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GENDER, REPRODUCTIVE RIGHTS AND INTERNATIONAL MIGRATION

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Gender, Reproductive Rights and International Migration

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1. The "feminization of migration": data, distribution and trends

1.1. General data: ¿feminization of migration?

The number of international migrants has grown steadily in the past four decades to an estimated 175 million in 2000, up from an estimated 75 million in 1960 (Table 1)[1]. The estimates available indicate that the number of international migrants constitute 2.9% of the world's population in 2000. The proportion of international migrants is far higher in and from certain countries, for example, estimates suggest that about 9% of the Mexican population lives in the US. 60% of the world's migrants reside in the more developed regions and 40% in the less developed regions. While some migration is global in scope, close to half of all reported migrants move from one developing country to another, generally from low-income to mid-income countries[2]. In Latin America and the Caribbean, for instance, regional destinations include Costa Rica for Nicaraguan migrants, the Dominican Republic for Haitian migrants and Argentina for Bolivian migrants. Similarly, Southern Africa (including South Africa, Botswana and Lesotho) is a key destination region for migrants from elsewhere in Africa. In South-East Asia, considerable migration takes place from Indonesia, the Philippines and Thailand to Hong Kong, Malaysia, Singapore and Taiwan. In Southern Asia, India receives migrants from Afghanistan, Bangladesh, Bhutan, Myanmar and Nepal.

Table 1
International migration 1960-2000

Major area, region, country or area	Estimated number of international migrants at midyear (Both sexes)				
	1960	1970	1980	1990	2000
World	**75 900 698**	**81 527 177**	**99 783 096**	**154 005 048**	**174 933 814**
More developed regions	32 084 671	38 282 819	47 726 643	89 655 849	110 291 047
More developed regions without the former USSR	29 142 984	35 190 307	44 475 573	59 333 317	80 822 344
Less developed regions	43 816 027	43 244 358	52 056 453	64 349 199	64 642 767
Least developed countries	6 254 996	7 126 628	9 043 303	10 992 041	10 458 106
Africa	8 977 075	9 862 987	14 075 826	16 221 255	16 277 486
Asia	29 280 680	28 103 771	32 312 541	41 754 291	43 761 383
Europe	14 015 392	18 705 244	22 163 201	26 346 258	32 803 182
Latin America and the Caribbean	6 038 976	5 749 585	6 138 943	7 013 584	5 943 680
Northern America	12 512 766	12 985 541	18 086 918	27 596 538	40 844 405
Oceania	2 134 122	3 027 537	3 754 597	4 750 591	5 834 976
USSR (former)	2 941 687	3 092 512	3 251 070	30 322 532	29 468 703

Source:
Population Division of the United Nations, Trends in Total Migrant Stock: The 2003 Revision, diskette (New York, United Nations, 2003).

The migration of women has always been an important component of international migration. As Hania Zlotnik has pointed out, the main revelation of the set of global estimates by sex is that women and girls have accounted for a very high proportion of all international migrants for a long time[3]. Already in 1960, female migrants accounted for nearly 47 out of every 100 migrants living outside of their countries of birth. Since then, the share of female migrants among all international migrants has been rising steadily, to reach 48 percent in 1990 and nearly 49 percent in 2000 (table 2). Although this

[1] United Nations (2003) Tends in Total Migrant Stock, 1960-2000: 2003 Revision, Population Division.
[2] ILO (2004) Towards a fair deal for migrant workers in the global economy, Geneva, p. 5.
[3] Zlotnik, H. (2003) The Global Dimensions of Female Migration, Migration Information Source, Migration Policy Institute, p. 1

trend is consistent with an increasing "feminization" of international migration, the increase recorded is small compared to the high level of feminization that already existed in 1960. For more than 40 years, female migrants have been almost as numerous as male migrants. These data should led as to revise the extended idea of a recent "feminization of international migration", shifting the emphasis on numbers to other aspects more related to new trends, characteristics, consequences and impacts of female and male migration.

Table 2
Female migration: 2000

Major area, region, country or area	Estimated number of female migrants at midyear				
	1960	1970	1980	1990	2000
World	**35 469 362**	**38 507 161**	**47 156 135**	**73 817 887**	**85 080 716**
More developed regions	15 629 174	18 742 613	23 882 284	45 347 826	56 228 897
More developed regions without the USSR (former)	14 203 958	17 259 476	22 306 792	29 860 914	40 896 880
Less developed regions	19 840 187	19 764 548	23 273 851	28 470 062	28 851 819
Least developed countries	2 896 736	3 323 332	4 129 540	5 102 639	4 929 009
Africa	**3 794 583**	**4 208 331**	**6 216 156**	**7 441 517**	**7 595 140**
Eastern Africa	1 293 119	1 475 861	2 301 832	2 875 736	2 172 969
Middle Africa	590 194	826 174	885 992	678 235	688 812
Northern Africa	736 578	463 260	705 274	1 047 756	832 620
Southern Africa	295 111	315 178	391 477	559 760	652 419
Western Africa	879 580	1 127 858	1 931 582	2 280 030	3 248 320
Asia	**13 572 729**	**13 096 395**	**14 340 682**	**17 862 959**	**18 936 075**
Eastern Asia	1 278 511	1 420 383	1 785 838	2 102 777	2 960 174
South-central Asia	8 522 472	7 910 730	7 626 765	8 679 779	6 607 013
South-eastern Asia	1 996 622	1 650 835	1 386 772	1 444 668	1 994 868
Western Asia	1 775 123	2 114 447	3 541 309	5 635 735	7 374 020
Europe	**6 799 126**	**8 981 401**	**10 752 040**	**13 120 718**	**16 736 713**
Eastern Europe	1 839 170	1 564 127	1 396 956	1 289 489	1 547 640
Northern Europe	1 146 007	1 971 053	2 397 504	2 741 423	3 223 267
Southern Europe	746 303	966 136	1 211 280	1 853 954	2 736 125
Western Europe	3 067 646	4 480 085	5 746 300	7 235 852	9 229 682
Latin America and the Caribbean	**2 702 258**	**2 690 034**	**2 957 603**	**3 497 251**	**2 983 844**
Caribbean	204 522	288 102	362 570	433 491	523 755
Central America	226 661	200 950	276 194	940 403	531 621
South America	2 271 075	2 200 983	2 318 839	2 123 357	1 928 467
Northern America	**6 227 246**	**6 638 354**	**9 516 257**	**14 074 660**	**20 543 473**
Oceania	**947 643**	**1 408 956**	**1 797 350**	**2 333 426**	**2 945 035**
Australia/New Zealand	910 724	1 354 625	1 713 969	2 228 821	2 818 208
Melanesia	20 306	36 923	39 807	39 724	37 536
Micronesia	11 493	8 275	25 776	38 030	53 275
Polynesia	5 120	9 133	17 798	26 851	36 016
USSR (former)	**1 425 777**	**1 483 690**	**1 576 046**	**15 487 356**	**15 340 437**

Source:
Population Division of the United Nations, *Trends in Total Migrant Stock: The 2003 Revision*, diskette (New York, United Nations, 2003).Source: Population Division of the United Nations, Trends in Total Migrant Stock: The 2003 Revision, diskette (New York, United Nations, 2003).

1.2. Gender distribution of international migration

A more detailed look at the differences by region shows that female migrants have generally accounted for a larger fraction of the migrant stock in developed countries than in the developing world. In 1960, 48% of all migrants in developed countries were women, whereas the equivalent proportion in developing countries was 46%[4]. By 2000, the difference between the two had risen further, since the proportion of women among migrants reached 51% in the more developed regions and still accounted

[4] Zlotnik, H. (2003) The global dimensions of female migration, Migration Information Source, Migration Policy Institute, 1 March, p. 2.

for about 46% of all international migrants in developing countries. Europe had the highest proportion of female migrants and Western Asia and Southern Africa had the lowest.

The cause of these differences should be sought in the laws and regulations governing the admission of migrants in countries of destination and those governing their departure from countries of origin, in conjunction with the interplay of factors determining the status of women in countries of origin and destination. By permitting the family reunification of legally admitted migrants, developed countries facilitate the admission of migrant women. In contrast, the developing countries that are major receivers of international migrants generally admit them exclusively for labour purposes, and male migrants have tended to predominate in labour migration flown. However, it is important to consider that, since the late 1970s, the participation of women in labour migration flows directed to developing countries has increased. For instance, in Western Asia, among the oil-rich countries of the Gulf Cooperation Council and in the countries of the Pacific Rim in Eastern and South Eastern Asia the proportion of women among the international migrants has been rising steadily since 1980[5]. By 2000, the number of female migrants was estimated to have surpassed the number of male migrants in Eastern and South Eastern Asia (5 million versus 4.9 million).

The gender distribution of international migrants varies substantially by countries of destination and origin. For instance, the proportion of legal immigrants who are women is particularly high in the traditional immigration countries (Australia, Canada and the US). In 2002, 54% of legal immigrants to the US were women[6]. The existence of gender-specific economic niches for immigrants and the tendency of migration to sustain itself in particular forms has produced overwhelmingly male or female migratory linkages between certain pairs of countries. In Italy, for instance, women constitute 85% of the Cape Verde immigrants and men constitute 96% of the Senegalese[7]. In the places that permit only temporary migration, the proportion of men migrating may be higher, particularly if admission is limited to certain types of occupation typically dominated by men. Gender differences also can be seen among different emigration countries. For instance, while the Philippines have a considerably higher proportion of female migrants living abroad (approximately 60% according to data collected during the 90s), Mexico has many more male emigrants (69% according to census conducted in 1995) (ILO 1999)[8].

- Asia: ILO[9] estimates that 22 million Asians work outside their home country. The feminization of migrant workers is particularly evident in this region, where hundreds of thousands of women migrate each year in both unskilled and skilled professions –the majority in domestic and entertainment and, to a lesser extent, in nursing and teaching. The six States of the Gulf Cooperation Council (GCC) –Bahrain, Kuwait, Qatar, Oman, Saudi Arabia, and the UAE- are home to approximately ten million foreign workers, with the largest number in Saudi Arabia[10]. In Saudi Arabia, the Statistics Department of the Ministry of Economy and Planning reported in 2004 that non-Saudis counted for 67% of the kingdom's labour force. Foreigners held 90 to 95% of the private sector jobs[11]. The kingdom is the number one destination for migrants from Bangladesh.

[5] Zlotnik, H. (2003) The global dimensions of female migration, Migration Information Source, Migration Policy Institute, 1 March, p. 2.
[6] DAW (2005) Survey on the Role of Women in Development. Women and International Migration, Department of Economic and Social Affairs, New York..
[7] Jorgen Carling (2205) Gender dimensions of international migration, Global Commission on International Migration.
[8] DAW (2005) World Survey on the Role of Women in Development. Women and International Migration, Department of Economic and Social Affairs, New York.
[9] ILO (2004) Towards a Fair Deal for Migrant Workers in the Global Economy, Geneva, p. 7.
[10] Deficiencies in demographic and labor statistics of the GCC states should be noted (Fasano, U. and R. Goyal (2004) Emerging Strains in GCC Labor Markets, IMF Working Paper, WP/04/71. Human Rights Watch (2004) Bad Dreams: Exploitation and Abuse of Migrant Workers in Saudi Arabia, Vol. 16, No. 5, p. 11.
[11] Human Rights Watch (2004) Bad Dreams: Exploitation and Abuse of Migrant Workers in Saudi Arabia, Vol. 16, No. 5, p. 12.

There are at least 850.000 workers from Indonesia and Sri Lanka in Saudi Arabia. The overwhelming majority of them are women. Of the 500.000 Indonesian migrant workers in Saudi Arabia, over 90% are women domestic workers. By 2003, Indonesian workers were leaving for Saudi Arabia at the rate of 19.000 a month[12]. The proportion of Sri Lankan migrants who are women in Middle East has grown steadily, from 33% of the total in 1986 to 65% by 1990[13]. The overwhelming majority of Sri Lankan women migrants in the Middle East region are employed as domestic workers.

In recent years the most popular destination for Asian migrant women has shifted from the Middle East to other Asian countries whose economies have boomed in recent decades. By 1997, destinations such as Malaysia, Singapore, Japan, Hong Kong, and South Korea had surpassed the countries of the Middle East[14]. Cases such as Singapore, a prosperous city-state in Southeast Asia, have attracted women migrant domestic workers from around the region. Approximately 150.000 women, primarily from Indonesia, the Philippines, and Sri Lanka, hold work permits for two-year employment stints in Singapore. Approximately one in every seven Singaporean households employs a "live-in" migrant domestic worker[15]. The child care, domestic duties, and elder care, these women perform help free up Singaporean men and women to work outside of their homes. The Singaporean government also views employment of foreign domestic workers as a strategy to boost a below-replacement birthrate –domestic services ease the burden on working women and Singaporean families who decide to rear children.

The main source countries of Asian female migrants are Indonesia, Philippines, Sri Lanka and Thailand, while the main destinations are Hong Kong, Malaysia, Singapore and the Middle East[16]. In the case of the Philippines, women account for about 61% of all new hires of overseas land-based contract workers in 1998; as for Indonesia, they accounted for around 78% of officially reported emigrants in 1996-97. In Sri Lanka, in 2000, of the estimated stock of 858.000 emigrants, almost 600.000 were women, the majority of whom went to work as housemaids and 90% of whom went to Middle East[17].

- Africa: males have tended to outnumber females among international migrants. The proportion of females among international migrants in Africa has generally been lower than the average for the world as a whole[18]. However, the proportion female among international migrants in Africa has increased and steadily and faster than at the world level. By 2000, it is estimated that 46.7% of the 16 million international migrants in Africa were women, up from 42% in 1960. In 1960, Africa had the lowest proportion female among international migrants in comparison to other major areas. By 2000, the proportion female among international migrants in Asia (43%) was lower than that in Africa (47%) but in all other major areas female migrants constituted more than 50% of the international migrant population. At the regional level, Southern Africa has traditionally had the lowest proportion of females among the international migrant stock (42% in 2000, up from 30% in

[12] Human Rights Watch (2004) Bad Dreams: Exploitation and Abuse of Migrant Workers in Saudi Arabia, Vol. 16, No. 5, p. 14.
[13] Human Rights Watch (2004) Bad Dreams: Exploitation and Abuse of Migrant Workers in Saudi Arabia, Vol. 16, No. 5, p. 14.
[14] Wickramasekera, P. (2002) Asian Labor Migration: Issues and Challenges in an Era of Globalization, International Migration Papers, No. 57, ILO, Geneva, pp. 14-16.
[15] Human Rights Watch (2005) Maid to Order: Ending Abuses Against Migrant Domestic Workers in Singapore, Vol. 17, No. 10, pp. 2-3.
[16] The feminization of labour migration is particularly pronounced in the Philippines, Indonesia, and Sri Lanka. In these countries, national-level estimates indicate that women comprise 60-75% of legal migrants, a significant proportion of whom are employed as domestic workers in the Middle East, Singapore, Malaysia, and Hong Kong (Asian Migrant Centre and Migrant Forum in Asia).
[17] ILO (2004) Towards a Fair Deal for Migrant Workers in the Global Economy, Geneva, p. 11.
[18] Zlotnik, H. (2004) International Migration in Africa: An Analysis Based on Estimates of the Migrant Stock, Migration Information Source, Migration Policy Institute, 1 September.

1960). Females were also significantly underrepresented among the international migrant stock of Eastern and Western Africa; they constituted 41% to 42% of all international migrants in those regions in 1960. However, their proportion has increased steadily to reach nearly 48% by 2000, a figure only slightly below the world average of 49%. In contrast, the proportion of females declined steadily among the international migrants in Northern Africa, passing from 49.5% in 1960 to nearly 43% in 2000. Decolonization and the continued dominance of temporary worker migration in that region probably accounts for such a trend[19].

- Latin America and the Caribbean: data on the stock of international migrants is abundant and the trend towards the increasing feminization of international migration is well established. It is particularly noteworthy that Latin America was the first region of the developing world to record parity in the number of female and male migrants: in 1990, three million of the region's six million international migrants were women[20]. However, the situation is very heterogeneous within the region. Data disaggregated by country reveals that the main interregional flows of women migrants were those of Venezuela and Ecuador for Colombian women, Costa Rica for Nicaraguan women and Chile for Peruvian women. In cases like Chile, a feminization of the migration is clearly evidenced (in 1992 the proportion of Peruvian women was 50%, in 2002 had arisen to 60.8%), mainly associated to the demand for domestic workers[21]. Regarding LAC migration out of the region, main destination countries are Spain and Japan. In the case of Spain, data reveals a remarkable proportion of women in migration: those countries which present major rates of feminization are Brazil and the Dominican Republic (70%)[22]. Other countries (Mexico, Peru, Venezuela and Colombia) also have a remarkable proportion of female migrants to Spain. According to some authors, Latin American migration to Spain has been headed by women who become household heads[23].

- Developed Countries: in Northern America (Canada and US), female migrants have outnumbered male migrants since 1970. Both Europe and Oceania have displayed an increasing proportion of female migrants since 1970. In Oceania, female migrants constituted more than half of all migrants present in the region in 2000 (2.9 million out of 5.8 million). In Europe, female migrants became more numerous than male migrants were earlier. By 1990, nearly 52% of all migrants in Europe were women (25 million out of 48 million). The significance of women in migration to Europe does not only relate to the growth in numbers, but also to their increasing contributions to the economic and social life in receiving countries. The changing labour markets within Europe need to be taken into account. For instance, the role of migrant women as domestic workers constitutes one of the main forms and characteristics of the feminization of migration flows to Europe. In countries such as Spain and Greece domestic work is the largest area of employment for migrant workers[24]. Traditionally, an area associated with "out-migration", southern Europe has more recently witnessed a major reversal of historical patterns: Italy, Spain, Greece, Portugal, and Cyprus have become receivers of relatively large numbers of labour and forced migrants.

[19] Most of the information about female migrants in Africa has been taken from Zlotnik, H. (2004) International Migration in Africa: An Analysis Based on Estimates of the Migrant Stock, Migration Information Source, Migration Policy Institute, 1 September.

[20] Zlotnik, H. (2003) The global dimensions of female migration, Migration Information Source, 1 March; Cortés Castellanos, P. (2005) Mujeres migrantes de América Latina y Caribe: derechos humanos, mitos y duras realidades, CELADE/UNFPA.

[21] Cortés Castellanos, P. (2005) Mujeres migrantes de América Latina y Caribe: derechos humanos, mitos y duras realidades, CELADE/UNFPA.

[22] Gil Araujo, S. (2004) Migración Latinoamericana en España: estado de la cuestión, in Cartografías migratorias. Migraciones internacionales en el marco de las relaciones norte sur, CEP/FUHEM, Madrid.

[23] Martínez Buján, R. (2003) La reciente inmigración latinoamericana a España, Series Population and Development, no. 40, CELADE.

[24] Anderson, B. (1998) Overseas Domestic Workers in the UE, Report for Stichting Tegen Vrouwenhandel (Utrech); Floya, Anthias y Gabriella Lazaridis (eds.) (2000) Gender and Migration in Southern Europe: Women on the Move, Oxford & New York: Berg.

1.3. New trends in international female migration

In 1984, Thadani and Todaro described four principal types of women migrants, distinguished by their marital status and their reasons for migrating: (a) married women migrating in search of employment; (b) unmarried women migrating in search of employment; (c) unmarried women migrating for marriage reasons; and (d) married women engaged in associational migration with no thought of employment[25]. However, generally speaking, migration theories have not addressed the gender aspects of international migration partly because of the assumption that most migrant workers were men and women are their dependents. Yet, women are no longer just following their fathers and husbands. They migrate in their own capacities as workers. Increasingly, more women are travelling on their own as their family's primary income earner as a consequence of a number of social and economic transformations. In the most developed destinations countries, populations are ageing, which increases the demand for female health workers. Another contributing factor is raising prosperity: in some of the faster growing developing economies, such as Malaysia and Chile, as families become wealthier they employ foreign-domestic help.

Family formation and family reunification are major official reasons for international migration since many countries have migration policies favouring the admission of migrants in those categories. Migrants officially designated for family reunification still are more likely to be women. This is for two reasons: (a) family reunification often follows male-dominated labour migration, and (b) gender norms may permeate seemingly neutral rules and regulations that govern admission, reducing the likelihood that women will migrate as autonomous migrants. But eligibility for family reunification is not universal. Many contract labour arrangements preclude admission of family members. Definitions of family vary for the purposes of immigration admission. In the US, for instance, parents and siblings of US citizens are eligible as well as spouses and children of both citizens and legal permanent residents. The European Union directive on family reunification covers spouses and minor children, allowing member States to set policies individually on other family members. Many States also restrict the admission of more than one spouse in a polygamous marriage. Those provisions may affect not only women but also children's admission. State policies vary with regard to the admissibility of non-married partners and spouses in same-sex unions[26].

However, as already mentioned, more women migrate on their own to improve their living conditions. In Mexico, for instance, between 1998 and 2000 female migration increased in 6.0%, showing this trend a high number of women migrating in search of work and not for family reunification reasons. In fact, 63% of female migrants were single, 79% were not household heads, and 42% send remittances to their families[27]. However, the causes of migration are very complex. In Latin America and the Caribbean, some anthropological studies reveal that, in some contexts, especially indigenous communities, female decision-making with regards to migrating is strongly linked to singleness and the absence of a male partner[28]. In countries such as Costa Rica, Mexico, Haiti, Guatemala, and Peru, single mothers have more chances to be expelled by rural economies[29]. In December 2005, the Pew Hispanic Center published a Survey of Mexican Migrants, the report suggests that failure to find work at home does not seem to be the primary reason that the estimated 6.3 million undocumented migrants from Mexico

[25] Thadani, V. N. and M. P. Todaro (1984) Female migration: a conceptual framework, in Women un the Cities of Asia: Migration and Urban Adaptation, J. T. Fawcett, Siew-Ean Khoo and P. C. Smith (eds.) Boulder, Colorado: Westview Press.
[26] DAW (2005) World Survey on the Role of Women in Development. Women and International Migration, Department of Economic and Social Affairs, NY, p. 28.
[27] Consejo Nacional de Población (2000) Mujeres en la Migración a Estados Unidos, Boletín de Migración Internacional, No. 13, CONAPO, Ciudad de México, p. 3 and 8.
[28] Mora, L. (2003) Las fronteras de la vulnerabilidad: género, migración y derechos reproductivos, ECLAC Regional Conference on Internacional Migration and Human Rights in the Americas, Santiago de Chile.
[29] Mora, L. (2003) Las fronteras de la vulnerabilidad: género, migración y derechos reproductivos, ECLAC Regional Conference on Internacional Migration and Human Rights in the Americas, Santiago de Chile.

have come to the US. Policies aiming at reducing migration pressures by improving economic conditions in Mexico may also need to address factors such as wages, job quality, long-term prospects and perceptions of opportunity[30].

Alongside women's increasing participation in conventional labour migration, specifically female forms of migration have emerged. These include the commercialized migrations of domestic workers (sometimes labelled "the maid trade"), the migration and trafficking of women in the sex industry, and the organized migration of women for marriage (sometimes labelled "mail-orders brides"). Migration for employment and marriage, for instance, are inextricably connected to the gender division of labour within and outside the household. The demand for foreign household and care workers has grown in OECD countries with rising female employment rates, changes in family structures and an ageing population leading to higher dependency ratios. According to the SOPEMI report (2003), more than 10% of foreign workers in Southern Europe are employed in household services, especially in Greece, Italy and Spain. In France and the US, about 51.000 and 150.000 foreigners respectively provide care for elderly and children at home. More than 950.000 Italian families hired foreign workers to tend to the needs of the elderly or children in 2002[31].

2. Gender perspectives in analyzing international migration

2.1. Research stages in engendering migration studies

In spite of the world's remarkable female participation in international migration, the incorporation of a stronger gender perspective on migration is still needed. Often migration studies and policies related to migration do not consider adequately gender perspectives into their priorities. In that sense, a recent study on gender and migration in Europe concluded that most research appears to be gender-neutral while utilizing models of migration based on the experiences of men. Women, where their presence is acknowledged, are often treated as dependents, migrating for family reunion, and their contributions to the economies and societies of destination countries ignored"[32].

Three phases can be defined when analyzing research on gender and migration:

- The first stage of feminist scholarship emerged in the 1970s and 1980s, and might be labelled "women and migration". This early phase of research sought to remedy the exclusion of women subjects from immigration research, and to encounter sexist as well as androcentric biases[33]. Women were unproblematically assumed to automatically follow male migrants as "associational" or dependent migrants, and were often portrayed as somehow detached or irrelevant to the labour force. Risk attitudes regarding migration were male-dominated and the work of migrant women was invisible. In the 1970s, first theories on gender and migration integrate factor such as sex-disaggregated data, sexual division of labour and female subordination in the economy into analysis of migration. Most research studies conducted under this approach aimed at analyzing gender disparities in international and national labour markets and, later on, at integrating the household as an analytical sphere to be taken into account in analyzing family decision-making and migration.

[30] http://pewhispanic.org/reports/report.php?ReportID=58
[31] OECD (2003) Trends in international migration, Paris.
[32] Kofman, E. and et alter (2000) Gender and International Migration in Europe: Employment, Welfare and Politics. London and New York: Rutledge.
[33] Hondagneu-Sotelo, P. (2005) Gendering Migration: Not for "feminist only" – and not only in the household, Working Paper Series, No. 05-02f, The Center for Migration and Development, Princeton University, p. 4-5; Boserup, E. (1970) Woman's Role in Economic Development, Martin Press, New York; Thadani, V. y M. Todaro (1978) *Towards a theory of female migration in developing countries*, Working Papers, Population Council Centre For Policy Studies, New York; Berhmann, H. Y B. Wolf (1982) Micro-determinants of female migration in a Developing country: are labor market considerations or marriage market considerations more important?, Population Studies Center, Universidad de Pennsylvania, Philadelfia.

- The second stage of research emerged in the late 1980s and 1990s, displacing an exclusive focus on women with recognition of gender as a set of social practices shaping and shaped by immigration[34]. This research focused mainly on two aspects: the gendering of migration patterns and on the way migration reconfigures new systems of gender inequality for men and women. The second stage research is also notable for drawing attention to the ways in which men's lives are constrained and enabled by gender, and also the ways in which immigrant gender relations become more egalitarian through the processes of migration.

- The third stage of feminist scholarship in immigration research is now emerging, and here the emphasis is on looking at gender as a key, constitutive element of immigration. Research is beginning to look at the extent to which gender permeates a variety of practices, identities and institutions implicated in immigration[35]. Here, patterns of labour incorporation, globalization, religious practice and values, ethnic enclave businesses, citizenship, sexuality and ethnic identity are interrogated in ways that reveal how gender is incorporated into a myriad of daily operations and institutional political and economic structures.

How can or should we understand the gender dimension of international migration? As we have seen, there is now a vast body of literature addressing how gender relations affect the size, direction and composition of migration flows, as well as the experiences of individual migrants. A gender perspective on migration addresses the limited attention given to the presence of migrant women and their contributions, beginning with considering gender as a core organizing principle of social relations and, therefore, also migration. A gender perspective on migration extends current understanding about international migration by examining the gender-specific causes of migration, their causes and impacts as well as the potential for women's empowerment and gender equality[36]. A gender perspective goes beyond the differences between women and men in relation to migration behaviour and focuses explicitly on the inequalities that also exist. Gender inequality can be a factor in precipitating migration and migration can reproduce old forms of gender inequality or reinvent new forms of gender discrimination. Incorporating gender perspectives into analyses advances understanding of the different and often unequal experiences of women and men in immigration, and facilitates formulation of interventions that take into account the needs, priorities and contributions of women as well as of men[37].

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[34] Grasmuck, S. and P. Pessar (1991) Between Two Islands, Dominican International Migration, University of California Press, Berkeley; Pedraza, S. (1991) *Women and Migration: the Social Consequences of Gender*, Annual Review of Sociology, No. 17, pp. 342-364; Hondagneu-Stotelo, P. (1994) Gendered Transitions. Mexican Experiences of Immigration, University of California Press; Grieco, E.M. y M. Boyd (1998) *Women and migration: incorporating gender into international migration theory,* Center for the Study of Population Working Papers, vol. 35, no. 3, pp. 98-139; Thadani, V. N. and M.P. Todaro (1984) Female migration: a conceptual framework, in J.T. Fawcett et alter (ed.) Women in the Cities of Asia: Migration and Urban Adaptation, Westview Press, Boulder, Colorado; Chant, S. and S. Radcliffe (1992) Migration and development: the importance of gender, in S. Chant (ed.) Gender and Migration in Developing Countries, Belhaven Press, London; Grieco, E.M. and M. Boyd (1998) Women and migration: incorporating gender into international migration theory, Working Paper, Center for the Study of Population, Florida University State; Higo, G. (1993) Migrant women in developing countries, in Internal Migration of Women in Developing Countries: Proceedings of the United Nations Expert Meeting on the Feminization of Internal Migration, Aguascalientes, México.

[35] Pessar, P.R. and S.J. Mahler (2003) Transnational Migration: Bringing Gender In, International Migration Review, 37(4): 812-846; Saasen, S. (2000) Women's Burden: Counter-Geographies of Globalization and the Feminization of Survival, Journal of International Affairs, No. 53, pp. 503-524; Bryceson, D. and U. Vuorela (2002) The Transnational Family: New European Frontiers and Global Trends, Cross-Cultural Perspectives on Women, No. 25, The Center for Cross-Cultural Research on Women, University of Oxford; Mahler, S.J. and P.R. Pessar (2006) Gender Matters: Ethnographers Bring Gender from the Periphery toward the Core, Gender and Migration Revisited, Special Issue, International Migration Review;

[36] DAW (2005) World Survey on the Role of Women in Development. Women and International Migration, Department of Economic and Social Affairs, NY, p. 1.

[37] DAW (2005) World Survey on the Role of Women in Development. Women and International Migration, Department of Economic and Social Affairs, NY, p. 15.

For both women and men, economic and political conditions provide the general context which migration decisions are made and international migration occurs. However, the decision to migrate depends on gender relations and gender stratification at different levels. When policies and practices that discriminate against women are in place, women's capacities to participate and contribute fully in society are diminished. Such conditions affect the potential of women to migrate and whether they migrate autonomously or with other family members. Gender relations and hierarchies in both origin and destination countries also determine the gender-specific impacts[38]. Specific conditions govern the extent of labour migration of women. Firstly, gender-specific labour demand in receiving countries stimulates the migration of women, as we have already seen. Secondly, in source countries, a gender-specific labour supply is produced by gender norms and stereotypes. Recruitment organizations, either private or State-based, in source countries also reinforce such gender stereotypes. Thirdly, in destination countries gender-specific expectations about reciprocity may also favour the migration of women. Fourthly, migration of women is related to empowerment.

2.2. Different gender approaches to analyzing international migration

The main present approaches to explain new trends in international female migration, its causes and consequences, are the following ones:

- *The feminization of migration as the part of a global process of "internationalizing the gender division of reproductive labour"*: The context of professional employment in industrialized countries still requires "finding someone else to deal with domestic chores". In this sense, migration of domestic workers is a form of demand-based migration founded on the gender of labour in receiving countries[39]. Parreñas and Hochschild have studied these processes, focusing especially in the case of Filipina migrant workers[40]. Their argument is that migration of domestic workers is part of a *global care chain*, a series of personal links between people based on the paid or unpaid work of caring. A typical chain ends with a woman in a rich country pursuing professional employment and finding herself unable to fulfil her obligations within the family. Focusing on care chains highlights the way in which gender relations at origin and destination are linked in the migration process. The problems produced by the gender division of labour in industrialized countries are not solved, but passed on to other women.

- *The emergence of the so-called "countergeographies of globalization" as part of the feminization of survival*[41]: According to Saskia Saasen there are systematic links between two sets of developments (the growing presence of women from developing economies in global circuits and the rise in unemployment and debt in those same countries). One way of articulating this in substantive terms is to posit that: are (a) the shrinking opportunities for male employment in many of these countries; (b) the shrinking opportunities for more traditional forms of profit-making. Prostitution and labour migration are growing in importance as ways of making a living for women.

[38] DAW (2005) World Survey on the Role of Women in Development. Women and International Migration, Department of Economic and Social Affairs, NY, p. 15.
[39] Anthias, F. and Lazaridis, G. (eds) Gender and migration in Southern Europe, Oxford: Berg.
[40] Parrreñas, R. S. (2003) The Care Crisis in the Philippines: Children and Transnational Families in the New Global Economy, in B. Ehrenreich and A. R. Hochschild (ed.) Global Women: Nannies, Maids, and Sex Workers in the New Economy, Metropolitan Books, New York, pp. 39-55; Parreñas, R.S. (2002) The Global Servants: Migrant Filipina Domestic Workers in Rome and Los Angeles, Palo Alto (California), Stanford University Press; Hondagneu-Sotelo, P. (2001) Domestica: Immigrant Workers Cleaning and Caring in the Shadows of Affluence, University of California Press, Berkeley. Hochschild, A.R. (2002) Love and Gold, in B. Ehrenreich and A.R. Hochschild (ed.) Global and Women, Metropolitan Books, New York.
[41] Sassen, S. (2000) Women's Burden: Counter Geographies of Globalization and the Feminization of Survival, Journal of International Affairs, No. 53, pp. 503-524;

- *The gendered geographies of power*[42]; a conceptual model according to which gender operates simultaneously on multiple spatial and social scales (body, family, the state) across transnational terrains. It is both within the context of particular scales as well as between and among them that gender ideologies and relations are reaffirmed, reconfigured or both.

2.3. Globalization, female migration and gender division of labour

Much work on globalization and migration has focused on production neglecting reproduction that also takes place across borders and is an important aspect of the migration experience. If international migration studies prompt us to rethink the terrain in which social processes take place, social reproduction or the activities, attitudes, responsibilities and relationships required for the maintenance of daily life across generations must be among them. Within this context, the analysis of female international migration is closely linked to the reproduction at the global level of the traditional sexual division of labour.

Three results of the inequalities arisen from globalization[43]: (a) around the globe, paid domestic work is increasingly performed by women who leave their own nations, their communities, and often their families of origin; (b) the occupation draws not only women from the poor socio-economic classes but also women from of relatively high stays in their own countries; (c) the development of service-based economies in post-industrial nations favours the international migration of women labourers. Unlike in earlier industrial eras, today the demand for gendered labour favours migrant women's services. Worldwide paid domestic work appears to have grown in many post-industrial societies. In many countries, the combination of women's increasing labour force participation, a private sector that has failed to innovate "family-friendly" working conditions, and few feasible child care options have led to a strong demand for foreign domestic workers' labour. Worldwide, paid domestic work continues its long legacy as a racialized and gendered occupation, but today divisions of nation and citizenship are increasingly salient. Anthony Richmond has called it part of a broad, new "global apartheid"[44].

The increasing demand for migrant women to alleviate the reproductive labour of the growing number of working women in post-industrialized countries has sparked the formation of an international division of reproductive labour[45]. Under this system, migrant domestic workers perform the reproductive labour of class-privileged women in industrialized countries and are forced to leave their children behind. In this sense, we can see the formation of a three-tier chain of the commodification of mothering between middle-class women in the US and Italy, migrant Filipina domestic workers, and Filipina domestic workers in the Philippines who are to poor to afford the costs of emigration.

As previously mentioned, the demand for foreign household and care workers has grown in the OECD countries with rising female employment rates, changes in family structures and an ageing population leading to higher dependency ratios[46]. Within this framework, the need for household services is expected to increase. According to the last SOPEMI report (2003), more than 10% of foreign workers in Southern Europe are employed in household services, especially in Greece, Italy and Spain. In France and the US, about 51.000 and 150.000 foreigners respectively provide care for the elderly at home. More than 950.000 families in Italy hired foreign workers to tend to the needs of elderly or children in 2002. Another important aspect of this is that many of these workers may be in irregular

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42 Mahler, S.J. y P. Pessar (2001) *Gendered geographies of power: analyzing gender across transnational spaces*, en S.J. Mahler y P.Pessar (comps.) Identities: Global Studies in Culture and Power, Princeton University, pp. 441-459.

43 Hondagneu-Sotelo, P. (2001) Domestica: Immigrant Workers Caring and Cleaning in the Shadows of Affluence, The University of California Press, p. 16.

44 Taken from Hondagneu-Sotelo, P. (2001) Domestica: Immigrant Workers Caring and Cleaning in the Shadows of Affluence, The University of California Press, p. 15.

45 Parreñas, R.S. (2000) Migrant Filipina Domestic Workers and the International Division of Reproductive Labor, Gender and Society, No. 14, pp. 560-80.

46 OECD (2003) Trends in internacional migration, Paris.

status as shown by regularization exercises[47]. In some European countries (France, Greece, Italy and Spain) domestic work or housekeeping is the most common occupation open to female migrants. During the 1990s, numerous migrants with residence permits entered Italy, Greece and Spain as domestic workers through the quota system, and a large proportion of those regularized were domestic workers.

The report on *Employment In Household Services,* based on the results of research carried out in eight EU Member States (Austria, Finland, France, Germany, Italy, the Netherlands, Portugal, and UK) and covering five fields: child care, elder care, domestic cleaning, home maintenance and catering, demonstrates the rapid growth of employment in household services and points to the many contributing factors, notably needs arising from different aspects of demographic and labour market developments, together with social and cultural changes[48]. Women have traditionally dominated this area of work. The resulting high gender segregation creates its own problems in terms of pay and professional status and the reconciliation of family and working life. Some interesting data on household service growth:

- In Finland, up to 70% of adult women are in employment, and the population is ageing faster than anywhere else in the EU. At least 100.000 people require home care, which means the creation of tens of thousands of jobs.

- In Germany, recent estimates suggest that around 7 million people are employed in personal services: of those, approximately 75% are women – and an increase of about 200.000 jobs is expected here. It is estimated that approximately 4 million people work in household services, 2 million of these in undeclared jobs.

- In the Netherlands, mothers with young children want to continue working in the labor market. Long-term paid parental leave is extremely rare, and so the demand for childcare continues to rise. Despite marked growth in the range of facilities available, most childcare is still provided on an informal basis. The number of people working in childcare centres has doubled in recent years.

- In the UK, in 1998 over 3.2 million people held jobs in the household services sector, representing a 10% increase between 1992 and 1998. Women make up three-quarters of the household services workforce, with jobs sharply sex-segregated. Many jobs in the sector are part-time jobs and this trend is increasing. The number of childcare workers increased by more than 30% between 1992 and 1998. An increased demand for household services in support of the elderly population arises from an ageing population and greater numbers of single person household among the elderly.

Developed nations and wealthier countries from the developing world use vastly different methods to "import" domestic workers from other countries. Some countries have developed highly regulated, government-operated, contract labour programs that have institutionalized both the recruitment and working conditions of migrant domestic workers. Canada and Hong Kong exemplify this approach. Since 1981 the Canadian federal government has formally recruited thousands of women to work as live-in nanny/housekeepers for Canadian families. Most come from the developing world, the majority in the 80s from the Caribbean and in the 90s from the Philippines. Since 1973, Hong Kong has relied on the formal recruitment of domestic workers, mostly Filipinas, to work on a full-time, live-in basis for Chinese families. In the US, Canada, and Europe, gender and race work together to render LAC women more employable in theses labour-intensive industries than their male counterparts. Although domestic service is considered to be a menial job, in many cases this female immigrant workforce

[47] OECD (2003) Trends in internacional migration, Paris.
[48] European Foundation for the Improvement of Living and Working Conditions (2001) Employment in household services, Geneva.

possesses a relatively high level of education, as is the case with Peruvian domestic workers in Chile whose ranks include some 70% who have completed either high school or university education[49].

2.4. Gender, health sector reforms and migration

The dramatic increase of international migration in the health care sector is part of much larger changes associated with economic globalization and its labour markets, demographic changes in developed countries, public and health sector reforms and changing gender roles. The health sector is one of the fastest growing sectors in the global economy, including companies specializing in health services, insurance, medical equipment, hospital care training. The increasing global integration of health care markets facilitates the global integration of health care labour markets. In addition, the growing concentration of capital in the health sector translates into a powerful political lobby for "de-regulation" and privatization policies. At the national level, as a result of pressures from multinational institutions (IMF, WB, WTO), many developing and transition countries have opened their services sectors to international trade, inviting a flood of international finance capital that has significantly transformed their public health systems. The expansion of private equity and venture capital and the entry of multinational health care companies have stimulated new public-private partnerships and the commercialisation of health care institutions. In this context, privatization of health and international migration of health workers are not to be understood as separate phenomena.

Labour market characteristics and working conditions are important factors in understanding migration patterns of long-term care workers. Three points must be made at the outset in describing long-term care markets. First, long-term care does not constitute one labour market but at least three relatively related: (a) skilled workers (registered nurses), unlicensed low-skill aides and other long-term workers rarely immigrate to pursue a career in health or long-term care, but they find such jobs; (c) domestic service workers, may women of whom operate in the "grey economy", constitute a large segment of caregiving in many developed countries. An important factor to take into consideration is the fact that long-term care involves what Friedman (2005) has called "anchored" jobs because they must be done in a specific location, involving face-to face contact with a customer, client, patient, or audience[50]. Long-term care requires workers on location.

Discussions about the shortage of health and long-term care workers in more developed countries frequently cite demographic trends as the cause. Such discussions emphasize the structural and long-term nature of a growing shortage of workers. The demographic challenge is portrayed as twofold: (a) an aging population demanding more long-term care services; and (b) a diminishing supply of workers (mostly women) to fill the jobs associated with long-term care. The number of working-age people is declining in many developed countries at the same time that the number of older persons at high risk of needing long-term care services is increasing rapidly. These trends are likely to accelerate in the coming decades[51]. The relationship between aging and disability has led to projections of increased demand for long-term care services –and the workforce to provide them- over the next few decades. The German Federal Ministry of Health and Social Security (2005) estimated that the number of persons requiring long-term care in Germany will increase by 63.5 per cent between 2002 and 2030[52]. For the European

[49] Ortega, S. (2001) In search of the Chilean Paradise: Peruvians in Chile Forge a Community", NACLA Report on the Americas XXXV(2): 18-23.

[50] Friedman, T. L. (2005) *The World Is Flat: A Brief History of the Twenty-First Century*. New York: Farrar, Straus, and Giroux, p. 238).

[51] Some projections consider that the working-age population will decrease by 19.5% in Western and Central Europe by 2050, while the older population will increase by as much as 50 percent. Holzmann, R. and R. Muenz (2004) Challenges and Opportunities of International Migration for the EU, Its Member States, Neighboring Countries and Regions: A Policy Note. Washington, DC: World Bank.

[52] Federal Ministry of Health and Social Security (Bundesministerium fuer Gesundheit und Soziale Sicherung), Germany. 2005. "Selected Facts and Figures about Long-Term Care Insurance." Available at http://www.bmgs.bund.de/downloads/Pflegevers_Tabellen.pdf

Union, as a whole, long-term care expenditures will nearly double as a percentage of the GPD from 1.3 to 2.3 percent, between 2000 and 2050[53]. Even though past projections have often overstated future demand for long-term care services, it is important to take into account that demographic trends related to potential demand for services and workers differ greatly from country to another. Women's increased labour force participation complicates family caregiving but has also increased the traditional pool of potential long-term care workers. While demography may be starting to play a role in creating shortages, one must look to a more complex array of economic and sociological factors.

Migration to provide services to frail older persons is not restricted to skilled professionals. Increased percentages of the nurse aides in long-term care settings in the United States come from the Caribbean, Mexico, Africa, and the Philippines. Public cash benefits to persons with disabilities in Austria and Italy have helped fuel a large influx of live-in domestic workers who supplement familiy caregiving in those nations. The most intimate care to frail older persons in developed countries is increasingly likely to be provided by young women whose native language, race, and culture are different from those they serve.

Most countries welcome the arrival of professionals from other countries. Australia and Canada, for example, have points systems that make it easier for professionals from developing countries to enter as immigrants. During the 90s, many developed countries recruited foreign health professionals; consequently nearly one-third of doctors and 13% of nurses in the UK are foreign born, and half of extra employed by the National Health Service over the past decade qualified abroad[54]. From 1995 to 2000 in the OECD countries, the foreign labour force grew by 3-4% per year; however, the highly educated migrant workforce grew much faster –on average 35% annually in the UK over the past five years, and 14% a year in the US[55]. Affluent countries have a long history of brain drain from poorer countries: Dovlo and Nyonator (undated) noted that 75% of graduates of the University of Ghana Medical School emigrated within a decade from graduation of first out of ten cohorts. Stilwell and others (2004) showed that among doctors in Cape Verde more than ¾ work in Portugal[56]. A similar situation can be found in other Portuguese-speaking countries.

In the context of the global demand for health care workers, the gendered nature of global industrial restructuring has meant that women workers from South are often drawn into the global economy as solutions to the high cost of labour in the North. In this context, women are the most affected, as they comprised the majority of the health care workers. In the developed countries, many have left the health care sector because of deteriorating working conditions and pressures of poorly financed health care systems. To temporarily address the gap in their human resources, rich countries recruit health workers and professionals in huge numbers from developing countries were the health situation is already worse and the human resource badly needed. These highly gendered processes of structural reforms have also had direct bearing on the migration of care workers in many developing countries. Care workers from Kerala, India, often seek migration to the Middle East as a means of alleviating the severe income insecurity and increase demands upon their productive and reproductive labour exacerbated by SAPs.

The consequences of "care-drain" and actual net income losses can be severe. Analyses of the gendered impacts of structural reforms on both informal and formal labour markets help to address the question of why the international migration of nurses and other female-dominated care occupations is such a large scale phenomena. Even though medical practitioners and nurses represent a small proportion of the highly skilled workers who migrate, but the loss for developing countries of human resources may

[53] Przywara, B. (2005) Projections of Expenditures on Health and Long-Term Care at the EU Level, presentation to an OECD/European Commission Workshop in Brussels, February 21–22.
[54] ILO (2004) Towards a Fair Deal for Migrant Workers in the Global Economy, Geneva, p. 10.
[55] ILO (2004) Towards a Fair Deal for Migrant Workers in the Global Economy, Geneva, p. 10.
[56] Stilwell, B. et alter (2004) Migration of Health-Care Workers from Developing Countries: Strategic Approaches to Its Management." *Bulletin of the World Health Organization* 82: 595–600.

mean that the capacity of the health system to deliver quality health care is significantly compromised. ILO, WHO and the International Council of Nurses (ICN) have all published recent reports on the globalization of health care labour markets.

Regarding migration of nurses, a study conducted by the International Council of Nurses (ICN) in 2005 reveals the following information[57]:

- Ghana is a mid-sized sub-Saharan country, which has been impacted by the outflow of nurses to the UK and to other English speaking countries. Approximately 6,500 nurses were re-employed in the public sector in Ghana in 2002 and nurse vacancy rates are estimated to have increased significantly over the period between 1998 and 2002. There are different sources of data on outflow of nurses from Ghana to other countries. As in many countries, these different data sources are not always in alignment. Buchan and Dovlo[58] cited Ghanaian data estimating that in 2001, 2,972 nurses left Ghana compared to 387 in 1999; mainly, in this case to the UK, USA and Canada, whilst the General Secretary of the Ghana Registered Nurses Association (GRNA) reported that membership had reduced from over 12,000 in 1998 to under 9,000 in 2003. Verification data from the Nurses and Midwives Council for Ghana show an upward trend in verifications issued to other countries to the year 2001, a dip in 2002, and apparent increase in 2003 (data for the first five months only of this year). The UK is the main source of verification requests, accounting for three quarters of the total. Buchan and Dovlo report that Ghanaian nurses prefer the UK as a destination because it does not require the nurse to sit pre-entry examinations and only requires an adaptation once registration and qualification in Ghana have been verified and accepted[59]. For Ghanaian nurses, the need to write examinations and other higher costs (exam fees, air ticket costs, etc.) makes the USA less attractive. Focus groups' discussions with nurses and doctors in Ghana conducted for Buchan and Dovlo highlighted various key reasons for outflow to other countries, which may be grouped into the following key areas[60].

- Barbados: Migration is a widely accepted social phenomenon and part of the social and economic fabric of Caribbean life. As a relatively small country, with well-educated English speaking health professionals, Barbados, like other Caribbean islands, can be vulnerable to the effects of out-migration. The vulnerability of the Caribbean to the possible negative effects of out-migration of health professionals is exacerbated by its geographical proximity to North America and by its long established migratory paths both to North America and the UK[61]. In 2003, the draft nursing strategy for Barbados noted, "Records show that between 2000 and 2001 approximately 10% of nurses have left the nursing sector, with a significant percentage seeking employment overseas"[62]. Research conducted in 2003 estimated the annual number of general nurses resigning from the Queen Elizabeth Hospital (QEH) (the only general hospital on the island), reportedly to migrate, over the period 2000-2003 (see Table 5)[63].

[57] Buchan, J. et alter (2005) International Migration of Nurses: Trends and Policy Implications, The Global Nursing Review Initiative, No. 5.
[58] Buchan, J. and D. Dovlo (2004) International Recruitment of Health Workers to the UK: A Report for the Department For International Development, DFID HSRC, London.
[59] Buchan, J. and D. Dovlo (2004) International Recruitment of Health Workers to the UK: A Report for the Department For International Development, DFID HSRC, London.
[60] Buchan, J. and D. Dovlo (2004) International Recruitment of Health Workers to the UK: A Report for the Department For International Development, DFID HSRC, London.
[61] Thomas-Hope, E. (2002) Skilled Labor Migration from Developing Countries: Study on the Caribbean Region, International Migration Paper, No. 50, ILO, Geneva.
[62] (Ministry of Health, Barbados 2003: 11). Taken from Buchan, J. et alter (2005) International Migration of Nurses: Trends and Policy Implications, The Global Nursing Review Initiative, No. 5, International Council of Nurses, Geneva, p. 11.
[63] Buchan, J. and D. Dovlo (2004) International Recruitment of Health Workers to the UK: A Report for the Department For International Development, DFID HSRC, London.

Emigration of nurses from the Caribbean: the case of Trinidad and Tobago[64]

In 2003, ECLAC carried out a research study on the migration of nurses in the Caribbean SIDS over the last 50 years, focusing on the situation in Trinidad and Tobago. The study made an attempt to assess the scope of nurse migration by drawing on data available in Trinidad and Tobago as well as in the two main destination countries, the United States and the United Kingdom, as well as to capture the main push factors triggering this mass exodus in the homeland and the various counteracting strategies. The need to address the present nursing crisis is crucial since with the ageing of the population and emerging HIV/AIDS crisis the demand for more nursing care will increase considerably in the near future. Today every tenth person in Trinidad and Tobago is 60 years and older and in about 20 years according to projections every fifth person will belong to this age group. The projected infection rates for HIV/AIDS are soaring. Based on estimates from UNAIDS (UNAIDS/WHO, 2002) currently about 3% of the population of Trinidad and Tobago is HIV/AIDS positive with rapidly growing infection rates projected.

- The Philippines: The Philippines is well known as a source country for nurse migrants, and other types of migrant worker. While there is no explicit policy that encourages migration, there are a number of government agencies established to facilitate the deployment and the protection of its citizens abroad: the Philippine Overseas Employment Authority (POEA) and the Office of Workers Welfare Administration (OWWA). These have been cited as "good practice" in handling the needs of workers deployed overseas. These organizations also facilitate worker migration. Filipino overseas migration reflects the issues of Philippine socio-political and economic life. Overseas migration results in the loss of millions of skilled and unskilled Filipino workers to first world countries due to the limited employment opportunities and relatively low wages in the country. With persistent but fluctuating 10-year trends of health worker migration since the 1950s, it has been shown that the country has become dependent on health human resource out-migration to address surpluses and other employment related issues. Over the years, health worker migration patterns have largely been driven by economic and career development opportunities overseas. The Department of Foreign Affairs in the Philippines reports that there are approximately 7.2 million Filipino migrants all over the world. A recent estimate is that 85% of employed Filipino nurses are working internationally – over 150,000 nurses[65]. After stagnating in the mid 1990s, (due to a reduction in demand from destination countries, particularly the USA) annual outflow of nurses in recent years appears to have increased.

In a recent report on health systems, the OECD highlighted that "there are increasing concerns about nursing shortages in many OECD countries"[66]. There appears to be an upward trend in inflow of nurses to some developed countries, as a response to these nursing shortages. Recent research used registration data from five destination countries – Australia, Ireland, Norway, the UK and the USA –to examine the international flows of nurses[67]. According to the PSI (www.world-psi-org):

- Canada predicts a shortfall of 78.000 nurses by 2021 and Australia 40.000 by 2010.
- Sub-Saharan Africa needs more than 620.000 nurses now to tackle the HIV/AIDS epidemic and meet basic UN development goals.
- Zambia´s public sector retained only 50 out 600 physicians trained in medical school from 1978 to 1999.

[64] ECLAC (2003) Migration of Nurses from the Caribbean: Causes and Consequences for the Socio-Economic Welfare of the Countries. Trinidad and Tobago: A Case Study, Port of Spain.
[65] Lorenzo, F. (2002) Nurse Supply and Demand in the Philippines, Institute of Health Policy and Development Studies, University of the Philippines, Manila.
[66] OECD (2004) Towards High Performing Health Systems, Paris.
[67] Buchan, J. et alter (2003) International Nurse Mobility: Trends and Policy Implications, Royal College of Nursing/WHO/International Council of Nurses, Geneva.

- The Philippines is the world's biggest exporter of labour. It sends 14.000 nurses abroad each year – twice as many as it trains- to work in the US, Saudi Arabia, Ireland and Britain causing shortfall at home.

In fact, rich countries rely on foreign health staff, increasingly from Asia and Africa:

- In New Zealand, over 50% of registered nurses are foreign trained.
- In Britain 43% of nurses were foreign trained in 2003 compared to 10% a decade earlier
- Britain recruits about 15.000 nurses a year and loses around 8.000 to emigration.
- Almost 25% of doctors in Canada, Australia and the US are foreign trained.
- The number of health care migrants to the UK is estimated to have increased fivefold in the past decade[68].

Global Campaign on Women and International Migration in the Health Sector[69]

Public Services International (PSI), a global federation of unions representing 20 million workers involved in the delivery of public services in 130 countries around the world, launched in May 2003 a Campaign on Women and International Migration in the Health Sector evolved as a result of growing concern among trade unionists regarding the impact of international migration on the quality of public health services and health service employment. The action research campaign thus far has involved a survey of nurses and other health care workers in fourteen different countries; as well as other information gathering, networking, membership mobilization, and qualitative research. Participating countries include: Poland, the Netherlands, Scotland, Wales, Ireland, Canada, Chile, Ecuador, Barbados, the Netherlands Antilles, Fiji, Sri Lanka, the Philippines, Ghana and Kenya.

3. Human rights and sexual and reproductive health of international migrants

3.1. Available data and trends in migrants' sexual and reproductive health

Studies of migrant women in the US, UK, Australia, Spain, Sweden and Denmark indicate that socio-economic and socio-cultural factors influence the pregnancy and childbirth experiences of migrant women and may, in terms of reproductive health, tend to become even more pronounced[70]. Gender plays also an important role regarding socio-cultural factors that affects migrants' health. A very common complication is the fear and embarrassment of women from certain cultural contexts to be examined by a male doctor, a significant issue in reproductive and obstetric health[71]. Such concerns may prevent some migrant women from approaching health services or delay them from doing so until their condition is grave, as may also taboos surrounding sexual organs and nudity which may exist in

[68] Buchan, J. (2002) International Recruitment of Nurses: United Kingdom Case Study, Queen Margaret University College, Edinburgh.
[69] http://www.world-psi.org/
[70] Cape, K. (1994) Birth in a new country, in L.P. Rice (ed.) Asian Mothers, Australian Birth: Pregnancy, childbirth and childbearing, the Asian experience in an English speaking country. Melbourne: Ausmed Publications, pp. 101-118; Tran, H. (1994) Antenatal and postnatal maternity care for Vietnamese women, in Rice, L.P. (1994) (ed.) Asian Mothers, Australian Birth: Pregnancy, childbirth and childbearing, the Asian experience in an English speaking country. Melbourne: Ausmed Publications, pp. 61-76; Johnson, A. et alter (1991) Maternal care in a multicultural society, in B. Ferguson and E. Browne (ed.) Health Care and Immigrants: A Guide For Helping Professionals, MacLennan & Petty, Sydney;
[71] Rice, L.P. (1994) (ed.) Asian Mothers, Australian Birth: Pregnancy, childbirth and childbearing, the Asian experience in an English speaking country. Melbourne: Ausmed Publications.

their culture[72]. Poor communication between migrants and healthcare providers, and insufficient use of trained interpreters has been identified as a key cause of poor gynaecological care in Denmark and the increased risk of delayed or missing obstetrical care[73].

Studies have also shown that migrant women are more likely to be given an epidural block during labour[74] and that the recourse to caesarean section is more likely for migrant women[75]. A study of intrapartum differences between Filipino, Vietnamese and Australian-born women in Brisbane, Australia, found that the Filipino women who were giving birth for the first time and who had Caucasian partners experienced worse outcomes in all parameters of labour[76]. Compared to the Australia-born sample, Filipino migrant women spent up to twice as long in labour (12-24 hours compared to less than 12 hours). They were more likely to receive oxytocin augmentation (31% compared to 17%); were twice as likely to receive instrumental assistance in delivery (18% compared to 9%); and had a greater rate of caesarean section birth (18% compared to 13%). While these data point to a higher proportion of cephalopelvic disproportion in infants born to Filipino women married to Caucasian men, the author also stats that many clinicians took recourse to instrumental delivery and caesarean section much earlier, simply because they had expectations than Filipino women were more prone to mechanical difficulties.

A study on the cultural and social meanings of childbearing, comparing women of Chinese and Scottish heritage in Scotland came to interesting conclusions[77]. This study does not support the transcultural nursing model; instead it suggests that a culture that is in contact with other cultures undergoes a continual process of change. Health service managers should understand that providing culturally sensitive care demands thought, self awareness, and additional resources in terms of time, flexibility, training for staff at all levels, support and facilities. Midwives' supervisors have a major part to play in encouraging their staff to reflect on issues of accountability and the eradication of racial discrimination in the care they give to women: "*In practice, the health providers should be aware of the substantial differences in the notion of health, social and cultural expectations between the different patient groups. This may be reflected in their choice of medication, food, bodily cleansing and contacts, and mobility. For example, Scottish women would choose to use folic acid, vitamins and iron tablets in pregnancy and analgesia for pain control in labour. In contrast, most Chinese women would avoid doing so, when they could. The health worker should be aware of this and help them choose the appropriate food according to these beliefs. This means the food provided for them in the NHS should be suitable to their needs in terms of choice, quantity, quality and concept of balance. The hospital dietitians and catering staff need to find out a good range of acceptable and feasible menus in order to meet the needs of their clients. For most Chinese women, maternity hospitals in Scotland are better organized and equipped than those they know of in their home country. Therefore, for them, as with most Scottish women, hospitalized childbirth is not the problem. But many Chinese women know little about the routines, practices and personnel of Scottish maternity wards. More explanation is needed for Chinese women before their admission*".

According to a paper written by Carballo and Nerukart (2001)[78]:

[72] Parsons, C. (1990) Cross-cultural issues in health care, in Reid J, Trompf P. (eds) The Health of Immigrant in Australia: A Social Perspective. Sydney: Harcourt Brace, 108-153

[73] Carballo, M. et alter (2004) Migration and Reproductive Health in Western Europe, p. 14)

[74] Johnson, A. and others (1991) Maternal care in a multicultural society, in B. Ferguson and E. Browne (eds.) Health Care and Immigrants: A Guide For Helping Professionals, Sydney: MacLennan & Petty.

[75] Howell, R. (1989) Filipino and Vietnamese women: a study of intra-partum differences. Australia and New Zealand Journal of Obstetrics and Gynaecology, 29 (4) 399-402.

[76] Howell, R. (1989) Filipino and Vietnamese women: a study of intra-partum differences. Australia and New Zealand Journal of Obstetrics and Gynaecology, 29 (4) 399-402.

[77] Cheung, N. F. (2002) The cultural and social meanings of childbearing for Chinese and Scottish women in Scotland, Mdwifery 18(4): 279-95.

[78] Carballo, M. and A. Nerukart (2001) Migration, Refugees, and Health Risks, Emerging Infectious Diseases, vol. 7, no. 3, Supplement, June, pp. 556-560.

- Difficult pregnancies and pregnancy-related illness among migrants are problems throughout the European Union. In the United Kingdom, babies of Asian mothers tend to have lower birthweights than other babies, and perinatal and postnatal mortality rates are higher among immigrants born in Pakistan and the Caribbean than in the general population.

- Data from Belgium indicate that in 1983 the highest perinatal and infant mortality rates were for babies of immigrant women from Morocco and Turkey. By 1993, the situation had improved substantially for the domestic Belgian population and for Moroccan immigrants, but among Turkish immigrants high perinatal and infant mortality rates persisted and in 1993 were still 3.5 times higher than those for Belgians.

- In Germany, perinatal and neonatal mortality rates are consistently higher in foreign-born groups, especially Turkish immigrants, than in the population as a whole. The rate of perinatal mortality for babies born to German mothers is approximately 5.2% and among non-nationals approximately 7%, and the incidence of congenital abnormalities and maternal mortality is also higher among immigrants.

- In Spain, premature births, low birthweight, and complications of delivery are especially common with infants born of women who have immigrated from sub-Saharan Africa and Central and South America. African immigrant women giving birth in hospitals, for example, have an incidence of premature births almost twice as high as in Spanish women and low-weight rates are also approximately double those of women born in Spain. Over 8% of babies born to women from Central and South America are underweight and 6.3% are born prematurely. Unwanted pregnancy and poor knowledge about contraceptive and where to get contraceptive devices and advice on contraception are common problems among immigrant women, and requests for abortions tend to be twice as common among them as Spanish women, especially those coming from North Africa and the sub-Saharan region.

A literature review carried out by IOM[79] of the published papers on the pregnancy outcome of migrant women from 61 epidemiological studies comparing immigrant and native women published between 1971 and 1998, revealed that:

- The majority of the studies analyzed data routinely available from national and regional statistics, while only a few were specifically designed to collect ad hoc data on pregnancy outcome of immigrant and native women. Since routine statistics do not report data such as tobacco consumption, alcohol, maternal education, socio-economic status, etc., many studies have inherent limitations when it comes to explanatory information. Large, prospective studies of pregnancy outcome, which look at several variables of interest, would be much more informative, but they are unfortunately very scarce. When the reasons behind the poor pregnancy outcome were investigated, it was found that the same factors – maternal age, parity, education, and social class – played a relevant role in determining a poor reproductive health outcome for both native and non-native women.

- The reasons for the poorer pregnancy outcome of immigrant women are still not well understood. During the 1970s, the blame was put on immigrant mothers, responsible for wanting large families, booking late for antenatal care, and in general unable to adjust to Western lifestyle. No specific solution was suggested, but to wait until a sufficient exposure to receiving societies would have changed the attitudes of immigrant families. As time went by, however, many countries experienced decreasing trends in infant and perinatal mortality, due to advances in the preventive and health care sciences, but the racial discrepancy remained. Infant mortality, as well as other

[79] IOM (2001) The Reproductive Health of Immigrant Women, Migration and Health Newsletter, No. 2.

indicators of the health of mothers and children, is the net effect of a number of biological and social factors which put immigrant women in a vulnerable situation. Migration stress, the rupture of previous social networks, religious and cultural factors, poor access to health care services, and discrimination within the health system have been frequently indicated as the main causes, alone and in combination with inferior health status of immigrant women and children.

- Although the studies did show differences, on average immigrant women were more frequently of low socioeconomic status than native women (70% versus 42%), had no or little education (25% versus 13%), and received more frequently inadequate or no antenatal care (15% versus 8%).

- The health problems affected the mothers as well as their babies. Overall, out of all pregnancies of immigrant and native women, 0.82% and 0.67% respectively ended up with a stillbirth. Similarly, infant mortality was higher for immigrant women as compared to native women (0.87% versus 0.82%).

- The issue of access to health services has been extensively investigated in different societies and among varied ethnic groups. Several studies have documented the poor and irregular uptake of antenatal care of immigrant women, and the higher proportion of women having their babies without professional help. Although it is difficult to make generalizations because there are specific factors at work in different societies, mothers from different ethnic groups may have different expectations and knowledge of their own health and of the value of health services in the receiving country. This is especially true for those with poor education and of recent immigration, who do not have the support of well integrated communities from similar background. Poor knowledge of the language of the receiving countries, due to less opportunity to learn it and to definite social roles which keep the woman inside the home, may further compound the difficulties of access to existing health services. Access to health services may also be limited for some groups, due to prohibitive costs or to lack of entitlement to welfare services and health care in the receiving society. Specific groups such as illegal entrants, asylum seekers, temporary or seasonal workers and their families, who now represent a main type of immigration, have in fact reduced or no entitlement to health care services. And finally, racism within the health services may act in very subtle ways, by exacerbating poor communication between patients and health care providers, creating a hostile environment, or disregarding specific needs of the patients.

- Although access to health care and health services utilization are important factors, which may prevent unnecessary mortality and morbidity, we consider today the determinants of health of communities in a broader framework, where several factors play a relevant role. Members of ethnic groups usually belong to socially excluded groups, as a result of a combination of class factors and racialization. There is a well-established link between poverty and poor health, both for native and immigrant communities. Those who are socially marginalized, such as the unemployed, the homeless, poor immigrants and refugees, often experience much worse health outcomes than the general population.

- A growing body of evidence documents that harm to health comes not only from material deprivation, but also from social and psychological problems resulting from living in relative poverty and from exclusion from social participation. If this is the case, the health of immigrant communities– and of mothers and children in particular – needs to be tackled by multidimensional policies that increase protection, economic integration and participation in social life.

- There are likely to be important lessons to be learnt from countries where good policies and practices are widely applied, such as Canada, Australia and Sweden. In these countries, studies have shown equal or better pregnancy outcomes for immigrant women as compared to native women. Although the ethnic composition varied significantly, factors such as poor command of the

language, lack of familiarity with the local culture, and belonging to lower social classes were likely to be present, at least for newcomers. However, a common trait of public policies in Canada, Australia and Sweden was the development over time of broader policies aimed at the social and political integration of immigrants and refugees, in full respect of cultural identities. Within this context, specific policies were developed to promote training and employment opportunities, as well as to identify and systematically reduce linguistic and cultural barriers in order to facilitate access to health and welfare services. It is likely that both social policies and policies focused at increasing access to health care have a synergistic effect on the reproductive health of immigrant communities. In a world where poverty and social exclusion are actually increasing, a number of specific actions need to be taken to improve the health of socially disadvantaged groups, including immigrant communities. The particular forms of disadvantage and the distinct needs of specific groups need to be identified and attended.

- The improvement of the reproductive health of immigrant women – an important priority for the public health of receiving countries – needs to be addressed in this large framework. Part of such improvement will be through a reduction of poor social circumstances, which in turn will affect the health of mothers before and during pregnancy (diet, exercise, likelihood of smoking, but also mental well-being and coping skills), and part through specific action increasing access to preventive and curative services.

In Latin America and the Caribbean, reliable data on migrants' sexual and reproductive health are very scarce. In destination countries of migration as Dominican Republic, Belize, Costa Rica and El Salvador, female migrants tend to have a higher number of children than native women. By contrast, in sending countries such as Peru, Guatemala and Nicaragua, the fertility rate of native women is higher than that of migrants. Generally speaking, migrant women declare not to have desire their last pregnancy in higher percentages than native women. In Dominican Republic, Costa Rica and Colombia, the use of contraceptives is higher among native women. The use of reproductive health services among migrant women is, in general, less frequent than among native women. In the Dominican Republic, Peru, Costa Rica, Belize and Nicaragua, the percentage of migrant women having received a prenatal control was considerably smaller than that of natives[80].

[80] Chen Mok, M. et alter (2001) Salud Reproductiva y Migración Nicaraguense en Costa Rica 1999-2000: Resultados de una Encuesta Nacional de Salud Reproductiva, Programa Centroamericano de Población de la Escuela de Estadística and Instituto de Investigaciones en Salud, Universidad de Costa Rica, San José.

National Survey on Reproductive Health and Migration (1999-2000) in Costa Rica[81]

Costa Rica is the only country worldwide that has carried out a National Survey on Reproductive Health and Migration. The survey revealed the following information:

- Fertility rate of migrant women was 40 percent higher than that of natives.
- Contraceptives use rate was also higher among Costa Rican women in reproductive age (80%) than that of Nicaraguan women migrants (70%).
- Migrant women present also higher percentages of registered children of unknown fathers (15 percent compared to 8% among Costa Rican women).
- Preventive health activities presented also higher percentages among Costa Rican women: self breast testing (45% natives, 27% immigrants), pap testing in the last year (45% natives, 37% immigrants).
- Immigrant women use health services less than native women: 66% visited a doctor in the last year (compared to 83% of Costa Rican women), 59% had an adequate prenatal control (vs. 83% of Costa Rican women); 91% received skilled labour care (vs. 96% of native women).
- Migrant women experienced less caesareans (13% compared to 20% among native women).

3.2. Human rights and access to sexual and reproductive health care of migrants

At the global level, governments have consistently reaffirmed the human rights of migrants and their families, calling specific attention to the needs and rights of women migrants and refugees in the plans of action adopted at the UN conferences of the 1990s. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, adopted in 1990, came into force in 2003. However, in practice, countries limit some human rights to citizens only, and make distinctions between documented and undocumented. In several instances, countries make allowances for all migrants to access health care—although, for undocumented migrants these are often limited to medical emergencies[82].

Undocument migrants and access to health care

Information obtained from regularization programmes and other sources suggests that 10 to 15% of worldwide migrants are irregular[83]. In the US, there were an estimated 7 to 8 million irregular migrants in 2000. In the Russian Federation the Ministry of Interior in September 2003 estimated that there were 5 million foreigners whose legal status was unclear, of whom 1.5 million were "clearly unauthorized". Irregular migration is not confined to the developed countries. In Argentina, for example, it was estimated that there were 800.000 irregular migrants, mainly from bordering countries. Many parts of Asia, Africa and Latin America have long and porous borders that people commonly cross without going through migration posts, as with the DRC in Africa and the border between Myanmar and Thailand.

Increasing irregular migration into Western Europe and the status of rising numbers of undocumented migrants have become policy challenges requiring attention and action from a human rights perspective. Although reliable data is not readily available, estimates are that between 120.000 and

[81] Chen Mok, M. et alter (2001) Salud Reproductiva y Migración Nicaraguense en Costa Rica 1999-2000: Resultados de una Encuesta Nacional de Salud Reproductiva, Programa Centroamericano de Población de la Escuela de Estadística and Instituto de Investigaciones en Salud, Universidad de Costa Rica, San José.
[82] UNFPA (2006) State of the World Population, New York.
[83] ILO (2004) Towards a Fair Deal for Migrant Workers in the Global Economy, Geneva , p. 11.

500.000 migrants enter the EU by irregular means annually[84]. In terms of international human rights law, the rights of undocumented migrants, including the right to health, are protected by several conventions to which the European Union member States are party. Current political discussion and policy regarding irregular migration, however, centre mainly on policing and return programs with little attention to the human rights of undocumented migrants. New barriers are been placed in the way of undocumented migrants having equal access to preventive, curative and palliative health services.

In that context, an interesting study carried out in 2004 explores the gap between countries obligations to respect the right to health of undocumented migrants and access to health care for this group, focusing on the cases of Germany and the Great Britain[85]. In the case of Germany, residing in the country without a valid permit or visa is a crime according to the Law on Foreigners (sections 92, 92a and 92b). This law prescribes that all those without a visa or valid permit can be fined or imprisoned for up to one year. This in effect means that, by virtue of their "illegalized" status, undocumented migrants are essentially excludes from the health care system. A research carried out by Braun and others (2003)[86] identified the main legal obstacles for undocumented migrants to access to health care. In theory, undocumented migrants can obtain medical care and financial support through the Social Welfare Centre; however, other laws make impossible for undocumented migrants to make such claims without risking deportation[87].

Regarding emergency and hospital care, hospitals, emergency units and general practitioners are obligated by law to provide medical treatment regardless of health insurance or residency status. The pregnancies of undocumented female migrants are considered high risk by obstetricians because of the psychological and physical strain their undocumented status imposes. Under German law, maternity leave extends from the six weeks prior to delivery to the eight weeks afterwards and during this period undocumented women are able to legalise their residence status by applying for a Duldung[88]. If a pregnant undocumented migrant woman does not apply for a legal residence status and delivers her child at home or as a private patient in a hospital, the child will be born into illegality as it is impossible to get a birth certificate since the mother is unregistered. Without a birth certificate, the mother can not prove parenthood and the child could be taken away from her, for example in the case of deportation.

In the case of Britain, the government has not explicitly addressed undocumented migrants' right to health care in its legislation. Up until recently, state funding of health care, an absence of systematic internal checks on lawful residence status and the importance of length of residence or intention to reside, combined to make health care largely accessible to undocumented migrants. However, this access has changed considerably due to the introduction of revised National Health System regulations in April 2004 stipulating charges for hospitals services, other than accident and emergency care, for overseas visitors as well as the necessity of proving legal residence status in the UK[89]. Further changes are planned as the government has submitted new proposals for the exclusion of overseas visitors from eligibility to free primary health care services in a bid to make regulations governing access to primary and secondary services consistent. In marked contrast to previous NHS documentation, the status of

[84] IOM (2003) Facts and Figures on International Migration.
[85] Scott, P. (2004) Undocumented Migrants in Germany and Britain: The Human "Rights" and "Wrongs" Regarding Access to Health Care, Electronic Journal of Sociology.
[86] Braun, T. and others (2003) Gesunndheitsversorung 9ilegalisierter Migrantinnen und Migrantes- ein europäischer Vergleich. Forthcoming.
[87] According to article 76 of the Law on Foreigners, any member of an official borrad who has information on an individual without a valid residence permit must pass this on to the Ministry of the Interior. Public servants, therefore, have a "duty to denounce" all undocumented migrants voluntarily at the risk of being penalized if they do not.
[88] A Duldung is a "temporary suspensión of deportation" residence status and it is given to a migrant whose request for asylum has been refused but they can not be returned because of politicans strife in their home country or because of medical reasons. It has to be renewed every 3 to 6 months and entitles to very few rights, among them access to medical care, usually only for acute conditions.
[89] Imlementing the Ovearseas Visitors Hospital Charging Regulations. Guidance for NHS Trusts in England. Department of Health, May 2004. www.dh.gov.uk/PublicationsandStatistics.

"illegal immigrants" is also clearly addressed and in the case of hospital services, health professionals will have the responsibility to report undocumented migrants. The general rule is that "overseas visitors" are required to pay for hospital treatment. However, prior to April 2004, people who had been in Britain for 12 months and anyone who came into the country with the intention of taking up permanent residence were exempt.

In France, a law dating from 30 December 2002 changed the French law on access to health care for undocumented migrants. From then onwards, all undocumented migrants have to pay part of the medical treatment. On the top of that, who are not able to proof that they are in France for more than three months, do not receive state medical assistance anymore, but they are only eligible for treatment for emergencies and life threatening conditions. The NGO FIDH made a complaint against the new French law legislation to the Committee on Social Rights of the Council of Europe considering that contravenes to the provisions of articles 13 and 17 of the Revised Social Charter. The Committee ruled that "legislation or practice that denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter"[90].

Médécins Sans Frontières Sweden released in 2005 a survey entitled Experiences of Gömda in Sweden: Exclusion from Health Care for Immigrants Living Without Legal Status. Gömda, meaning "hidden", is a general term used to describe immigrants living without legal status in Sweden. According to this survey, 82% of the respondents reported facing physical barriers to accessing health care – as a result of high cost for medical consultations and medication or being refused care due to lack of valid documents- and indirect barriers – stemming from fear of approaching services and being dissuaded from seeking care despite having health needs. The majority of respondents reported deterioration both in their physical health (65%) and mental health (64%) since living in Sweden without legal status.

3.3. Some initiatives to protect migrants' right to health care

- In 2004, FIAN Germany (the German section of the international FoodFirst Information and Action Network) and the Büro für Medizinische Flüchtlingshilfe wrote a shadow report on health care for undocumented migrants to the UN Committee on Social, Economic and Cultural Rights UN in Geneva. The report was presented in front of the commission in July. However, when the commission presented her concluding observations at the end of August, the problem of illegalized migrants was not even mentioned. One of the reasons for this very disappointing result seems to be that not enough pressure has been put on the Commission concerning this theme. The International Covenant on Economic, Social and Cultural Rights, a UN Treaty that has been ratified or signed by more than 150 nations, includes a comprehensive statement on the right to health in international human rights law. According to Article 12(1), State parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". All governments are invited to submit reports to the Committee responsible for Article 12 every 4 years, detailing the health care situation in their country. The committee also welcomes 'shadow' reports from other sources, such as non-governmental organisations. The General Comment gives such organisations the opportunity to call into question government reports on issues of importance, challenging human rights organisations to submit authoritative shadow reports, preferably in a standardised form.

- In Central America, a Seminar on Human Rights and Migrants Access to Emergency Health Care organized by the Regional Conference on Migration analyzed in 2003 the requirements to obtain access to emergency health care as well as whether it is provided to migrants. The

[90] www.gisti.org/doc/actions/2005/ame/index.html

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, adopted in 1990, came into force in 2003.

- In 2006, Government of Mexico announced it was extending health care to all Mexican migrants and their families that travel from the United States. The "popular insurance" scheme is slated to extend coverage to 1 million people on a range of health issues, including cancer, leukemia, HIV/AIDS, cataracts and kidney-related illnesses[91].

- The European initiative Migrant Friendly Hospitals (2003) aims to identify, develop and evaluate models of effective interventions, having the following objectives: to strengthen the role of hospitals in promoting the health and healthy literacy of migrants and ethnic minorities in the UE and to improve hospitals services for these groups by defining measures of quality, developing migrant and minority-friendly hospitals. As a result of this initiative, the Amsterdam Declaration Towards Migrant-Friendly Hospitals in an Ethno-Culturally Diverse Europe was launched in 2004 by all partners of the project.

- In Singapore, the government provides a telephone number that migrant domestic workers can call free of charge to obtain information on their rights and on the procedures for changing employers.

- In Berlin, the *Büro für medizinische Flüchtlingshilfe* was established in 1996 as an anti-racist, non-governmental resource providing free and anonymous medical treatment twice a week for undocumented migrants and refugees. There are now ten similar offices in Germany all loosely connected by the "NO one is illegal" campaign. In addition, some charity and church organizations are extending their medical aid to include undocumented migrants. Since 2001, the Catholic charity Malteser Hilfsdient has started offering a medical service free of charge without verifying the patients' residence status[92]. There is also the possibility for undocumented migrants to take advantage of some health care measures, as for instance the new law for infectious diseases stipulates that some infections such as tuberculosis are diagnosed and treated anonymously and free of charge at public health offices. Vaccinations for children are also offered by some co-operating public health services without verification of residence status. HIV/AIDS testing is also anonymous and free.

- *Médécins du Monde* has issued comments on the European Directive on common standards and procedures for returning illegally staying third-country nationals published on 1 September 2005, advocating for a stop to the deportation of seriously ill foreigners who cannot get access to effective health care in their countries of origin.

[91] UNFPA (2006) State of the World Population, New York.
[92] Scott, P. (2004) Undocumented Migrants in Germany and Britain: The Human "Rights" and "Wrongs" Regarding Access to Health Care, Electronic Journal of Sociology.