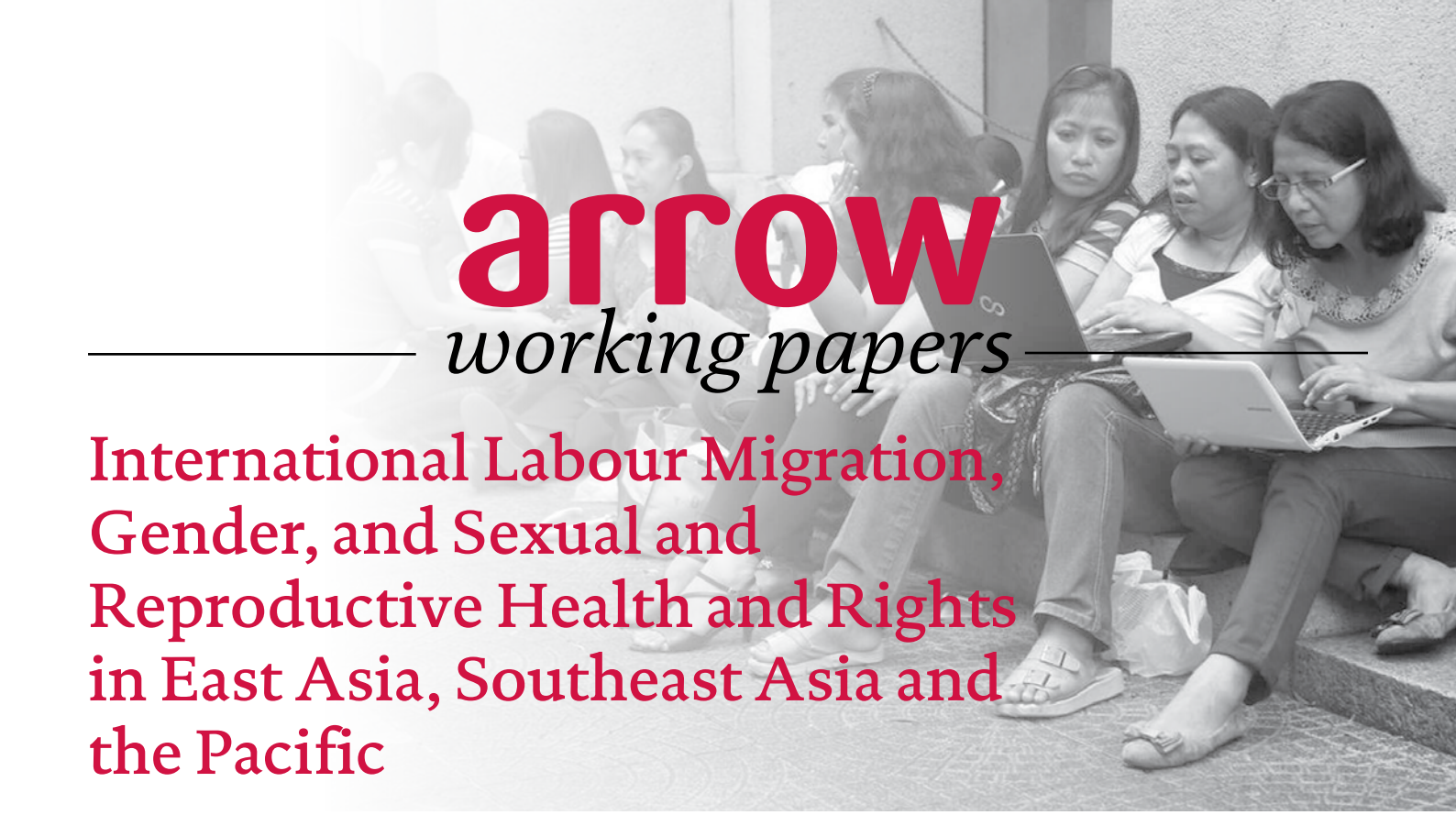

arrow
working papers

International Labour Migration, Gender, and Sexual and Reproductive Health and Rights in East Asia, Southeast Asia and the Pacific

by Maria Lourdes S. Marin *

CONTENTS

* Executive Director, ACHIEVE, Inc., the Philippines. Email: darnalipad_2000@yahoo.com

Published by

The Asian-Pacific Resource and Research Centre for Women (ARROW)

ABOUT THIS PUBLICATION

ARROW's working papers provide analyses and perspectives from the Asia-Pacific region and the Global South on emerging and cutting-edge issues related to women's health, sexuality, reproduction and rights. This paper was developed as part of the Concept Note for ARROW for Change bulletin Vol. 19 No. 1 2013 on migration, gender and sexual and reproductive rights, and presents an overview of the sexual and reproductive health rights issues facing women migrant workers. The paper also looks at policy and programme interventions for migrant workers, and provides recommendations for future directions.

ABOUT ARROW

ARROW is a non-profit women's NGO with a consultative status with the Economic and Social Council of the United Nations. Based in Kuala Lumpur, Malaysia, ARROW has been working since 1993 to promote and defend women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights. We work with a core set of national partners across Asia and the Pacific, as well as with regional partners from Africa, Middle East, Eastern Europe, and Latin America and the Caribbean. We also work with allied international organisations, and through our information and communications and advocacy programmes, we are able to reach key stakeholders in more than 120 countries worldwide.

1. Introduction

Population mobility and migration *(see Definitions)* have become permanent facets of a rapidly globalising world. Propelled by modern transport technology and communication systems, people from all regions of the world are moving at a much faster pace. Globalisation has changed not only the scope, but also the patterns of migratory movements, from traditional, more permanent movement in one direction, to a repeated and bi-directional movement of people that is referred to as circulatory migration or repeated return.[1]

Population dynamics, with international migration as an increasingly important component, is envisaged to affect development in both developing and developed countries.[2] Migration affects population growth, age and sex structures. In emigration countries, it depletes cohorts, mostly at young adult ages, and it increases the youth bulge in immigration countries.[3] Along with unemployment and poverty, population growth is higher among developing and least developed countries. In contrast, developed countries, which have low and declining fertility, are experiencing shrinking working-age populations and rapid population ageing. This is the case in Japan[4] where the working age (15-64) population is projected to fall from 85 million in 2005 to 72 million in 2025. Thus, Japan is debating whether to open itself to front-door immigrants to stabilise the population and labour force, admit side-door guest workers who would be expected to leave after several years, or keep migration doors mostly closed and persuade Japanese workers to work longer and more productively. Research shows that international migration can play a role in limiting population decline and reductions of the working-age population and population ageing, especially in countries with low fertility, although it cannot reverse these trends.[5]

Migration is brought about by a confluence of social, economic, cultural, environmental and physical factors. People move for a variety of reasons, resulting from personal, as well as societal circumstances. Motivations include the need for improved economic conditions, not just for oneself but for the family; escape from difficult or abusive social relationships; and, personal desires and goals for adventure, marriage, studies and travel. Movement may be temporary or permanent, forced or voluntary, and internal or external. Forced movement includes movement or displacement due to 'natural,' environmental or climate-changed-induced disasters, wars, internal conflicts, famine or development projects.[6]

In recent years, more attention has been paid to climate change migration or environmental migration *(see Definitions)*. There are, however, ongoing debates about the direct causality of climate change to migration, mainly because of the multi-causal nature of migration, including social, political and development changes. Climate change, on its own, does not directly displace people or cause them to move, but it produces environmental effects and exacerbates current vulnerabilities that make it difficult for people to survive where they are.[7]

While environmental migration is a more recently recognised phenomenon, in the last four decades, migration for employment, also known as labour migration, has become one of the more predominant forms of migration. Labour migration in East Asia, Southeast Asia and the Pacific has varying demographics, characteristics and patterns.

In 2005, the United Nations estimated the population of migrants in East Asia and South East Asia at 5.6 million, of whom probably 4 million are economically active.[8] In 2010, the entire Asia region accounted for 27.5 million of international migrants, representing close to 13% of the total global figure of 214 million.[9] Almost half of all international migrants from Asia (48%) are women. Approximately 37% move to OECD (Organisation for Economic Co-operation and Development) member countries; 43% migrate within the region and the rest migrate to other countries outside the region. On the other hand, the Pacific region had approximately six million international migrants in 2010, of which 51.3% were women from ages 20-64.[10]

In South East Asia, countries such as the Philippines and Indonesia are among the world's largest origin countries for migrant workers, with women comprising almost half of the total migrant workers deployed. The Philippines has an estimated total of 4.4 million contract workers deployed abroad.[11] Latest figures from Indonesia estimate a total of 4 million migrant workers, of which 75% are women.[12]

Cross-border labour mobility is also a feature of countries within the Association of Southeast Asian Nations (ASEAN). This has two main geographical patterns: i) Thailand as the major destination of countries bordering the Mekong river, namely: Burma, Cambodia, Lao PDR and Vietnam, and ii) Singapore, Brunei Darussalam and Malaysia as the major destination countries for workers from Indonesia and the Philippines. Thailand is estimated to host 3.14 million migrants coming from its neighbouring countries, Burma, Cambodia and Laos, of which, half are unregistered. Malaysia has 1.8 million registered migrant workers in 2010, with Indonesians accounting for half of the total figures.[13] In Singapore, the share of Indonesian migrants is lower at 59%, because of the presence of a large number of non-ASEAN expatriate workers.[14] Predominant inter-country migration flows in the ASEAN region are from the 'unskilled' or semi-skilled sectors, such as construction, agriculture, domestic work and entertainment.

Other Asian destinations include Hong Kong and South Korea. As of May 2010, the population of foreign domestic workers in Hong Kong was 276,737. Of these, 132,846 are Filipinos, 136,460 are Indonesians, 3,789 Thais, and 3,642 are made up of other nationalities.[15] This does not include the number of undocumented migrant workers who may be engaged in domestic work or other types of informal work. The foreign labour force in South Korea is pegged at 0.6% of the total labour force in the country, numbering almost half a million.[16]

Meanwhile, the Pacific region has a strong tradition of mobility, with the primary motive for migration being economic. However, political, environmental and cultural considerations also affect migrant flows.[17] Migration for work is predominantly among men, who work in the maritime, transport and military sectors.[18] In the case of women migrant workers, nurses from Fiji have migrated to rim countries and secondarily to the Middle East.[19] Within the Pacific, New Zealand launched a scheme in 2007 to recruit Pacific Island temporary workers to work in the horticulture and viticulture industries.[20] The scheme entails deployment of up to 5,000 seasonal workers from Kiribati, Samoa, Tonga, Tuvalu and Vanuatu for periods of up to seven or nine months. New Zealand has expanded its coverage to allow about 1,750 Pacific Islanders from five Pacific Island countries, namely: Fiji, Kiribati, Samoa, Tonga and Tuvalu, to immigrate to the country annually. The selection is done through a ballot, to ensure that not only skilled migrants are able to immigrate. On the other hand, Australia's 'humanitarian' migration policy targets mainly refugees and asylum seekers.

The UN DESA report in 2010 notes that Asia hosts 12.9 million international migrants under age 20, representing 39% of the total global figures. There is no readily available and accessible regional data among migrants that is disaggregated according to legal status, occupations, sex and age.

The age of majority matters for purposes of migration because it generally determines the moment at which a person is entitled to seek admission into another country on his or her own right, without being necessarily dependent of someone else. There are specific age restrictions on some categories of migrants, for instance, among contract workers, and these vary according to country.[21]

However, national data among migrants point out that a substantial number are young. A World Bank report notes that the majority of Indonesian migrant workers are married and from the age group of 21 to 30 years old.[22] In Vietnam, internal migrant workers, especially among female migrants, are getting younger. The median age of female migrants dropped to 23 years from 24 in 1999 and 25 in 1989, while the median age of female non-migrants increased sharply to 31 years from 28 in 1999 and 25 in 1989.[23]

1.1 International Labour Migration

In 2010, remittances from labour migrants in South Asia, East Asia and the Pacific accounted for US$174 billion.[24] This implies that labour migration has become a critical sector in most of the economies of countries in the region.

However, the contribution of international migrants to both countries of origin and destination depends crucially on whether their human rights are safeguarded and they are protected from discrimination.[25] Such rights have been codified internationally through the United Nations Convention for the Protection of the Rights of Migrant Workers and their Families, as well as a series of International Labour Organisation (ILO) Conventions. The international migrant rights regime does not make distinctions between high- and low- skilled migrant workers.[26] The basic labour rights of workers to organise, bargain collectively, and to be protected against forced labour and discrimination are supposed to apply to all migrant workers.[27] Similarly migrant workers are also entitled to social protection, access to legal redress, health care and family life.

Unfortunately, migrant workers are often denied these rights, especially when countries of destination explicitly institute policies that curtail their civil and liberties, e.g., prohibition to join or form unions, such as in Malaysia, Singapore and the Gulf Cooperation Council (GCC) countries. Migrant workers, especially those considered as 'low-skilled,' e.g., factory workers, construction workers and domestic workers, are also denied freedom of movement, due to the rampant practice of employers confiscating their passports and travel documents.

As non-citizens, foreign migrant workers face numerous risks to their own human security owing to their economic, social and political marginalisation. Apart from exposure and vulnerability to threats, they are hindered from making choices that would allow them to mitigate their exposure to those threats or determine their own future.[28]

The category of a migrant—whether a person is a professional/high-skilled or low-skilled—determines how cumbersome procedures of admission and how generous conditions of stay can be.[29] It is particularly striking that national policies or legislation of origin countries that cover migrant workers would have a more protectionist slant compared to employment conditions and guidelines imposed by destination countries.

In recent years, management and control of labour migration flows have become part and parcel of government regulatory bodies from both origin and destination countries. Various modalities of labour migration regulation have been developed and continue to evolve in countries whose economies have come to acknowledge the significant contribution of migrant workers' remittances in propping up foreign exchange earnings. Many countries in the region have moved toward this direction, such as Cambodia, Indonesia and the Philippines, with the establishment of government agencies that facilitate outward labour migration.

1.2 Women and Labour Migration

Gender, as a core organising principle of social relations, impacts on labour migration. A gendered understanding of labour migration involves a specific examination of the causes, processes and impact of migration from the perspective of female, male and transgender migrants. For example, experience shows that 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.[30]

General Recommendation No. 26 of the 42nd Session of the Committee on the Elimination of Discrimination against Women,[31] affirmed in 2008 that migration is not gender-neutral. It asserted:

> The position of female migrants is different from that of male migrants in terms of legal migration channels, the sectors into which they migrate, the forms of abuse they suffer and the consequences thereof. To understand the specific ways in which women are impacted, female migration should be studied from the perspective of gender inequality, traditional female roles, a gendered labour market, the universal prevalence of gender-based violence, and the worldwide feminisation of poverty and labour migration.

Women migrants, especially those working in the service sector, are especially vulnerable to a host of abuses, including sexual violence, economic exploitation, physical and verbal abuse and labour rights violations. While such vulnerabilities can happen to women who migrate either through regular and irregular circumstances, the latter are more disadvantaged because they often have limited options in seeking legal remedies or redress and have less access to correct information and services.

The gender division in reproductive labour is clearly manifest in migrant labour flows in the region. The statistics of migrant workers, when disaggregated according to occupation, sex and countries of origin, give evidence to massive flows of women domestic workers in the region. In East and Southeast Asia, the absorption of local women in paid employment created a shortage of care workers in the homes. As such, the hiring of foreign domestic workers was a response to address the void left by local women who took on paid employment.[32] In the Middle East, where millions of Filipino and Indonesian women work, the hiring of foreign domestic workers was not motivated by the entry of local women in paid employment, but was more related to lifestyle changes, i.e., having a domestic worker was a status symbol.[33]

Patriarchal norms and values in many societies already consider domestic work as 'women's' work and therefore undervalue it. Added to this, domestic labour is further devalued in connection with transfer to foreign workers, who come mostly from developing countries and are paid a lower salary, and with the disregard of the protection of the rights of domestic workers.[34]

Other occupations where women migrants end up working in are in caregiving, entertainment, sex work and other service employment.

The World Bank notes that men and women show important differences in the determinants of their decision to migrate, as well as their opportunity cost of migration. There are also differences in patterns of remittances, budget allocation of remittance income, and hence, gender differences in the impact of migration or remittances on household decisions and welfare.[35] A study on Filipino labour migration in Italy reveals that women are the primary senders of remittances from Italy to the Philippines. They are also the preferred financial administrators of their households' daily expenses.[36]

The gendered impact of migration is felt and experienced not only by migrants, but also by their families and household members. In countries with predominantly feminised migration patterns, power dynamics in the household undergo transformation. Roles and functions within the family have to be negotiated and restructured, along with household arrangements. For example, in an earlier study done in the Philippines on the impact of female out-migration on household gender relations, men are seen to either adapt to the situation and take on the burden of caring for the family left behind, or are unable to cope and thus end up passing on the burden to other female members of the family.[37] A more recent cross-country study in Indonesia, the Philippines and Vietnam showed that when care cannot be further purchased from elsewhere, or where help is simply unavailable, the left-behind fathers take up caregiving tasks. Nevertheless, 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.[38]

For women who work abroad, especially those engaged in care work, transnational parenting or mothering is almost a given. Being away from their families may have an initial liberating effect, but societal expectations about women's reproductive role in nurturing the family may inadvertently cause guilt feelings. In a study on mental health of Filipino women migrant domestic workers, one of the sources of stress identified is the difficulty of the women in balancing the demands of work abroad and family life in the country of origin.[39]

1.3 Migration and Health

The relationship between migration and disease has long been acknowledged. However, it is only during the last century, and as a result of progress in medical sciences, that public health linked to mobility has been explored.[40] The links between migration and health are complex. Migrants' health depends on their personal history before moving, the process of moving itself, and the circumstances of resettlement.[41]

Health, as defined by the World Health Organisation since 1948, is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[42]

However, health in the context of migration has been largely reduced to health screening. Many governments institute increasingly repressive entry regimes.[43] Approximately 60 governments have established health-screening procedures upon application, arrival and renewal of work permits.[44] Many developed countries in Asia (e.g., Brunei, Malaysia, Singapore and Taiwan) and the Middle East (all the Gulf Cooperation Council countries) that rely on migrant workers to keep their economies functioning have instituted migration policies that use health as a primary criterion for permitting migrants entry and stay for employment. Under these policies, migrants are being screened for up to 22 conditions and diseases, including pregnancy and HIV.[45]

A prospective migrant worker who fails the medical tests could get barred from entering the country or deported back to the country of origin. Among the tests conducted are: complete physical examination and history, chest x-ray, optical check-up, complete blood count, blood typing, routine urinalysis, psychometric evaluation, routine Fecalysis and dental check up.[46] Depending on the job category and the requirements of the employer or the country of destination, other tests that are administered include: HIV test, Hepatitis B screening, Leprosy test, Malarial smear, Liver function test, Venereal Disease Research Laboratory (VDRL) test, drug and alcohol tests and others.[47] Additionally, women applicants, especially those entering the service sector, are required to undergo pregnancy testing.

Globally, at least 66 countries have special entry regulations for people living with HIV and AIDS and 30 countries deport HIV positive foreigners.[48]

Mandatory HIV testing and pregnancy tests are not intended to benefit migrant workers' health: they function merely as a screening device to identify those with exclusionary health conditions.[49] Health screening of migrants ensure that those who migrate to work are the 'fittest' of workers.

However, conditions in the migration process and their employment can increase their vulnerability to ill-health and disease. The availability of health insurance, services and information in the schedule of benefits and entitlements of migrant workers vary greatly across occupations and country policies. Yet, many governments turn a blind eye to health and safety violations by employers.[50]

Nevertheless, it is also possible that gaining better access to services, including health care, may be among the key motivations for some people to move. Among top high-school graduates from Tonga and Papua New Guinea, 'health care' and 'children's education' were mentioned more often than 'salary' as reasons for migrating, and answers such as 'safety and security' were almost as frequent.[51] Migrant workers who work in professional sectors, such as in the medical, IT, finance and hospitality industry would have better access to health care, compared to workers belonging to non-professional sectors.

Permanent migrants often have greater access to health services than temporary migrants, and the access of irregular migrants tends to be even more restricted.[52] Barriers to health services arise due to financial constraints, as well as status, cultural and language differences, especially for irregular migrants.[53]

Migration, whether forced or voluntary, can create a strain on individuals and families. Mental health issues, however, are often not addressed as a key health concern of migrants, owing to a lack of data and subsequent lack of programmed interventions.

2. Sexual and Reproductive Health and Rights Issues of Women Migrant Workers

Despite the recognition of international organisations, such as the World Health Organisation (WHO) and International Organisation for Migration (IOM), of migrant health rights and issues, this has not translated to comprehensive programmes and policies of national migration regulatory bodies and institutions.

Sexual and reproductive health and rights (SRHR) *(see Definitions)* in the context of migration is even more invisible, and this is evidenced by the scant amount of data and information on SRHR conditions of women migrant workers in the region.

Women migrant workers are not a homogeneous group and their SRHR conditions vary according to their occupational and geographical contexts, their varied identities (depending on age, educational status, economic status, disability status, caste, ethnicity, religion, sexual orientation and gender identity, amongst others) as well as their migration history. Their movement is mediated by their SRHR situation in the countries where they come from, and in the countries where they move into. Women migrant workers travel with their sexual histories and sexual and reproductive health (SRH) notions and practices.[54] Sexual and reproductive health beliefs, attitudes, practices and expressions may be carried over from one's country of origin and these may or may not change overtime, depending on one's level of exposure and interaction in the country of destination.

Migrant workers are in a unique, but difficult position. They are expected to adhere to the cultural norms, practices and values of their state origin, even as they are ensconced in the realities of their adopted environment. Straddling a transnational existence also means simultaneously maintaining social, emotional and sexual relations in both locations. This has implications on their sexual and reproductive health and implies the necessity for them to navigate the boundaries of a temporary existence and remote location vis-à-vis their bodily desires, behavioural intentions and subsequent actions.[55]

2.1 Policies and Regulations

SRHR of women migrant workers are regulated by State policies and practices governing the migration regimes of countries of origin and destination.

At the pre-departure stage, migrant workers who go through formal channels have to comply with state-managed procedures, which include formal trainings, medical exams and pre-departure briefings, among others.

Countries of origin determine the content and methodology of pre-departure programmes for outgoing migrants. Often, SRHR topics are not included in the curriculum, especially those involving women migrant domestic workers. Seminar or training modules often are slanted towards ensuring that the women perform better in their work, that they do not assert their rights, and that they remain subservient and obedient to their future employers.

In recent years, a number of countries have introduced topics, such as prevention of violence against women (VAW), HIV and AIDS and cultural adaptation in the curriculum. However, there is no evaluation of the scope, coverage and impact of these topics. It is also problematic that despite having standard modules, the execution is not uniform, as it reflects biases of the institutions implementing it. In the Philippines, apart from designated government agencies, the pre-departure seminar is conducted by accredited NGOs, training centres and recruitment agencies. Thus, expectedly, NGOs would place more emphasis on rights education, while recruitment agencies allot more time for business entities to advertise their services, e.g., real estate, banking services, remittance services and others. What also needs to be examined is the approach of these pre-departure programmes to put the onus on women to protect themselves from possible dangers or harm. Without addressing the structural factors in which

violence, abuse or exploitation of migrant workers occur, the woman migrant could end up being blamed for putting herself in precarious situations.

A big challenge is that domestic work is not recognised as 'work' in many countries. The exclusion of women migrant domestic workers in labour laws of destination countries, and the privatised setting in which their employment occurs makes it difficult to supervise their working and living conditions, and thus renders them highly vulnerable to exploitation, abuse and violence. Adequate protection and access to redress mechanisms are not guaranteed to women migrant domestic workers, yet, as temporary guests of a foreign country, their sexual and reproductive rights are subjected to conditions and regulations that have a significant bearing on their legal status. Violations of these rules can result to punishment and sanctions, which can range from fines, jail time, whipping or caning, and in extreme circumstances, capital punishment.

For instance, Malaysian regulations prohibit foreign domestic workers from getting pregnant. Otherwise, they risk deportation and stand to lose the costs they invested in being able to migrate for work. They also get barred from further employment in the country. In the same vein, the Malaysian Labour Department's handbook for the recruitment of foreign domestic workers state that it is the responsibility of the employer to ensure that foreign domestic workers do not marry anyone from any nationality while still employed.[56]

Meanwhile, Chapter 91A of Singapore's Employment of Foreign Manpower Act details the conditions of work permit or visit pass for foreign workers. Among the provisions in the Section on Conduct include:

1. The foreign worker shall not go through **any form of marriage or apply to marry under any law, religion, custom or usage with a Singapore Citizen or Permanent Resident in or outside Singapore, without the prior approval of the Controller,** while he/she holds a Work Permit, and also after his/her Work Permit has expired or has been cancelled or revoked.

2. If the foreign worker is a female foreign worker, **the foreign worker shall not become pregnant or deliver any child in Singapore during the validity of her Work Permit/Visit Pass**, unless she is a Work Permit holder who is already married to a Singapore Citizen or Permanent Resident with the approval of the Controller. This condition shall apply even after the Work Permit of the foreign worker has expired or has been cancelled or revoked.

3. **The foreign worker shall not indulge or be involved in any illegal, immoral or undesirable activities, including breaking up families in Singapore.** [author's emphasis][57]

The above examples illustrate the extent in which destination countries curtail and violate the sexual and reproductive rights of women migrant workers. Prohibiting abortion, pregnancy, childbirth and marriage, while regularly testing them for sexually transmitted infections (STI), including HIV, puts women migrants in a bind, as they also have limited or no access to contraception and other safer sex methods. The explicit message of these regulations is that women migrants cannot have relationships and be sexually active, because it could threaten or negatively impact on the social, political and economic fibre of their current country of residence. Such policies also exhibit racial and class bias, as these are targeted mainly to migrant women in domestic work.

Conversely, migrant women who end up marrying while in the context of migration, can also end up getting stigmatised in their home communities for being 'materialist, immoral, selfish and a threat to nationalist identity,' as in the case of Vietnamese women who end up migrating for marriage.

Yet, there is no evidence to show that if women migrants exercise their sexual and reproductive rights, it could massively bring in detrimental results to the destination country. In Hong Kong, migrant domestic workers who get pregnant are protected by law and their employment cannot be terminated during the course of their pregnancy.[58] This has not led to astronomical numbers of domestic workers getting pregnant and subsequently giving birth. Thailand, as a matter of practice and policy, does not require HIV

testing of migrants and does not deport anyone on the basis of HIV status. This has not led to massive numbers of migrants getting infected with the virus or resulted in draining their public health resources.

2.2 Employment Status

Labour migrants enjoy legal or regular status in a foreign country for as long as their employment remains valid. Thus, their rights and entitlements are tied to their employment status. Once this is breached, e.g., if they are terminated from work or they run away from abusive conditions, they lose their work permit and subsequently, their legal status.

Employment contracts spell out entitlements and benefits, which should include fair wages, health insurance, work leave privileges, decent accommodation and the like.[59] In recent years, origin countries have made attempts to improve the working conditions of their workers by coming out with policies that put in place more stringent measures in the recruitment and placement of migrant workers. This has included pegging a minimum salary; defining the conditions of work; requiring mandatory health insurance and stipulating redress mechanisms. There were also efforts to come up with standardised work contracts and forge bilateral agreements and memorandum of understanding.

Unfortunately, protective policies and laws in origin countries often have no bearing in destination countries. Thus, even when work contracts are processed and signed before the workers leave, these could get substituted the moment they step into foreign soil. Such practices effectively render them vulnerable to abuse and exploitation. In many countries in the Middle East, contract substitution occurs, not just among semi- or low-skilled workers, but even among professionals. In some instances, contracts are not substituted but they are violated through the following schemes: reduced salaries; longer work hours; prohibition of days off and denial of health insurance. Thus, migrant workers in these situations may be compelled to either seek redress—if it is attainable—or endure the situation for the duration of their employment. A reduction of income could mean that they would resort to other means to recoup what they lost or to forgo spending for other needs such as health and leisure. In many cases, access to redress is erratic and prohibitive and most migrant workers would rather go home than stay without any income in a foreign country for an indeterminate period to pursue a legal case.

2.3 Barriers to Access to SRHR Services and Information

When people have information, and are able to access and avail of health services, diseases are prevented or their progression is delayed, and the overall cost of treatment for such diseases does not overburden the public health system. However, migrant workers, who have temporary status, often fall through the cracks of the health system, both of their countries of origin and destination.[60] Health systems in many destination countries are often not accommodating to the SRH needs of women migrant workers. In addition, regulations and policies that curtail migrants' SRHR, such as the prohibition of sexual relations, pregnancy, or abortion—that could lead to possible termination or deportation (as discussed in the previous section)—serve as a major barrier for women migrants in accessing SRHR services and information.

Among the other main barriers that impinge on women migrants' access to SRHR services and information are:

Language. Women migrants have difficulty communicating their conditions to health care providers who speak in a foreign language.[61] SRHR conditions, in particular, are regarded as very sensitive topics, and women often have difficulty communicating symptoms or explaining their condition in a foreign language.

Familiarity with the Health System. Health facilities, especially in developed countries, are now utilising digital technology and systems in patient care and treatment. Migrant workers who are not exposed to such technology experience difficulty in navigating the system and getting the services they need. Other barriers also include health providers' and migrants' lack of information regarding legislative measures concerning access by migrants; ambiguously or imprecisely defined entitlements; time-consuming

administrative reimbursement procedures; and, lengthy and complex application processes to obtain regular access to health care, among others.[62]

Mobility and Timing. Because of the limited mobility of migrant workers, many are unable to seek healthcare when they need it. In most cases, the only available time for migrant workers to seek services is during their day off. However, not all countries have mandatory days off for migrant workers.

Costs. Most migrant workers are entitled to mandatory health insurance. However, not all migrant workers are aware of this entitlement and if they are aware, they have no knowledge of the exact coverage and the procedure for making claims. Employers usually purchase the health insurance package of migrant workers and the coverage is often dependent on the premium of the health policy purchased. In many instances, the coverage is very basic and does not include SRH-related services, such as pap smears, contraceptive counselling, treatment of STIs, pre-natal care (in the event that they get pregnant) and abortion services.

Migrant workers are not usually able to avail of full treatments for lingering illnesses, e.g., cancer or HIV. However, there have been cases in Hong Kong where domestic workers are able to avail of treatments and procedures such as chemotherapy, hysterectomy and prolonged medication.[63] In Thailand, health promotion and prevention services, which include antiretroviral therapy in pregnant women for prevention of mother-to-child and transmission of HIV and contraception for male and female migrant workers, including tubal ligation, are covered in the benefit package of registered workers.[64]

Attitude of Employers. Even though migrant workers are entitled to health benefits or medical leaves, they usually refrain from availing of these, for fear that they could be terminated once it is known that they may be afflicted with an illness. Thus, even migrant workers who may be experiencing a variety of symptoms of possible illnesses do not inform their employers, endure these conditions, ask advice from their peers, and self-medicate as much as they can, until they think the symptoms are gone. This makes early detection of preventable RH-related life-threatening illnesses, such as cervical and breast cancer, which have been found to occur among migrants, difficult.[65]

Availability of Health Services. Depending on the coverage of their health insurance, there are migrant workers who end up seeking medical care or treatment in the destination country. This is especially true for migrants who are on long-term employment and thus, may have developed physical or psychosocial conditions that require the use of local health facilities. In the process, some may have also developed amicable relationships with their employers and thus, are not worried about possible job termination. However, if their insurance coverage only entitles them access to public facilities that cater mainly to locals, this may necessitate a longer waiting time.

In some instances, facilities may not even be readily available, especially for migrants who may be working in remote or rural areas.

Age-appropriateness. While structural issues create significant barriers to the provision of reproductive health services across all the settings and populations, adolescents in particular, face additional difficulty in gaining access because of community attitudes.[66] Young Burmese refugees and migrants working in Thailand were reportedly 'shy' and apprehensive about procuring reproductive health information and family planning services.[67] Young people in migrant communities often confront cultural clashes emerging from the norms and mores of their families versus those of the country their family moved into. Thus they are careful not to breach community norms, such as not engaging in sexual relations before marriage, as this could result to being shamed and punished, especially if they attempt to approach health providers for counselling and RH services.

Knowledge about SRHR. The lack of comprehensive sexuality education in countries of origin and the inadequacy of pre-departure programmes in addressing unmet SRH information needs of women migrant workers, as well as pre-existing cultural notions and biases, manifests strongly in the level of knowledge that migrants have about SRHR issues.

In a study conducted by Action for Health Initiatives (ACHIEVE), Inc., among 302 Filipino women migrant domestic workers, one out of every five of those who joined this study (n=61) had absolutely no knowledge of when, in a woman's monthly cycle, sexual intercourse will most likely result in a pregnancy.[68]

A qualitative study conducted in Hong Kong among Filipino women migrant domestic workers, revealed various SRH misconceptions, such as:[69]

- Wearing a wired bra is bad for the breasts.
- Breast cancer can be the result of one's breasts never having been touched upon reaching adulthood.
- The pap smear is for 'cleaning' the vagina.
- Pap smears are not good for those who are sexually active because the results will be 'unclear.'

The absence of information on SRHR in the country of destination means that migrant workers either rely on their knowledge or on those of their peers. While the internet is now a predominant source of portable information on just about everything, not all migrant workers are savvy in utilising this technology to get information. Furthermore, they are most likely to be prevented by their employers from using the computer to access the internet.

The next best source would then be their peers and migrant compatriots. Bound by common cultural and social ties, migrant workers rely on their friends for information, and such exchanges may occur on a face-to-face basis or through mobile phones or social media, especially if the migrant's mobility is curtailed. Thus, it is also common for misconceptions to be passed around in these social circles. On the other hand, the same social circles have the potential to be used effectively as means for providing accurate SRHR-related information.

In some situations, migrants would rather contact their families back home, either through SMS, phone calls or email, for instant information on folk remedies for various conditions and illnesses. Migrant Laotian women beer promoters, for example, would rely on their mother's advice for health problems, as they were shy to discuss their health issues with a physician.[70]

3. Sexual and Reproductive Health and Rights Outcomes

Women migrant workers go through periods of homesickness, adjustment and adaptation in their countries of destination. These phases are experienced in a myriad ways, depending on their proximity to a community of fellow migrants; their level of contact with families back home; and their willingness to settle into their new environment. The shift in spatial location could potentially lead to a shift in sexual and social interactions.

Despite the restrictive settings in some destination countries, migrant workers are able to connect with social and sexual networks. Such connections are often facilitated by relatives or people they know who have come before them. Those who experience stresses and pressures at work cope and seek solace from their peers or partners. There are many factors that facilitate the establishment of relationships and this may include: need for companionship; economic support; need for sex; need to affirm one's attractiveness; search for a potential spouse; peer pressure; and relief from stress and pressures.

Peer pressure is a critical factor in a migrant worker's ability and decision to enter into sexual relationships. In some instances, women migrants who are single and who do not have partners are subjected to pressure and told that they risk being regarded as inferior, prudish and unattractive in the community. Those who suffer from isolation and loneliness are often easily swayed due to a felt need to 'belong' to a community. Information from migrant workers themselves point out that even those who are married, or are in existing relationships with partners in the country of origin, engage in sexual or romantic relationships once they are abroad. In some contexts, the lack of social shackles and traditional

constraints, coupled by an invigorated sense of freedom, provide the impetus for women migrants to engage in sexual acts or relationships. Such actions may have particular benefits, e.g., if it is done for economic reasons or to ease one's loneliness. However, if it is done outside the parameters of safe and consensual acts or relationships, it could lead to negative consequences such as unwanted pregnancies or sexually transmitted infections (STIs).

With lesbian migrant workers, only anecdotal accounts exist about their situation, particularly when it comes to their SRHR. In Hong Kong, Filipino lesbians have formed a support group, FilGuys, and have organised activities to foster camaraderie and solidarity. Such organising is uniquely possible only in Hong Kong, which has Anti-Discrimination Ordinances on Sex and Race. Hong Kong also proscribes a mandatory once-a-week day-off, which enables these groups to organise meet-ups and events.

The level of acceptance of lesbian groups in migrant communities, and even by their respective foreign posts, vary across cultures and nationalities. The Philippine Consulate in Hong Kong has supported the activities of FilGuys, while officials at the Indonesian Consulate have expressed concern over the growing visibility and public display of affection of young Indonesian lesbian migrants in the territory.

Filipino lesbian domestic workers who were interviewed in the ACHIEVE study on access to SRH services of women migrant workers in destination countries admitted that they hesitate to seek SRH services because of shame and self-stigma associated with their 'female' bodies.[71] They also expressed discomfort about being physically examined, which would require exposing their private body parts especially to a male, foreign doctor. Thus, none of them had undergone pap smears or any gynaecological exam in the course of their employment, which ranged from two years to 15 years.

Interestingly, gender constructs of femininity and masculinity play out strongly in the work environments of lesbian migrant workers.[72] Some shared experiences of employers expressing preference for them because they were perceived to be able to do anything and that "they would not get pregnant or leave work due to marriage." Others recounted incidents of lesbian friends who were admonished to 'feminise' their appearance and tone down their masculine expressions. This was particular in the case of lesbians whose tasks included taking care of young children.

3.1 Access to SRH Services

Migrants, refugees and displaced people are among the underserved populations, whose special contraceptive needs still need to be successfully accommodated.[73] Migrant communities can be very difficult to reach with sexuality education and sexual and reproductive health services. In Thailand, they experience poor sexual and reproductive health outcomes, such as sexually transmitted infections (STIs) and unintended pregnancy, at a higher rate than the non-migrant population.[74]

Data on pregnancy among migrants is not readily available, although presumably, countries requiring mandatory pregnancy screening, such as Brunei, Malaysia, Singapore and Taiwan, would have figures of those who are officially diagnosed. Abortion is legal in Hong Kong and Singapore, yet anecdotal information from migrant associations in these countries point to the incidence of unsafe, backdoor abortions among women migrant workers, who cannot afford the cost of safe medical abortions.

In Hong Kong, Indonesian migrant domestic workers learn from their Filipino friends that using misoprostol (more popularly known by the brand name Cytotec), a drug that can treat gastric ulcer, can induce labour and terminate pregnancy (in combination with mifepristone). However, there is no information about correct dosage and there have been anecdotal accounts of fake versions of the drug being sold in the migrant community.[75]

Apart from unwanted or unplanned pregnancy, women migrants who engage in unprotected sex also face the risk of sexually transmitted infections (STI), including HIV. Various studies undertaken in the last decade have examined HIV risks and vulnerabilities of women migrant workers and have concluded that migration for work, in and by itself, is not a factor for HIV infection and spread. However, there

are conditions in the migration process that render women migrant workers vulnerable, such as lack of information and access to HIV prevention services; attitudes of invincibility that increase risk-taking behaviour; low income that preconditions them to enter into economically beneficial relationships and others.[76]

In 2010, the Association of Hospital and Medical Centre for Indonesian Manpower (HIPTEK) reported 174 HIV cases among 162,000 prospective migrant workers tested at 10 health centres. The Philippines has undertaken passive surveillance of HIV cases among overseas Filipino workers (OFWs) since the late 1990s. Migrant workers constitute a cumulative total of 20% of all reported HIV cases since 1984 and this number can be attributed largely to the conduct of compulsory testing among OFWs.[77] Women migrants comprise only 22% of total OFW cases and most of these are domestic workers. A report from Caring for Migrant Workers, an NGO dealing with the health issues of deported migrant workers from Malaysia, revealed that during 2010 they had taken care of more than 50 AIDS cases of deported Indonesian migrant workers.[78]

3.2 Gender-based Violence against Women Migrant Workers

Gender-based violence is a systemic problem that occurs in all phases of the migration cycle. There are women migrants who experience gender-based violence even before they move. Whether they are fleeing from abuses in the household or societal discrimination, women may see that the only escape from these harsh realities would be to relocate themselves away from the site of the abuse.

On-site, women migrants who are predominantly employed in gender-segregated, low-paying and unregulated sectors, such as domestic work, care-giving, factory, agriculture, entertainment and sex work, often have little social and legal protection and access to redress. Apart from direct violence from employers or other members of the household in which they work, women migrants are at risk of physical violence by state actors, such as police officers, customs officers or workers in detention centres.[79]

Migrant women workers are therefore exposed to violence in unconventional forms, including exploitative working conditions such as long working hours, non-payment of wages, forced confinement, starvation, beatings, rape, or sexual abuse and exploitation. Migrant domestic workers who spend more time being physically isolated and who generally have less access to local community support are exposed to several forms of mistreatment, which in some cases has led to extreme violence or their death.[80] Gender-based violence stands out as one of the main violations faced by women migrant workers and poses a direct risk to them of unwanted pregnancy and HIV infection.[81]

4. SRHR Responses for Migrant Workers: Policies and Programmes

4.1 Programme Interventions

In recent years, efforts have been made to respond to SRHR issues of women migrant workers both in the origin and destination countries. These have ranged from education and awareness-raising of women migrants of their sexual and reproductive health and rights to institutional reforms in government programmes and policies addressing the needs and concerns of migrant workers. Government regulatory agencies in Cambodia, Indonesia and the Philippines have pushed for expansion of the pre-departure trainings of women migrant workers, particularly for domestic workers. This included adding content on gender-based violence; general health; and HIV and AIDS. However, the implementation of such education programmes have to be consistently assessed and monitored to check whether these are responsive to the needs of women migrant workers when they are onsite. Very few NGOs and CBOs have undertaken community-based SRH education programmes for women migrant workers. While there are

many migrant-support NGOs and migrant associations, their focus have mainly been confined to labour rights issues and prevention of violence against women migrants.

Currently, there are no known sustainable post-arrival SRHR programmes in place in destination countries. Instead, what exists are one-off seminars or workshops conducted by NGOs and migrant support organisations, such as in Hong Kong, Malaysia, Singapore and South Korea.

In Singapore, the Ministry of Manpower (MOM) provides newly arrived domestic workers with a guidebook that contains helpline numbers for those who experience physical abuse. However, this can be confiscated by employers, or workers do not have the means to contact MOM because they are not allowed to use the telephone or to have a mobile phone.[82] The most common complaint among domestic workers is verbal abuse, but this is not considered punishable in Singapore's penal code.

In Thailand, NGOs and migrant organisations, with support from international agencies, have been undertaking programmes addressing SRH of women and young migrants, specifically, Burmese migrants. These include culturally-adapted SRH education programmes, including HIV prevention; provision of direct health and psychosocial services; and, advocacy for the recognition of migrants' rights, among others. In some provinces, anti-retroviral treatment is provided to a limited number of HIV-positive migrant workers.

Hong Kong has instituted policies to enable migrant workers access to health services. Employers are required to obtain a Hong Kong identification card for their domestic workers. The ID card enables the workers to have access to public health facilities for medical services for only HK$100. They are then able to reimburse this expense from their medical insurance. However, the utilisation of this benefit rests a lot on the domestic worker's knowledge of the system, her employer's attitudes and the immediate availability of the services needed. Migrants can also request for the services of an interpreter in designated government hospitals as per the Race Discrimination Ordinance. However, not many migrant workers are aware of this service.

Pacific Island migrants in Australia and New Zealand can access health care, education and some other benefits immediately, with the assumption that these are deemed to be 'emergency' benefits. Those with residency status also get publicly funded services, such as free laboratory tests and x-rays at public clinics, free healthcare during pregnancy and childbirth, and free prescriptions for public hospital patients and subsidies on other prescriptions, among others.[83]

Women migrant workers are predisposed to various SRH conditions even before they leave but their vulnerabilities and risks increase during their employment and stay in the destination countries. It is imperative to establish a continuum of SRHR programmes throughout the migration cycle. This entails inclusion of SRHR in existing pre-departure, post-arrival and reintegration programmes. If such programmes do not yet exist, it is important to establish them, with a view to include a whole range of services, including SRH.

It also entails enabling the involvement of women migrant communities. Hong Kong, Malaysia, Singapore, Taiwan, Thailand and South Korea have robust women migrant communities and while they have limited capacities and rights to formally organise, such informal networks, support groups and social groups can be mobilised.

4.2 Policy Frameworks

The right to health of migrant workers is framed within the context of migrants' human rights. The 1990 UN Convention on the Protection of the Rights of Migrant Workers and Members of their Families,[84] which entered into force in July 2003, has specific provisions on health issues of migrant workers. Article 43 states that "Migrant workers shall enjoy equal treatment with nationals of the State of employment in relation to...access to social and health services, provided that the requirements for participation in the respective schemes are met" (Sec 1e). Another provision, Article 28, provides that migrant workers

and members of their families have the right to receive any medical care that is urgently required, regardless of their legal status. It must be understood though, that SRH-related conditions may not always necessarily be of urgent nature, and as such, flexibilities need to be applied in order to consider the integration of SRH services as part of the health entitlements of women migrant worker.

South East Asia, through the Association of South East Asian Nations (ASEAN), has addressed health challenges through its joint technical cooperation mechanisms and joint programme of action (JPA). Communicable and infectious diseases such as Severe Acute Respiratory Syndrome (SARS), avian influenza and the Pandemic Influenza caused by H1N1 virus have been dealt with swiftly by the regional body, owing to the emergency nature of the diseases. Similar efforts are being pushed with regards to HIV and AIDS, with several JPAs already formulated.

There are no existing policy frameworks and mechanisms that specifically address SRHR and migration issues. Even the ICPD,[85] which is the key document upon which all major concepts of SRHR were enshrined through a global consensus, does not address SRHR of migrant workers. While the Statement of Principles and the Programme of Action, contains provisions on migration, it is not directly linked to SRHR. Principle 12 for instance, only states that, "Countries receiving documented migrants should provide proper treatment and adequate social welfare services for them and their families, and should ensure their physical safety and security." Moreover, Chapter 10 of the POA, which has a lengthy discussion of the various facets of international migration, focuses more on the need to strengthen sustainable development, data collection on migration, international cooperation, and proper use of remittances, among others. Its sub-sections on documented migrants, asylum seekers, refugees and displaced persons mentions access to health services only in passing.

On the other hand, the UN Convention on the Elimination of Discrimination Against Women (CEDAW)[86] does not mention migration in any of its sections. However, much advocacy has been done by migrant-support organisations to still utilise the Convention and its reporting mechanisms to report on how UN Member States deal with women migrants, as many of the provisions can be broadly utilised, especially those dealing with State responsibility to eliminate discrimination. For example, Article 12, which reads: "Equal rights to health care and family planning services, appropriate services related to pregnancy, confinement, post natal care, nutrition during pregnancy and lactation" has been identified as a possible anchor within which health of women migrant workers can be invoked.

In its 42nd session in 2008, the Committee on the Elimination of Discrimination against Women came up with General Recommendation No. 26,[87] which specifically focused on women migrant workers. The recommendation sought to comprehensively address the issues of women migrant workers utilising CEDAW, as a key instrument to promote and protect their rights in the context of work. Health is mentioned specifically in a few paragraphs including one that 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/AIDS prevention."

Another health measure that countries of origin are required to undertake include setting standards and quality assurance of pre-departure medical screening, with emphasis on "being respectful of the human rights of women migrants" during the required pre-departure HIV/AIDS testing or pre-departure health examinations. However, it does not question the rationale for such 'required' medical test, despite the UN's global campaign to eliminate all forms of HIV-related travel restrictions, which include HIV testing of foreign workers. Instead, it mentions that "special attention should be paid to the voluntariness" of the test. The same provision does recommend for "prospective employers to purchase medical insurance for women migrant workers."

Specific health-related responsibilities placed on countries of transit and destination in the same General Recommendation only mention access to medical or health care services. While the absence of a specific mention also perpetuates invisibility, such an open-ended recommendation leaves a lot of opening for SRHR concerns of migrant workers to be integrated.

In the absence of SRHR and migration platforms and mechanisms, what are currently being utilised as an informal channel in addressing migrant's SRHR issues are multi-country platforms addressing HIV and AIDS. These include the Joint UN Initiatives on Mobility and HIV/AIDS in South East Asia (JUNIMA) and the ASEAN Task Force on AIDS and the Pacific Regional Strategy on HIV and Other STIs (2009-2013).

JUNIMA is a multi-sectoral body composed of governments (including the ASEAN Secretariat), international agencies and civil society organisations, migrant workers and people living with HIV (PLHIV). Its main mandate is to promote universal access to HIV prevention, treatment, care and support for mobile and migrant populations, mainly in South East Asia. Since 2009, JUNIMA has organised and facilitated two inter-country dialogues involving health, planning, foreign affairs, interior and labour sectors of ASEAN member governments on HIV-related services for migrant workers. However, regional commitment can only come about with concrete actions at the country level and this has not been very forthcoming in the region.

While ASEAN member countries have signed on to several Declarations on HIV and AIDS, which have acknowledged that migrants and mobile populations are vulnerable, the push for regional cooperation has not moved forward. Destination countries have not agreed to any joint action to remove mandatory HIV testing of migrant workers and deportation of those found positive, and to enable or facilitate access to treatment for those infected. This situation presents an opportunity to shift the discourse and reposition HIV and migration within the broader frame of migrants' health. However, this needs to be well-laid out so that HIV and AIDS issues, which can be a doorway to SRH discussions, does not become completely invisible.

Meanwhile, in the Pacific, mobility and HIV issues have started to gain acknowledgement through some efforts by the United Nations; there have been some activities with specific groups. The Pacific Regional Strategy on HIV and Other STIs (2009-2013) has included migrant and mobile populations in the key populations that need to be addressed, but targeted and tailored prevention programmes for mobile populations still need to be further developed.[88]

At the global level, the 61st World Health Assembly (WHA) in 2008 came out with a resolution on Health of Migrants, which was approved by all its member states. The resolution called upon member states to improve monitoring of migrants' health; share best practices for meeting migrants' health needs; promote migrant-sensitive health policies and equitable access to health promotion, disease prevention and care among migrants; and, forge multilateral cooperation, among others. The resolution also directed the Director General of the World Health Organisation (WHO) to support efforts towards the implementation of the resolution and to submit a report on its implementation in the 63rd WHA in 2010.

As part of their fulfilment of the 2008 Resolution, the WHO and the International Organisation for Migration (IOM) convened a global consultation on migrants' health. The gathering convened representatives from governments, international agencies and civil society organisations to develop an operational framework on migrants' health. While the approach was encompassing; that is, it attempted to include a wide range of migrants (immigrants, temporary workers, refugees, trafficked people, undocumented and others), the consultation referred mostly to permanent migrants. The operational framework includes four key pillars of migrants' health, namely: monitoring of migrants' health; migrant-sensitive health systems; policy and legal frameworks; and, partnerships and multi-country frameworks.[89] The challenge is how this framework gets applied and operationalised at the country level. While this has been championed by the WHO and IOM in the global arena, much needs to be done at the regional and more so, at the country levels.

HIV-Travel Restrictions

A concrete manifestation of policy disharmony is the imposition of restrictions on entry and stay of people living with HIV. While the International Labour Organisation (ILO) has affirmed that one's HIV status does not automatically translate into being 'unfit' to work, countries continue to impose HIV testing as a requirement for entry, employment and stay of migrant workers. There are unfounded fears that HIV positive migrant workers would act as vectors and spread the virus indiscriminately. It is also assumed that HIV-related care and treatment will unduly and massively burden the health care system of the destination country. Additionally, travel restrictions also manifest stigmatising attitudes and moralistic biases.

While the issue of HIV-related travel restrictions has been elevated at the global level, with countries such as the United States and recently, South Korea, lifting travel bans on people living with HIV, there are still around 46 countries who still impose it. In the Pacific region, six countries (Australia, Marshall Islands, Micronesia, Papua New Guinea, Samoa and Tonga) currently impose HIV related restrictions on entry, stay and residence of people living with HIV.[90]

5. Future Directions

The core issue of SRH and migration is the exercise of control by the state on sexuality and reproductive capacities of women migrant workers. At the onset, they migrate on a temporary scheme, as single entities deprived of the possibility and capacity to bring families and partners with them. They are subjected to a single-entry policy, which dictates that they cannot enjoy the privilege of moving in and out of the territory within the duration of their contract, to reconnect with their families and partners, back home. As migrants, they are subjected to a number of prohibitions: to have sexual relations with people they are not married to (as in the case of migrants, both men and women, in the Gulf States), to marry, to get pregnant and to have access to abortion, among others.

The control over the sexual and reproductive lives of migrants manifest the States' need to exercise absolute control over non-nationals and non-residents in their territory, an obvious attempt to put the interests of their nationals above anyone else who they may view as a threat to their health, national security and cultural purity. It also embodies their intent to prohibit the assimilation and integration of a migrant population in their society.

Conflicts in policies around immigration, labour and health are nowhere more pronounced than in the context of health rights of migrants. Since many rights and protections flow from state institutions, individuals not recognised as citizens of the state in which they live, constitute an extremely vulnerable group.[91]

A woman migrant worker's legal status is determined by her employment status, which in turn, is subject to requirements, including medical fitness. Thus, once she develops adverse health conditions, which may be a consequence of her work, and she does not have access to appropriate and timely services, she could be terminated from work and lose her legal status. It is often the case that immigration policies take precedence over everything else, and unless a strong case is built to harmonise these conflicting policy frameworks, migrants' human rights, and consequently health rights, will always get compromised.

Migration health is a specialised field of health sciences that addresses the individual health concerns of migrants, as well as public health issues related to the migratory movement of people. Links between migration health and public health involve partners in all phases of a migrant's journey, including in communities of origin, transit, destination and return and all mobility patterns, including irregular migration and circular migration.[92]

Addressing health issues in international labour migration requires multi-sectoral collaboration and multi-country approaches throughout the migration continuum. Partnerships, dialogue and collaborative programmes through bilateral, regional and global platforms should be utilised to advance the discourse on migrants' health and rights, particularly, sexual and reproductive health and rights.

These platforms include the Millennium Development Goal 8 (MDG 8), which specifically promotes global partnerships, including in migration-related concerns. Because of the scant reference to SRHR in international and regional declarations and conventions, such as the Convention on the Protection of the Human Rights of Migrant Workers and Members of their Families and the ASEAN Declaration on the Protection of the Human Rights of Migrant Workers, it is strategic to cross-reference these with other framework documents such as CEDAW and ICPD.

The 46th session of the Commission on Population and Development (CPD) in 2013 provides a good opportunity to push forward migration, rights and health issues, as its special theme for this session would be "New Trends in Migration: Demographic Aspects." In addition, the 47th session of CPD would be devoted to assessing the status of the implementation of the 1994 Programme of Action, in view of the UN General Assembly holding a special session on ICPD+20 on its 69th session in 2014.

With regards to migration platforms, the most immediate would be the second High-level Dialogue on International Migration and Development, which will be held in 2013. Preparations for this global event are ongoing, but the modalities and organisation, along with the final date, themes and outcomes, will be further taken up and finalised on the 67th session of the UN General Assembly in December 2012. It would be crucial to study the roadmap leading the High-level Dialogue, including engagement in national, regional and global process and provision of crucial interventions to advance the SRHR agenda in the migration and development discourse.

It is worth noting that the first High-level Dialogue held in 2006 resulted to the creation of the Global Forum on Migration and Development (GFMD), a voluntary, non-binding and informal consultative process, led by and open to all UN Member States and observers of the United Nations. Convened every year and now in its 6th year, the GFMD prides itself as the largest and most comprehensive global platform for dialogue and cooperation on international migration and development. Since the first GFMD in 2007, many CSOs have actively engaged in the process. However, in recent years, there have been expressions of dissatisfaction over the limited scope within which CSOs could fully influence and reframe the migration and development agenda. The voluntary and non-binding nature of the dialogue has also limited the enforcement or implementation of recommended actions to addressing crucial human rights issues of migrant workers. Thus, an alternative CSO forum, the World Social Forum on Migration, was established. It is now on its fifth year of being held in parallel to the GFMD.

A crucial strategy is to establish and sustain cross-movement dialogues and collaboration, such as those between and among SRHR groups, migration-support organisations, HIV networks and other allied civil society movements, such as those working in human rights, women's rights and the development sector. Such platforms will ensure that migration and SRHR are addressed either are as cross-cutting contexts or issues within the frame of human rights, development, gender and sexuality. It is also imperative to support and strengthen organising and mobilisation among women migrant workers, in contexts where these are possible and feasible. Current policy and programme interventions can be better informed, relevant and appropriate if women migrant workers are enabled to be directly involved in the development, implementation and assessment process.

Concretely, there is a need to scale up research and data generation on SRHR of women in the context of migrant labour, for purposes of enshrining improved policies and programmes. This should be supplemented by implementation of concrete programmes that enhance women migrant workers' access to SRH services and information, such as inclusion of comprehensive SRH services in their health insurance package, and establishment of linkages and referral networks to trained and migrant-friendly SRH service providers both in countries of origin and destination. It is imperative to educate

women migrant workers about SRHR issues at various stages of the migration process, so that they are empowered to make choices that could protect them from potential SRH risks and vulnerabilities. These responses can only be effective if framed within the broader context of the protection of the health and human rights of women migrant workers, wherever they are.

In addressing SRHR of women migrant workers, it is imperative to work at individual, societal and institutional levels. At the individual level, women must be able to take control over their sexual and reproductive capacities and choices, wherever they are. Concretely, this means having access to appropriate and responsive SRHR programmes and services that are mandated by policies and laws in both the country of origin and destination. On a long-term and institutional level, there is a need to create or re-create an environment where societal norms, cultural beliefs, political apparatuses and economic conditions can be reframed and re-structured, so that women migrants can move, work and live, with dignity, respect and full protection.

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.[93]

Country of Origin / Country of Destination: The country of origin is a source of migratory flows (regular or irregular),[94] 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.[95]

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.[96]

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. This working definition was developed by the International Organisation for Migration in the absence of an internationally agreed definition.[97]

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.[98]

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 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.[99]

Labour Migration: Generally defined as a cross-border movement for purposes of employment in a foreign country.[100]

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.[101]

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.[102]

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).[103]

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.[104]

Reproductive Health: A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. It addresses the reproductive processes, functions and system at all stages of life. It implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women, as well as gender non-conforming people, to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[105]

Reproductive Rights: Recognise that the sexual and reproductive health of both women and men, as well as gender non-conforming people, requires more than scientific knowledge or biomedical intervention. Rather, they require recognition and respect for the inherent dignity of the individual. They refer to the composite of human rights that protect against the causes of ill health and promote sexual and reproductive wellbeing.[106] They embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.[107] Reproductive rights include the right to safe, legal and accessible abortion services.

Sexual Health: A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[108] The purpose of sexual health care should be the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.[109] For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[110]

Sexual Rights: Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. They include the right of all persons, free of coercion, discrimination and violence, to: the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; seek, receive and impart information related to sexuality; sexuality education; respect for bodily integrity; choose their partner; decide to be sexually active

or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe and pleasurable sexual life.[111] Sexual rights also include the right to personhood (the right to make one's own choices), equality (between and among men, women and transgender people), and respect for diversity (in the context of culture, provided the first three principles are not violated).[112] Moreover, a human rights approach to sexuality and sexual policy implies the principle of indivisibility—meaning that sexual rights are inextricable from economic, social, cultural, and political rights. Freedom to express one's sexual or gender orientation or to be who one is as a sexual person, to experience erotic justice, is interdependent with a whole series of other rights, including health care, decent housing, food security, freedom from violence and intimidation, and to be in public space without shame.[113]

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.[114]

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***.[115]

ENDNOTES AND REFERENCES

1. International Organisation for Migration (IOM). Migration and health. Retrieved from www.iom.int/jahia/Jahia/about-migration/developing-migration-policy/migration-and-health
2. IOM & United Nations Department of Economic and Social Affairs (UN DESA). (2012). Migration and human mobility. Thematic think piece for the UN System Task Team on the Post-2015 UN Development Agenda. Retrieved from www.un.org/millenniumgoals/pdf/Think%20Pieces/13_migration.pdf
3. Rallu, J.L. (2008). Population, migration and development in Asia, with special emphasis on the South Pacific: The impact of migration on population and the MDGs. Thailand: UNESCAP Population Division, Department of Economic and Social Affairs.
4. Martin, P. (2009). Migration in the Asia-Pacific region: Trends, factors, impacts. Human development research paper 2009/32. UNDP. Retrieved from www.hdr.undp.org/en/reports/global/hdr2009/.../HDRP_2009_32.pdf
5. IOM & UN DESA. (2012). Migration and human mobility. Thematic think piece for the UN System Task Team on the Post-2015 UN Development Agenda. Retrieved from www.un.org/millenniumgoals/pdf/Think%20Pieces/13_migration.pdf
6. Sweetman, C. (2011). Introduction. *Gender & Development,* 19(1):1-9. doi: 10.1080/13552074.2011.567889
7. IOM. (2009). *Migration, environment and climate change: Assessing the evidence.* Retrieved from www.publications.iom.int/bookstore/free/migration_and_environment.pdf
8. Abella, M. (2008). Labour migration: Trends, issues and prospects. In Regional Thematic Working Group on International Migration including Human Trafficking, *Situation report on international migration in East and South-East Asia* (pp. 139-154). Bangkok: IOM Regional Office for Southeast Asia. Retrieved from http://publications.iom.int/bookstore/free/Situation_Report.pdf
9. IOM. (2011). *World migration report 2010.* Geneva: IOM.
10. United Nations Department of Economic and Social Affairs (UN DESA), Population Division. (2012). *The age and sex of migrants 2011 wall chart.* New York: UN DESA.
11. Commission on Filipinos Overseas. (2009). Stock estimate of overseas Filipinos, Dec 2009. Retrieved from www.poea.gov.ph/stats/statistics.html
12. Badan Nasional Penempatandan Perlindungan Tenaga Kerja Indonesia (National Body on the Placement and Protection of Indonesian Migrant Workers). (2012). Data on international migrant workers from 2006 - May 2012.
13. Kok, C. (2011, February 19). Striking a balance in foreign labour. *The Star Online.* Retrieved from http://biz.thestar.com.my/news/story.asp?file=/2011/2/19/business/8094068&sec=business
14. Pasadilla, G. (2011). Social security and labour migration in ASEAN. Asian Development Bank Institute. Retrieved from www.adbi.org/research-policy-brief/2011/11/28/4814.social.security.labor.migration.asean/growth.of.intraasean.labor.mobility/
15. CARAM Asia. (2010): *Malaysia vs. Hong Kong: Employers' perception and attitudes towards foreign domestic workers.* Kuala Lumpur: CARAM Asia.
16. Foreign labour force (most recent) by country. Retrieved from www.nationmaster.com/graph/lab_for_lab_for-labor-foreign-force
17. Marin, M.L. (2012). Navigating borders, negotiating bodies: Sexual and reproductive health and rights of women and young migrant workers in Asia-Pacific. In ARROW, *Thematic papers presented at the Beyond ICPD and MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement* (pp. 75-91). Kuala Lumpur: ARROW. Retrieved from www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf
18. Ibid.
19. Woolford, G. (2009). Social protection for migrants from the

Pacific Islands in Australia and New Zealand. New Zealand: The World Bank.

20. Ibid.

21. UN DESA, Population Division. (2010). *International migration in a globalising world: The role of youth.* New York: UN DESA.

22. World Bank. 2011. *The World Bank's migration and remittances factbook 2011*. Retrieved from http://go.worldbank.org/QGUCPJTORo

23. Lan, V.H. (2011). Socio-cultural influences on the reproductive health of migrant women: A review of literature in Vietnam. Vietnam: Ha Noi School of Public Health.

24. World Bank. 2011. *The World Bank's migration and remittances factbook 2011*. Retrieved from http://go.worldbank.org/QGUCPJTORo

25. IOM & UN DESA. (2012). Migration and human mobility. Thematic think piece for the UN System Task Team on the Post-2015 UN Development Agenda. Retrieved from www.un.org/millenniumgoals/pdf/Think%20Pieces/13_migration.pdf

26. Martin, P. (2009). Migration in the Asia-Pacific region: Trends, factors, impacts. Human development research paper 2009/32. UNDP. Retrieved from www.hdr.undp.org/en/reports/global/hdr2009/.../HDRP_2009_32.pdf

27. Abella, M. (2008). Labour migration: Trends, issues and prospects. In Regional Thematic Working Group on International Migration including Human Trafficking, *Situation report on international migration in East and South-East Asia* (pp. 139-154). Bangkok: IOM Regional Office for Southeast Asia. Retrieved from http://publications.iom.int/bookstore/free/Situation_Report.pdf

28. Sokoloff, C., & Lewis, R. (2005). *Denial of citizenship: A challenge to human security.* European Policy Centre Issue Paper 28.

29. IOM. www.iom.int/jahia/Jahia/pid/600

30. Marin, M.L. (2012). Navigating borders, negotiating bodies: Sexual and reproductive health and rights of women and young migrant workers in Asia-Pacific. In ARROW, *Thematic papers presented at the Beyond ICPD and MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement* (pp. 75-91). Kuala Lumpur: ARROW. Retrieved from www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf

31. CEDAW. (2008). General recommendation No. 26 on women migrant workers [CEDAW/C/2009/WP.1/R]. Retrieved from www2.ohchr.org/english/bodies/cedaw/docs/GR_26_on_women_migrant_workers_en.pdf

32. Battistella, G., & Asis, M. (2012). *Protecting Filipino transnational domestic workers: Government regulations and their outcomes.* Philippines: Philippine Institute for Development Studies. Retrieved from: http://dirp4.pids.gov.ph/ris/dps/pidsdps1112.pdf

33. Ibid.

34. Ibid.

35. Mora, L. (2006). *Gender, reproductive rights and international migration.* Santiago de Chile: CEPAL. Retrieved from: http://www.eclac.cl/celade/noticias/paginas/6/27116/moral.pdf

36. United Nations International Research and Training Institute for the Advancement of Women (INSTRAW). (2008). *Gender, remittances and local rural development: The case of Filipino migration to Italy.*

37. Pingol, A. (2001). *Remaking masculinities: Identity, power, and gender dynamics in families with migrant wives and househusbands.* Philippines: UP Centre for Women's Studies.

38. Yeoh, B.S.A., & Lam, T. (2013). Transnational migration in Southeast Asia and the gender roles of left-behind fathers. *ARROW for Change*, 19(1). [In press]

39. Batangan, M.T. (2011). *Women and migration: The mental health nexus: A research on individual and structural determinants of stress and mental health problems of Filipino women migrant domestic workers.* Philippines: Action for Health Initiatives (ACHIEVE), Inc. and Vrije Universiteit Medical Center Metamedica/Health Care and Culture (VUMC-MHCC).

40. IOM. *Migration and health.* Retrieved from www.iom.int/jahia/Jahia/about-migration/developing-migration-policy/migration-and-health

41. United Nations Development Programme (UNDP). (2009). *Human development report 2009: Overcoming barriers; Human mobility and development.*

42. Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

43. United Nations Development Programme (UNDP). (2009). *Human development report 2009: Overcoming barriers; Human mobility and development*.

44. Wiessner, P., & Lemmen, K. (2007), *Quick Reference: Travel and residence regulations for people with HIV and AIDS - worldwide* (6th ed.). Berlin: Deutsche AIDS-Hilfe e.V. Retrieved from http://aidsdatahub.org/dmdocuments/Quick_Reference_Guide_entry_and_residence_regulation.pdf

45. CARAM Asia. (2010). *Policy brief: Removal of mandatory HIV testing for migrant workers.* Kuala Lumpur: CARAM Asia.

46. ACHIEVE, Inc. & DAWN. (2007). *State of health of migrant workers: Mandatory health testing among migrant workers: Philippine report.* Philippines: CARAM-Asia.

47. Ibid.

48. Wiessner, P., & Lemmen, K. (2012). *Quick Reference Guide 2012/13: Travel and residence regulations for people with HIV and AIDS* (10th ed.). Berlin: Deutsche AIDS-Hilfe e.V. Retrieved from http://aidsdatahub.org/dmdocuments/Quick_Reference_Guide_entry_and_residence_regulation.pdf

49. CARAM Asia. (2010). *Policy brief: Removal of mandatory HIV testing for migrant workers.* Kuala Lumpur: CARAM Asia.

50. Ibid. p. iv.

51. United Nations Development Programme (UNDP). (2009). *Human development report 2009: Overcoming barriers; Human mobility and development*.

52. Ibid.

53. Ibid. p 53.

54. Marin, M.L. (2012). Navigating borders, negotiating bodies: Sexual and reproductive health and rights of women and young migrant workers in Asia-Pacific. In ARROW, *Thematic papers presented at the Beyond ICPD and MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement* (pp. 75-91). Kuala Lumpur: ARROW. Retrieved from www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf

55. Ibid.

56. CARAM Asia. (2011). *Reality check, rights and legislation for migrant domestic workers across Asia*. Malaysia.

57. Marin, M.L. (2012). Navigating borders, negotiating bodies: Sexual and reproductive health and rights of women and young migrant workers in Asia-Pacific. In ARROW, *Thematic papers presented at the Beyond ICPD and MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement* (pp. 75-91). Kuala

Lumpur: ARROW. Retrieved from www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf

58. Quesada, A. (2009). *Health of our : A qualitative study on access to sexual and reproductive health services of women migrant workers onsite.* Philippines: ACHIEVE, Inc. Retrieved from: www.sjhivctr.com/research/2011/AccesstoSRH.pdf

59. Marin, M.L. (2012). Navigating borders, negotiating bodies: Sexual and reproductive health and rights of women and young migrant workers in Asia-Pacific. In ARROW, *Thematic papers presented at the Beyond ICPD and MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement* (pp. 75-91). Kuala Lumpur: ARROW. Retrieved from www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf

60. Ibid.

61. Quesada, A. (2009). *Health of our heroes: A qualitative study on access to sexual and reproductive health services of women migrant workers onsite.* Philippines: ACHIEVE, Inc. Retrieved from: www.sjhivctr.com/research/2011/AccesstoSRH.pdf

62. Pace, P., & Gushulak, B. (2010). Policy and legal frameworks affecting migrant's health. Paper presented at the WHO-IOM Global Consultation on Migrant Health, Madrid, Spain. March 2010.

63. Quesada, A. (2009). *Health of our heroes: A qualitative study on access to sexual and reproductive health services of women migrant workers onsite.* Philippines: ACHIEVE, Inc. Retrieved from: www.sjhivctr.com/research/2011/AccesstoSRH.pdf

64. Srithamrongsawat, S., Wisessang, & R., Ratjaroenkhajorn, S. (2009). Financing healthcare for migrants: A case study from Thailand. Thailand: International Organisation for Migration (IOM) & World Health Organisation (WHO). Retrieved from: http://publications.iom.int/bookstore/free/Financing_Healthcare_for_Migrants_Thailand.pdf

65. Marin, M.L. (2012). Navigating borders, negotiating bodies: Sexual and reproductive health and rights of women and young migrant workers in Asia-Pacific. In ARROW, *Thematic papers presented at the Beyond ICPD and MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement* (pp. 75-91). Kuala Lumpur: ARROW. Retrieved from www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf

66. Ibid.

67. Oh, S., & Hobstetter, M. (2011). Forced migration and adolescent reproductive health. *Gender Perspectives,* 3(2):1-5. Retrieved from: http://web1.iseas.edu.sg/GenderEbulletin-Dec2011.pdf

68. Sobritchea, C. (2006). Life and health on the move: The sexual and reproductive health status of Filipino women migrant domestic workers. Philippines: ACHIEVE, Inc. Retrieved from: www.junima.org/resources/pdf/unveilingHiv.pdf

69. Quesada, A. (2009). *Health of our heroes: A qualitative study on access to sexual and reproductive health services of women migrant workers onsite.* Philippines: ACHIEVE, Inc. Retrieved from: www.sjhivctr.com/research/2011/AccesstoSRH.pdf

70. Webber, G.C., Spitzer, D.L. (2010). Sexual and reproductive health issues facing Southeast Asian beer promoters: A qualitative pilot study. *BMC Public Health,* 10(38): 1-12. Retrieved from: www.biomedcentral.com/1471-2458/10/389

71. Quesada, A. (2009). *Health of our heroes: A qualitative study on access to sexual and reproductive health services of women migrant workers onsite.* Philippines: ACHIEVE, Inc. Retrieved from: www.sjhivctr.com/research/2011/AccesstoSRH.pdf

72. Marin, M.L. (2012). Navigating borders, negotiating bodies: Sexual and reproductive health and rights of women and young migrant workers in Asia-Pacific. In ARROW, *Thematic papers presented at the Beyond ICPD and MDGs: NGOs Strategising for Sexual and Reproductive Health and Rights in Asia-Pacific Region and Opportunities for NGOs at National, Regional and International Levels in the Asia-Pacific Region in the Lead-up to 2014: NGO-UNFPA Dialogue for Strategic Engagement* (pp. 75-91). Kuala Lumpur: ARROW. Retrieved from www.arrow.org.my/uploads/Thematic_Papers_Beyond_ICPD_&_the_MDGs.pdf

73. Sciortino, R. (2010). *Achieving contraceptive security and meeting reproductive health needs in Southeast Asia.* Thailand: Asia Pacific Alliance for Sexual and Reproductive Health and Rights.

74. Megquier, S., & Chappanapong, A. (2012). *The story of love to improve sexual and reproductive health of young migrants in Thailand.* UNESCO Asia-Pacific Regional Bureau for Education & Plan International.

75. Quesada, A. (2009). *Health of our heroes: A qualitative study on access to sexual and reproductive health services of women migrant workers onsite.* Philippines: ACHIEVE, Inc. Retrieved from: www.sjhivctr.com/research/2011/AccesstoSRH.pdf

76. Quesada, A., & Marin, M. (2009). *Unveiling HIV vulnerabilities: Filipino women migrants in the Arab States.* Philippines: ACHIEVE, Inc.

77. Department of Health. (2012). June 2012 Philippine HIV and AIDS registry, National Epidemiology Center.

78. International Labour Organisation (ILO). (2012). Protecting the health rights of Indonesian migrant workers against gender based violence and HIV and AIDS vulnerabilities. Retrieved from www.ilo.org/global/about-the-ilo/press-and-media-centre/news/WCMS_176881/lang--en/index.htm

79. IOM. (2010). *Taking action against violence and discrimination affecting migrant women and girls fact sheet.*

80. Cruz, A., & Klinger, S. (2011). *Gender-based violence in the world of work: Overview and selected annotated bibliography*. ILO.

81. ILO. (2012). Protecting the health rights of Indonesian migrant workers against gender based violence and HIV and AIDS vulnerabilities. Retrieved from www.ilo.org/global/about-the-ilo/press-and-media-centre/news/WCMS_176881/lang--en/index.htm

82. Battistella, G., & Asis, M. (2012). *Protecting Filipino transnational domestic workers: Government regulations and their outcomes.* Philippines: Philippine Institute for Development Studies.

83. Woolford, G. (2009). Social protection for migrants from the Pacific Islands in Australia and New Zealand. New Zealand: The World Bank.

84. 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]. Retrieved from www2.ohcr.org/english/law/cmw.htm

85. United Nations Population Fund (UNFPA). (1994). Programme of action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. Retrieved from www.unfpa.org.mx/publicaciones/PoA_en.pdf

86. United Nations General Assembly. (1979). Convention on the Elimination of All Forms of Discrimination against Women. Retrieved from www.un.org/womenwatch/daw/cedaw/text/econvention.htm

87. CEDAW. (2008). General recommendation No. 26 on women migrant workers [CEDAW/C/2009/WP.1/R]. Retrieved from www2.ohchr.org/english/bodies/cedaw/docs/GR_26_on_women_migrant_workers_en.pdf

88. Conel, J., & Negin, J. (2010). *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).

89. World Health Organisation (WHO) & IOM. (2010). *Health of Migrants: The Way Forward*. Geneva: WHO.

90. The Global Database on HIV-Specific Travel and Residence Restrictions. Retrieved from www.hivtravel.org/Default.aspx?PageId=143&CountryId=23
91. Sokoloff, C., & Lewis, R. (2005). *Denial of citizenship: A challenge to human security.* European Policy Centre.
92. IOM. Migration and health. Retrieved from www.iom.int/jahia/Jahia/about-migration/developing-migration-policy/migration-and-health
93. IOM. (2004). *Glossary on migration*. Geneva: IOM.
94. Ibid.
95. Ibid.
96. 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.
97. IOM. (2004). *Glossary on migration*. Geneva: IOM.
98. Ibid.
99. Ibid.
100. Ibid.
101. Ibid.
102. Ibid.
103. Ibid.
104. Ibid.
105. Adapted from Reproductive health. WHO. Retrieved from: www.who.int/topics/reproductive_health/en/
106. Erdman, J.N., & Cook, R. 2008. Reproductive rights. Elsevier Inc. pp. 532-538
107. ICPD PoA, para 7.3 h Retrieved from www.unfpa.org/icpd/icpd-programme.cfm#ch7
108. Gender and human rights. World Health Organization. Retrieved from www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html
109. ICPD PoA, para 7.2
110. Gender and human rights. World Health Organization. Retrieved from www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html
111. Asian Communities for Reproductive Justice (ACRJ). 2005. *A new vision for advancing our movement for reproductive health, reproductive rights and reproductive justice.* California, USA: ACRJ. Retrieved from www.reproductivejustice.org/reproductive.html
112. Chandiramani, R. (2007). Why affirm sexuality? *ARROWs for Change*, 13(2):1-2.
113. Petchesky, R. (2006). Introduction: Sexual rights policies across countries and cultures: Conceptual frameworks and minefields. In R. Parker, R. Petchesky, & R. Sember, *SexPolitics: Reports from the front lines.* Sexuality Policy Watch. www.sxpolitics.org/frontlines/book/pdf/sexpolitics.pdf
114. WHO. (2006). Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva. Geneva: WHO.
115. IOM. (2004). *Glossary on migration.* Geneva: IOM.

Asian-Pacific Resource and Research Centre for Women (ARROW)

ISBN: 978-967-0339-07-8

The Asian-Pacific Resource and Research Centre for Women (ARROW)
1 & 2 Jalan Scott, Brickfields, 50470 Kuala Lumpur, Malaysia
tel: +603 2273 9913
fax: +603 2273 9916
web: www.arrow.org.my
email: arrow@arrow.org.my
facebook: The Asian-Pacific Resource and Research Centre for Women (ARROW) http://on.fb.me/oW6Z9w
follow us on twitter: @ARROW_Women

PRODUCTION TEAM

Project Coordinator and Editor: **Maria Melinda Ando**
Co-Copyeditor: **Gaayathri Nair**
Layout Artist: **Jim Marpa**
Cover Photo: **KC Wong (WongKC2012, Flickr creative commons)**

Our appreciation also goes to the following ARROW programme staff and Programme Advisory Committee members for their input in the conceptualisation of this working paper: **Anh Tu Hoang, Babu Ram Pant, Nalini Singh, Rishita Nandagiri, Sai Jyothirmai Racherla, Sivananthi Thanenthiran, Shubha Kayastha, Uma Thiruvengadam & Zhang Kaining.**

This work was carried out with the aid of a grant from the **International Development Research Centre (IDRC),** Ottawa, Canada through the Regional Office for Southeast and East Asia. The views expressed in this publication are those of the contributors and do not necessarily represent those of IDRC, or its Board of Governors.

ARROW's work is also supported with core funding from:

Sida