approach. Plans to take this campaign forward

to strengthen the SRHR of migrant women are focused on regional advocacy and networking with relevant ASEAN bodies and CSOs. Thus, one of the biggest challenges will entail building relations with often difficult to access ASEAN decision makers. Efforts will also include building space for a voice focused on SRHR of migrant women among CSOs with similar values from related sectors, such as those more broadly focused on migrant's rights and women's rights.

One immediate entry-point is an upcoming meeting of the ASEAN Commission for the Protection and Promotion of the Rights of Women and Children (ACWC) in Thailand in December 2012. Others include the ASEAN Forum on Migrant Workers (AFMW), the ASEAN Inter-governmental Commission on Human Rights (AICHR), the ASEAN Committee on Women (ACW) and their national level representatives. Increasing the communication between CSOs and migrants in both countries of origin and destination is also needed to strengthen the linkages and harmonise efforts across borders, in order to achieve better results in the protection and promotion women migrants' SRHR.

Editorial Note

ARROW also joined this regional meeting to speak on the need for advocacy on migrant women's SRHR at the ICPD beyond 2014 and the post-2015 agenda process.

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ASIA: Promoting Migrant Workers' SRHR

CARAM Asia (Coordination of Action Research on AIDS and Mobility) is an open network comprised of migrant organisations in over 15 countries from South, Southeast and East Asia, and the Middle East, with a secretariat based in Kuala Lumpur, Malaysia. The Task Force on Migration, Health and HIV (MHH), one of its three task forces, leads CARAM's advocacy to promote the sexual and reproductive health rights (SRHR) of migrant workers and their spouses.

Using a rights-based approach that incorporates a gender perspective and health framework, CARAM pursues a multi-level advocacy strategy that reaches from the grassroots to international meetings.

At the grassroots level, CARAM members transmit the voice of migrants and build the evidence base to support advocacy efforts through participatory action research (PAR). MHH task force members have conducted PARs

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1. CARAM Asia, et. al. HIV vulnerabilities of migrant women: From Asia to the Arab States. Colombo: UNDP Regional Centre in Colombo; 2008. Available from: www.caramasia.org/index.php?option=com_content&task=view&id=872&Itemid=343.
2. CARAM Asia. State of health of migrants. Kuala Lumpur: CARAM Asia; 2007. Available from: www.caramasia.org/index.php?option=com_content&task=view&id=592&Itemid=343
3. Action for Health Initiatives (ACHIEVE), Inc. Health of our heroes: Access to sexual and reproductive health services and information of women migrant domestic workers. Quezon City: Action for Health Initiatives (ACHIEVE), Inc; 2010. Available from: www.sjhivctr.com/research/2011/AccessstoSRH.pdf

and released reports on a number of topics, including HIV vulnerability of Asian migrant women in Arab States¹; mandatory health testing that includes HIV, sexually transmitted infections (STIs) and pregnancy²; and female migrant domestic workers' access to sexual and reproductive health services.³

As a network, CARAM then uses the research results and analyses to promote migrants' SRHR at regional dialogues, and at international fora that shape normative frameworks. For example, through its relationship with various United Nations agencies, CARAM has participated in and helped to organise a number of multi-stakeholder, regional dialogues that bring together governments, CARAM members and UN agencies to discuss migrants' health rights. These include a series of "Multi-Stakeholder Dialogues on HIV Prevention, Treatment and Care for Migrant Workers in ASEAN," and most recently, a "Regional Consultation on Violence against Migrant Women" and a "Regional Consultation on the Right to Health."

CARAM Asia, relying on the results of its PARs and, when possible, migrant spokespersons, has also represented migrants' issues at the international level: in AIDS conferences, as a member of the UNAIDS Task Team on HIV-Related Travel Restrictions, and in the High Level UN Meetings on the Political Declaration on AIDS. CARAM has also held outside events at migration-oriented consultative processes, such as the Colombo Process and the Global Forum on Migration and Development, and has had workshops with UN Special Rapporteurs on the Right to Health and on Migrant Workers.

It has been difficult to measure the impact of our strategies and initiatives on policies that impinge on migrant workers' sexual and reproductive health rights due to numerous factors. Nevertheless, CARAM Asia will continue to advocate for Asian women migrants' health rights by using participatory action research to transmit migrants' voices, build the evidence base, and advocate with stakeholders at various levels of influence.

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INDONESIA: The Solidaritas Perempuan's Experience in Increasing Women Migrant Workers' Access to SRHR Information and Services

The major law in Indonesia concerning migrant workers is Law No. 39/2004 on the Placement and Protection of Indonesian Migrant Workers in Foreign Countries (PPIMW). The title of the law sounds very convincing in protecting migrant workers from their vulnerability to violence and abuses (physical, psychological and sexual).

However, figures from the Ministry of Foreign Affairs (MoFA) reveal that the law is inadequate in preventing abuses. In 2010, there are 4,532 cases of violence against migrant workers recorded, and the highest number of incidents was found in Malaysia. The lack of legal

instruments providing protection during all stages of migration is one of the main causes of the problems faced by migrant workers.

Indeed, Law No. 39/2004 does not provide full protection as it focuses heavily on placement of migrant workers. This can easily be deduced from the higher number of articles regulating placement compared to those regulating protection (50 versus 8 articles).¹

Moreover, it can be argued that Law No. 39/2004 fails to guarantee, and even violates, the rights of Indonesian women migrant workers

to sexual and reproductive health and rights (SRHR). For example, it does not provide for menstrual leave. It also denies pregnant and HIV positive migrant workers of the right to work, since medical testing, including pregnancy and HIV testing, is mandatory for prospective migrant workers. Once found pregnant or tested positive, they are declared unfit to work).

Furthermore, access for Indonesian women migrant workers to SRHR information and services are exceptionally limited. Women migrant workers are vulnerable to rape and unwanted pregnancy, while they face lack of access to safe reproductive health and abortion services. The Indonesian Law No. 36/2009 on Health only allows abortion in rape cases with very strict requirements, such as pregnancy should not exceed six weeks. Moreover, the lack of information and legal protection compounds the vulnerability of migrant workers to HIV. Data from HIPTEK (the Association of Medical Centre) shows that in 2010, there were 0.11% prospective migrant workers to the Middle East who are HIV positive.

Furthermore, privatisation of healthcare in Indonesia has been driving costs up, leaving women migrant returnees with smaller opportunity to access sexual and reproductive health services. The insurance scheme for Indonesian migrant workers regulated by Decree of Ministry of Labor No. 7/2010 does not have any gender perspective. Specific needs and conditions of women, such as reproductive health, pregnancy and childbirth-related expenses, are not covered. Additionally, procedures for obtaining insurance benefits abroad are so complex and time consuming, it is nearly impossible to make and receive payment on a claim.

To address the situation of women migrant workers, Solidaritas Perempuan (SP) conducts awareness raising and empowering activities among prospective women migrant workers and their families about their rights, including on SRHR. SP holds regular discussions and disseminates IEC materials in seven main migrant workers' sending provinces under the 'Community Based Pre-Departure Programme.' In these discussions, SP emphasises sexual and

reproductive health and rights as part of a whole constellation of rights that must be respected, protected and fulfilled. These include the right to physical, mental and social well-being related with the reproductive system and its functions and processes and sexuality. SP also provides legal assistance for women migrant workers who face abuses and violations. Between October 2011 to August 2012, SP handled 32 cases, including assisting women migrant workers to obtain access to SRHR services.

At the level of policy advocacy, in 2011, as a member of the CEDAW Working Group Indonesia (CWGI), SP developed an independent report on the implementation of CEDAW in Indonesia. On that report, SP focused on the issues of discrimination and violence against women migrant worker's rights, including the issue of access to SRHR information and services.²

This report served as reference to the CEDAW Committee in reviewing the Indonesian Government report. At the regional level, SP also gives some inputs regarding the protection of women migrant workers' rights in the draft ASEAN instrument on the Promotion and the Protection of Migrant Workers and the draft ASEAN Human Rights Declaration.

In 2012, there are two milestones regarding national policy development. On 12 April 2012, Indonesia ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) through Law No.6/2012. Additionally, on 5 July 2012, the Parliament has decided to discuss the amendments of Law 39/2004. SP is currently doing intensive efforts to formulate inputs to the Parliament to ensure this new law will enhance the protection of women migrant workers' rights and increase their access to SRHR.

Despite successes, challenges remain. One of the main challenges is that the government and parliament members still see migrant workers as commodities rather than as human beings. They also have seen migration as a gender-neutral phenomenon. There is a need to get them to recognise and prioritise the protection of

Notes and References

- 1 Chapter V is titled 'Procedures of Placement', consists of 50 articles (Article 27 to Article 76); meanwhile, Chapter VI which title is 'Protection of Indonesian Migrant Workers' consists of 8 articles (Article 77 to Article 84).
- 2 Indonesia has ratified CEDAW by Law No.7/ 1984. With regard to the issue of women migrant workers and health, Indonesia tied with the implementation of General Recommendation No. 26 (2008) on Women Migrant Workers and General Recommendation No. 24 (1999) on women and health. The implementation of those recommendations can increase access of women migrant workers to SRHR. However, the CEDAW implementation in Indonesia is very weak.

For change to happen, the health of migrant workers in Indonesia, as well as in many countries, needs to go beyond being equated to medical testing as a requirement for migration employment. Health, including reproductive and sexual health, should not be seen as a tool for migration control; otherwise, migrant workers will always be in a vulnerable and unequal position during all the phases of migration.

women migrant workers rights and the specific needs of women migrant workers, including access to SRHR information and services.

For change to happen, the health of migrant workers in Indonesia, as well as in many countries, needs to go beyond being equated to medical testing as a requirement for migration employment. Health, including reproductive and sexual health, should not be seen as a tool for migration control; otherwise, migrant workers will always be in a vulnerable and unequal position during all the phases of migration.

Health and wellbeing needs to be seen as a right, and the new Indonesian law regarding the protection of the rights of migrant workers and their families need to reflect this. The revised law should remove discriminatory policies, such as mandatory HIV and pregnancy testing. Finally, for change to start to happen, the law should contribute to establish an enabling environment for migrant workers and their families to enjoy and fulfill their health rights, including SRHR.

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HONG KONG: Access to AIDS and Reproductive Health Services among Migrant Women

As of 2012, there are more than 300,000 foreign domestic workers working in Hong Kong. The majority of them are women migrant domestic workers from South East Asia, such as Indonesia and the Philippines. They provide important household support to hundreds of thousands of Hong Kong families, and contribute significantly to the Hong Kong community. However, access to sexual and reproductive health information and services is still a problem for many women migrant domestic workers.

From 2009 to 2010, a comparative research project entitled, *Health of Our Heroes: Qualitative Study on Access to Sexual and Reproductive Health Services and Information*

*of Women Migrant Domestic Workers*¹ was conducted by the Action for Health Initiatives, Inc. (ACHIEVE)² with partners (for Hong Kong, this was the St. John's Cathedral HIV Education Centre³). The study aims to identify the SRH needs and concerns of Filipino women migrant domestic workers; to conduct a mapping of available SRH services in Hong Kong, Qatar and Singapore for these workers; to identify personal, socio-cultural and structural factors that facilitate and hinder access to SRH information and services, and to generate research, policy and programme recommendations that can respond to issues of accessibility of SRH services to women migrant domestic workers.

In the Hong Kong study, 141 participants were interviewed. The findings identified irregular menstruation, excessive menstrual blood flow, breast cancer, breast cysts, myoma in the pelvic area, sexually transmitted infections (STIs), reproductive tract infections, birth control issues, unplanned pregnancy and unsafe abortion as some of the problems that women migrant domestic workers in Hong Kong encountered in the course of their work.

The study found that Hong Kong labour laws are deemed to be 'friendlier' compared to other destinations for women migrant domestic workers. Unlike in other countries, employment contract termination on the basis of pregnancy or illness is prohibited, and HIV testing as a pre-condition for employment of migrant domestic workers is also not imposed in the Territory. This means that, as a policy, HIV status cannot be a reason for deportation of those who are HIV positive.

The study also noted that there is a range of health services in Hong Kong that migrant workers can access, from government-run hospitals, private clinics and NGO-run health care centres. However, despite the availability of facilities and services, as well as the mandatory provision of medical insurance for domestic workers, access to these services is not always easy for these workers. A significant factor to access is the attitude of the employers: whether they would allow their domestic worker to go out for a check-up any day of the week; whether they would cover all the medical costs, including those beyond the insurance coverage; or whether they would continue to employ a domestic worker who is ill or pregnant. Despite existing policies, employers can still choose to ignore their obligations, and often without consequences.

At the personal level, there are various reasons why migrant domestic workers choose not to utilise medical or health care services. These

include fear that their employment will be terminated; concern over the potential medical costs because they are unaware of their right to medical insurance coverage; refusal to be confined in a hospital in a foreign country where they have no relatives to take care of them; distrust in the foreign health care system brought about by stories within the community regarding misdiagnoses in hospitals; or ill treatment by medical personnel.

To improve the sexual and reproductive health situation of domestic workers in Hong Kong and to ensure that the enlightened policies of Hong Kong continue to benefit these workers, the study recommends the following:

1. Inclusion of sexual and reproductive health information in the post-arrival orientation for migrant domestic workers.
2. Institutionalise orientation seminars for first-time employers, so that they will have a higher awareness of their obligations in terms of assisting the migrant domestic workers having the appropriate sexual and reproductive health services.
3. Wide-range dissemination of the provisions of the labour laws and anti-discrimination ordinances, such as the Race Discrimination Ordinance so that both the migrant domestic workers and the local population's awareness about equal and just treatment when it comes to accessing health services is enhanced.
4. Establish one or two public clinics which are close to the gathering points of foreign domestic workers and extend the service hours to weekends.
5. Stricter government monitoring of the implementation of policies related to migrant domestic workers, particularly those in relation to maternity and health benefits.

Notes and References

- 1 The full report of *Health of Our Heroes: Qualitative Study on Access to Sexual and Reproductive Health Services and Information of Women Migrant Domestic Workers* is available at www.sjhivctr.com.
- 2 Action for Health Initiatives (ACHIEVE) is an NGO based in the Philippines engaged in the development and implementation of programmes and projects addressing migration, health, gender, sexuality, reproductive health, and HIV and AIDS issues.
- 3 The St. John's Cathedral HIV Education Centre was founded in 1995 with the aim of striving for zero HIV infections in a zero discrimination society. A variety of AIDS and reproductive health programmes and activities are delivered to school youths, women, and foreign migrant workers in Hong Kong. More information can be found at www.sjhivctr.com

YUNNAN, CHINA: Working with Burmese Migrants

Yunnan Province lies on the southwest frontier of China, geographically bordering Burma, Laos and Vietnam. There is a long history of frontier trade by local people and ethnic exchange through kinship networks along the borders of China and Burma.

However, border-crossing movements have significantly increased in recent decades since economic reforms were implemented and China started to open up. Economic disparities between the two countries have led to an increase in the number of Burmese migrating to China in search of a better life. While this increased migration flow highlights the process of economic exchange, it also reveals the uncertainty and social threats migrants often face. Transnational movement often creates new forms of power structures that urge migrants to continually struggle with identity construction and interpersonal relationships.

In many settings, gender stereotypes and discrimination make female migrants more vulnerable to exploitation and violence, resulting in negative sexual and reproductive health outcomes. This situation also requires an immediate response from both sending and receiving countries in addressing potential risks associated with population movement—including migrants' vulnerability to drug trafficking and HIV.

In 2010, the Yunnan Health and Development Research Association (YHDRA)' initiated a pilot intervention project in Ruili City, the largest border-crossing port between Burma and China. This is part of the Women's Health and Rights Advocacy Partnership-Southeast Asia (WHRAP-SEA) project initiated by ARROW. The intervention was designed to empower and equip local ethnic young people with necessary knowledge and awareness of rights through a process of self-development and capacity

building. The project also attempted to integrate migrants from Burma to the local community, in order to mitigate obstacles that prevent migrants' access to essential health information and services. These obstacles include lack of legal citizenship and language barriers.

In the pilot villages, seasonal migrant workers from Burma and female migrants who have married Chinese citizens were included as key project stakeholders. A Burmese young woman was nominated to be a core member of a group of youth leaders on behalf of young migrants, participating in a wide range of activities, such as project design, training of trainers and project implementation.

Migrant workers were invited to join the community-based activities organised by local young people to provide information and knowledge on SRHR, while strengthening leadership of youth groups and linkages between migrants and locals. Some youth leaders who visited their relatives in Burma have shared what they have learned with counterparts in Burmese villages, further demonstrating their commitment and interest and replicating the project's outcomes. For example, in one village, the youth leaders have set up an information sharing mechanism with Burmese young people through a quarterly bulletin.

The problems inherent in past interventions designed by local government have often demarcated 'immigrants' in isolated settings or emphasised HIV prevention only. In contrast, the effectiveness of YHDRA's programme interventions can be attributed to its focus on integration and its emphasis on young people's leadership, autonomy, and the utilisation of the linkages between two countries' bordering communities. Based on the project evaluation, many participants, especially migrants, regarded

Note

the project positively, claiming that they would voluntarily conduct more activities in the future, such as peer education and group learning. The project attempted to develop a new way to respond migrants' health needs in destination countries. Positively, it has demonstrated a model of intervention that integrates young migrants into community-based activities in the receiving country. Local young people have learned to mobilise available resources to share information and knowledge through their cross-border networks. Largely due to language interoperability and cultural similarity among ethnic groups in border areas, such activities are more acceptable to migrants and allay a fear of bureaucratic tracking in public health care centres.

However, some challenges remain: a full approach should be developed to specifically address the vulnerability of female migrants, and make men accountable to their partners towards equitable relations, and safe and pleasurable practices. Moreover, in order to sustain ongoing interventions, further advocacy should urge local governments to establish formal mechanism in policies or development plans in both countries.

¹ YHDRA is a non-profit mass-based academic institution based in Kunming, China. The Association devotes itself to research, capacity building, social services and technical support to policy makers. It promotes gender equality in health and development and pays particular attention to less developed regions and vulnerable populations. For more information, please visit: www.yhdra.org

RESOURCES FROM THE ARROW SRHR KNOWLEDGE SHARING CENTRE

For a fuller list of resources with annotations, please see **ARROW's Annotated Bibliography on Migration, Gender and SRHR**, produced as an accompaniment to this AFC bulletin. Available from: http://arrow.org.my/IDC/Bibliographies/Migration_Annotated.pdf

CARAM Asia. Reality check, rights and legislation for migrant domestic workers across Asia. Kuala Lumpur: CARAM Asia; 2011. Available from: www.caramasia.org/reports/FDWlegislationAsia.pdf

This publication outlines the legislative frameworks that reference migrant domestic workers across Asia. It provides the context within which migrant domestic workers operate in each jurisdiction and aims to highlight the human rights abuses being faced by migrant domestic workers. While it does not focus specifically on sexual and reproductive rights (SRR), they do feature specific SRR issues quite prominently.

Conel J, Negin J. Migration, mobility and HIV: A rapid assessment of risks and vulnerabilities in the Pacific. Sydney: United Nations Development Programme (UNDP) and Secretariat of the Pacific Community (SPC); 2010. Available from: www.undppc.org/fj/_resources/article/files/Migration,MobilityandHIV_web.pdf

This report aims to provide a rapid assessment of migration and mobility as key influences on the distribution and spread of HIV in the Pacific. While targeted and tailored prevention programmes on mobility and HIV have been established in a number of countries, the Pacific has yet to develop appropriate responses that take migration and mobility into consideration and ensure that HIV interventions address the

drivers of mobility and the specific vulnerabilities that mobility creates. It is expected that this report will contribute to the development of multi-sectoral responses required to address the HIV epidemic in the Pacific region and provide the impetus for the development of effective and targeted interventions for people on the move.

Hoang LA, Yeoh BSA, Wattie AM. Transnational labour migration and the politics of care in the Southeast Asian family. *Geoforum*. 2012; 43(4):733-740. Available from: www.sciencedirect.com/science/article/pii/S0016718511002181

Drawing on in-depth interviews with non-parent carers of left-behind children in Indonesia and Vietnam, the paper aims to unveil complexities and nuances around care in the context of transnational labour migration. In so doing, it draws attention to the enduring influence of social norms on the organisation of family life when women are increasingly drawn into the global labour market. By contrasting a predominantly patrilineal East Asian family structure in Vietnam with what is often understood as a bilateral South-East Asian family structure in Indonesia, the paper seeks to provide interesting comparative insights into the adaptive strategies that the transnational family pursues in order to cope with the reproductive vacuum left behind by the migrant mother.

Lan VH. Socio-cultural influences on the reproductive health of migrant women: A review of literature in Vietnam. Vietnam: Ha Noi School of Public Health; 2011. Available from: www.unfpa.org/webdav/.../publications/2011/Migrant_Vietnam_.pdf

To gain a better understanding of the links between sociocultural factors and the reproductive health of migrant women, UNFPA Asia Pacific Regional Office commissioned literature reviews in four Mekong sub-region countries: Cambodia, Lao PDR, Thailand and Viet Nam. This report documents the findings of the Viet Nam review and makes recommendations on how policy makers, employers and service providers could better address the reproductive health needs of migrant women.

Marin ML. ARROW Working paper: International labour migration, gender, and sexual and reproductive health and rights in Southeast and East Asia and the Pacific. Kuala Lumpur: ARROW; 2012. Available from: http://arrow.org.my/uploads/Migration_WorkingPaper.pdf

This working paper presents an overview of the sexual and reproductive health rights issues facing women migrant workers. The paper also gives insight into the reproductive health outcomes of women migrant workers, looks at policy and programme interventions, and provides recommendations for future directions.

Oh S, Hobstetter M. Forced migration and adolescent reproductive health. *Gender Perspectives*. 2011; 3(2):1-5. Available from: <http://web1.iseas.edu.sg/GenderBulletin-Dec2011.pdf>

This article combines findings from a study on reproductive health in three populations along the Thailand-Burma border and research conducted on adolescent pregnancy in camps for Burmese refugees in Thailand. The data show that adolescents in three populations—communities in eastern Burma (isolated rural villages, conflict-affected areas, and internally displaced person (IDP) areas in eastern Burma), migrant communities and refugee camps in Thailand—face difficulties in gaining access to reproductive health information and services.

Quesada A. Health of our heroes: A qualitative study on access to sexual and reproductive health services of women migrant workers onsite. Philippines: ACHIEVE, Inc; 2009. Available from: www.sjhivctr.com/research/2011/AccessstoSRH.pdf

Through this research, ACHIEVE, carries on its mission to address the health issues of overseas Filipino workers (OFWs), particularly women migrant domestic workers. Generating evidence on access to sexual and reproductive health information and services onsite is critical in ensuring that the sexual and reproductive health and rights of women migrant domestic workers are given visibility and attention. It is also essential in the development of appropriate and responsive interventions that would address the sexual and reproductive health needs and concerns of women migrant domestic workers.

Sudhinaraset M, Astone N, Blum RW. Migration and unprotected sex in Shanghai, China: Correlates of condom use and contraceptive consistency across migrant and non-migrant youth. *Journal of Adolescent Health*. 2012; 50:68-74. Abstract available from: [www.jahonline.org/article/S1054-139X\(11\)00665-3/abstract](http://www.jahonline.org/article/S1054-139X(11)00665-3/abstract)

Despite the exceptionally large population of young internal migrants in China, as well as increasing rates of HIV and sexually transmitted infections in recent years, condom use and contraceptive consistency among this population remains critically under-studied. This study examines the association between migration and condom use and contraceptive consistency. A cross-sectional survey of 959 youth aged 15-24 years was conducted in rural and urban Shanghai. Logistic regression was conducted to examine the association between migration status and condom use and consistent contraceptive use. Analyses are stratified by gender. (Annotation copied from the abstract in the Journal website.)

United Nations Development Programme (UNDP). HIV vulnerabilities faced by women migrants: From Asia to the Arab states. Sri Lanka: UNDP Regional Centre Colombo; 2008. Available from: http://hdru.aprc.undp.org/resource_centre/pub_pdfs/P1105.pdf

The Arab States are the primary destinations for many migrant workers from various countries in Asia, including Bangladesh, Pakistan, the Philippines, and Sri Lanka. By analysing the economic, socio-cultural, and political factors

that influence the HIV vulnerability of migrant workers—especially female migrant workers—this study aims to aid the design of appropriate rights-based HIV prevention programmes. It

also is intended to identify emerging challenges and trends in the response to HIV and migration issues in host countries, particularly in the area of human rights and public health.

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DEFINITIONS

Circular Migration: The fluid movement of people between countries, including temporary or long-term movement, which may be beneficial to all involved, if occurring voluntarily and linked to the labour needs of countries of origin and destination.¹

Country of Origin / Country of Destination: The country of origin is a source of migratory flows (regular or irregular),¹ while the country of destination (also known as receiving country) is one that has accepted to receive a certain number of refugees and migrants on a yearly basis by presidential, ministerial or parliamentary decision.¹

Domestic Work: As per the International Labour Organisation (ILO) Convention on the Protection of Domestic Workers (ILO Convention 189), domestic work means work performed in or for a household or households. A domestic worker is any person engaged in domestic work within an employment relationship. A person who performs domestic work only occasionally or sporadically and not on an occupational basis is not a domestic worker.²

Environmental Migrants: Persons or groups of persons who, for compelling reasons of sudden or progressive change in the environment that

adversely affects their lives or living conditions, are obliged to leave their habitual homes, or choose to do so, either temporarily or permanently, and who move either within their country or abroad.¹

Irregular Migrant: A person who, owing to unauthorised entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. The definition covers inter alia those persons who have entered a transit or host country lawfully but have stayed for a longer period than authorised or subsequently taken up unauthorised employment (also called clandestine/undocumented migrant or migrant in an irregular situation). The term 'irregular' is preferable to 'illegal' because the latter carries a criminal connotation and is seen as denying migrants' humanity.¹

Irregular Migration: Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries, it is entry, stay or work in a country without the necessary authorisation or documents required under immigration regulations. From the perspective of the sending

- 1 International Organisation for Migration (IOM). Glossary on migration. Geneva: IOM; 2004.
- 2 C189 - International Labour Organisation Domestic Workers Convention, 2011 (No. 189). www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_ILO_CODE:C189.

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- 3 World Health Organisation (WHO). Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva. Geneva: WHO; 2006.

country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfil the administrative requirements for leaving the country.¹

Labour Migration: Generally defined as a cross-border movement for purposes of employment in a foreign country.¹

Migrant Worker: According to the United Nations Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, a migrant worker is a person who is to be engaged, is engaged, or has been engaged in a remunerated activity in a State of which he or she is not a citizen. A 'migrant worker' is defined in the ILO instruments as a person who migrates from one country to another (or who has migrated from one country to another) with a view to being employed otherwise than on his own account, and includes any person regularly admitted as a migrant for employment.¹

Migration: The movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification.¹

Migration Cycle: Labour migration cycle encompasses the preparation period in the country of origin prior to departure of the migrant worker (pre-departure); transit in a third country or location; arrival and period of employment (post-arrival); and return to origin country, whether permanently or temporarily (reintegration).¹

Migration Health: A specialised field of health sciences, characterised by its focus on the well-being of migrants and communities in countries and regions of origin, transit, destination and return. It has a dual focus, addressing individual migrants' needs, as well as the public health of host communities.¹

Sexuality: A central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.³

Temporary Migrant Worker: Skilled, semi-skilled or untrained workers who remain in the destination country for definite periods as determined in a work contract with an individual worker or a service contract concluded with an enterprise. Also called contract migrant workers.¹

For the definitions of **reproductive health, reproductive rights, sexual health and sexual rights**, see: Ando, MMFA . Definitions. ARROws for Change. 2009; 18(2 & 3):19.

For the definition of **universal access to sexual and reproductive health services**, see: Ando, MMFA. Definitions. ARROws for Change. 2010; 16(1):22.

THE MIGRANT WORKERS' CONVENTION: A Closer Look at Its Health and Gender Perspectives

Notes and References

The Convention on the Rights of All Migrant Workers and Members of their Families' (hereinafter referred to as 'the Convention') was adopted in 1990, but it was only in 2003 that it came into force.² It took 13 years to reach the required 20 States to ratify it before it could be enforced.

To date, 46 States have ratified the Convention.³ A great majority of the States that have done so are considered as primarily labour sending countries or States of origin.³ The States that have ratified it are obliged to submit regular reports to the Committee on Migrant Workers regarding their implementation of the rights stipulated in the Convention. These reports are submitted to the Committee one year after the country's ratification and every five years thereafter.

The Convention is primarily a treaty that calls for better protection of the rights of migrant workers and members of their families in all phases of the migration cycle. This involves States of origin, transit and destination, and states where migrant workers are employed. The Convention puts forth specific rights of migrant workers and members of their families that ratifying States are duty-bound to promote, protect and fulfill.

While a human rights approach and perspective is well reflected, the Convention falls short in reflecting and addressing gender issues inherent throughout the migration phenomenon. Consequently, sexual and reproductive health and rights (SRHR) of migrant workers are not addressed.

Gender Neutrality. The language of the Convention is gender-neutral as it consistently refers to all migrant workers regardless of gender. Its provisions are free of distinctions between men and women, and between male or female members of the families of migrant workers. In fact, the terms 'gender,' 'women' (except in the acronym of CEDAW), 'men,' 'female' and 'male' do not appear in the Convention. The Convention reiterates the applicability its provisions for all migrant workers and members of their families regardless of sex. Other than this, the Convention does not pro-actively seek to ensure gender-responsive implementation of the provisions of the Convention.

Furthermore, the Convention fails to recognise the inherent disadvantages faced by women migrant workers in the whole labour migration arena. A majority of women migrant workers from major labour sending countries are in the service sector, mainly in domestic work. This shows the persistence of gender division of labour in the international labour market. Moreover, since domestic work is considered an extension of women's reproductive role, it is not considered formal work in many destination countries. Thus, there is a big gap in policies and programmes that provide protection for women migrant domestic workers. They remain as one of the most vulnerable groups of migrant workers.

The Convention also fails to reflect the unique vulnerabilities faced by women in terms of their health in general, and in their sexual and reproductive health in particular. Women

- 1 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families [UN General Assembly Resolution 45/158 of 18 December 1990]. [cited 2012 September 25] Available from: www2.ohchr.org/english/law/cmwf.htm
- 2 International Labour Organisation. UN Convention on migrant workers rights enters into force. 2003 July 2 [cited 2012 September 25] Available from: www.ilo.org/global/about-the-ilo/newsroom/features/WCMS_075619/lang-en/index.htm
- 3 Status of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. [cited 2012 September 28] Available from: United Nations Treaty Collection http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtidsg_no=IV-13&chapter=4&lang=en

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- 4 UN Committee on the Elimination of Discrimination Against Women (CEDAW). CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), A/54/38/Rev.1, chap. I, 1999 [cited 2012 December 5] Available from: www.unhcr.org/refworld/category_LEGAL,CEDAW,,,453882973,o.html

migrant workers are highly vulnerable to abuses, which in turn make them highly susceptible to various health problems: sexual, reproductive and psychological health. Gender norms that dictate women's 'ignorance' about matters related to sex, sexuality and reproductive health perpetuates their inability to assert safer lifestyles, like using contraceptives and condoms, that could help protect them from sexually transmitted infections like HIV infection, and unwanted or unplanned pregnancy.

Lacking gender responsiveness, the Convention falls short in ensuring equal access of women, particularly women migrant domestic workers, to quality health care services.

Health of Migrant Workers and Members of Their Families. Article 28 of the Convention affords migrant workers and their families the right to receive emergency medical care to "preserve life and avoid irreparable harm to their health," regardless of legal status. However, emergency medical care is just one aspect of health.

In Article 43, the Convention guarantees equality of treatment between migrant workers with nationals of the State of employment in terms of "access to social and health services, provided that the requirements for participation in the respective schemes are met." In a similar vein, families of migrant workers are also guaranteed the same entitlements under Article 45 of the Convention.

The Convention in itself, fails to respond to the gender inequalities faced by women migrant workers in the labour migration arena. The lack of gender-responsiveness of the Convention results in a great gap in ensuring enjoyment of rights and services, particularly for women migrant workers.

Articles 43 and 45 imply a broader coverage of services. On the other hand, Article 28 only refers to emergency medical care. While the coverage of health services is broader for regular migrant workers and their families, irregular migrants are entitled only to life-saving emergency care. This limitation in the Convention fails to ensure the right to health services of a group of migrant workers due to their legal status in the country of destination.

Additionally, the Convention does not specify the range of health services and the various aspects of health and well-being to which migrant workers and their families are entitled. It then depends on States parties to provide for these details in their national laws and policies that stem from their ratification of the Convention.

Other international treaties can be invoked to supplement the gaps in the Migrant Workers Convention. For instance, the CEDAW General Recommendation No. 24⁴ enumerates provisions to promote and protect women's right to health, as well as freedom from restrictions in their access to health care services. It obligates States parties to respect, protect and fulfill women's right to health through the enactment and implementation of policies and programmes that address women's health needs.

Gaps and Challenges. In summary, the key issues with the Convention and its implementation are as follows:

1. The biggest challenge with the Convention is that the States that receive the largest numbers of migrant workers have not ratified it. Most countries in the Gulf, in North America and Western Europe, as well as the wealthy states in Asia, have not ratified it. This has the potential of depriving the migrant workers in these countries of the benefits of the Convention.
2. The Convention in itself, fails to respond to the gender inequalities faced by women migrant workers in the labour migration arena. The lack of gender-responsiveness

Invoke multiple treaties for a wider coverage of standards that could broaden the options for holding States accountable to the abuses and violations experienced by migrant workers. The CEDAW and relevant ILO Conventions could be used in conjunction with the Migrant Workers Convention to promote the rights of all migrant workers, especially the irregular migrant workers. This approach could help bridge some of the gaps in the Convention.

of the Convention results in a great gap in ensuring enjoyment of rights and services, particularly for women migrant workers.

3. The provision on access to health of migrant workers and members of their families is very general, leaving many areas to the interpretation of State parties. In practice, however, access to health of migrant workers remains limited and the treatment of the healthcare system of migrant workers in many States of employment is not equal to that of their nationals. Moreover, many policy makers are not aware of the SRHR of migrant workers, and migrant workers themselves find it too sensitive to talk about, opting to ignore sexual and reproductive health problems until they become unbearable.

Recommendations. To address the above gaps, suggestions for further action include:

1. Concerned stakeholders need to continue advocating to States of employment, or receiving countries, to ratify the Convention.

2. Advocacy to States of origin to develop bilateral agreements with States of employment need to be pursued to promote and protect the rights and welfare of migrant workers and members of their families.
3. Invoke multiple treaties for a wider coverage of standards that could broaden the options for holding States accountable to the abuses and violations experienced by migrant workers. The CEDAW and relevant ILO Conventions could be used in conjunction with the Migrant Workers Convention to promote the rights of all migrant workers, especially the irregular migrant workers. This approach could help bridge some of the gaps in the Convention.⁵
4. The lack of gender responsiveness in the Convention can be remedied at the national level by States parties when they enact their national laws and policies. For example, Hong Kong (China is not a signatory to the Convention) enacted a legislation that prohibits employers from terminating the work contract of women migrant domestic workers on the basis of pregnancy.
5. There is a need to advocate to States of origin and of employment to develop and implement comprehensive policies and programmes that address the health of migrant workers and members of their families, including their sexual and reproductive health.

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