A Report on the

7th and 8th Regional Conference on Migration

Milestones in a journey advocating for the protection of the human rights of all migrant workers and members of their families

Migrant Forum in Asia

PREFACE

In recent years the phenomenon of labour migration has grown in significance evoking responses of a varied nature from international organizations, multi-lateral institutions, governments, civil society and local communities.

As a network the Migrant Forum in Asia (MFA) first came together in Hsinchu, Taiwan in 1994 to look at the problems and issues that beset the migration process. From the very beginning MFA's focus has been to advocate for the protection of the rights of migrant workers and members of their families.

This publication puts out the report of two milestones in that journey - The 7th and 8th Regional Conference on Migration (RCM) held in Jakarta, Indonesia and Dhaka, Bangladesh, in 2001 and 2003- prior to the International Convention on the Protection of the Rights of All Migrant Workers and members of their families coming into force as International Law on 1st July 2003.

The report documents strategies and responses of the network to the key issues of the labour migration phenomenon in Asia as they emerged at that time. It also serves as a guide for the network and other partners dealing with the issue of labour migration on how to build capabilities on migrants rights awareness and advocacy for policy change.

We are grateful to our partners in Indonesia and Bangladesh for the support that they were able to extend in organizing this conference and to the Ford Foundation for granting us the resources to convene the 8th RCM and this report. We hope that it will attest to the value of our on-going struggle and commitment to the cause of the migrant worker and be instrumental in making real another world that we believe is so much more possible.

Migrant Forum in Asia
Regional Secretariat
Manila Philippines
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7th Regional Conference on Migration

"Developing National and Regional Advocacy Agendas on Migrants' Human Rights"

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Introduction and Background of the 7th RCM

The seventh Regional Conference on Migration was held in Jakarta from the 13th to the 16th of June 2001. It was co-hosted by the Asian Migrant Centre (AMC), Center for Indonesian Migrant Workers (CIMW) and the Migrant Forum in Asia (MFA). Approximately sixty participants from Hong Kong, Philippines, Japan, Korea, Taiwan, Bangladesh, Sri Lanka, India, Malaysia, Thailand, Nepal, Yunnan, China, Middle East, Vietnam and Indonesia were at the conference. While most of the participants were members of the different network organizations of MFA, concerned regional and international specialists were also invited.

This conference was the seventh in the series of Regional Conferences on Migration that began with the conference in Taiwan in 1994. The first conference discussed the issue of migrant workers in Asia and resolved to form the Migrant Workers in Asia, which later was renamed as the present-day advocacy network, Migrant Forum in Asia (MFA). Subsequent conferences were held in different cities in Asia. They focused on different themes ranging from particular needs of the time, as the 2nd RCM on preparing for the women's conference in Beijing, to developing common concepts of migration and methods of documentation. The RCMs have generated a common understanding of migrants' situation and the need for migrants' empowerment, and they have shared the particular challenges that were being posed to migrants due to their common predicaments and global processes.

The Key Objective

The primary objective of the seventh conference was to develop and strengthen national and regional advocacy work on migrants' human rights. Advocacy is one of the key programmes of MFA for tackling and ultimately eradicating migrants' rights violations. In the RCM's seventh year of existence, it was felt that there was a pressing need to map the ongoing advocacy effort of various member organizations and to develop a common understanding of advocacy work. Discussing gaps and limitations in current regional advocacy work would help us overcome these and suggest improvements in our collective advocacy efforts. The conference would conclude with a creation of a sub-regional and regional action plan on common advocacy issues identified by the participants of the conference.

Output: The conference came up with a listing of common advocacy issues on which MFA could work together. There were also recommendations for different kinds of regional and international responses that would be taken up, which would require supporting study, documentation and networking.

What is Advocacy?

The conference began with a general introduction t o advocacy for migrants' human rights which lay the context for the discussions of the subsequent days. Rex Varona of the AMC and Mayan Villalba of Unlad Kabayan spoke about what is advocacy, the problems that are faced particularly in the course of advocacy of migrants and how to monitor and assess the impact of advocacy.

They defined advocacy as generating support around a cause of position to effect change. This may involve a general campaign as well as more discrete lobbying. The particularities about advocacy for migrants is that the issues often straddle two countries, they involve race, gender and class-based discriminations, and there is considerable change of roles, jobs and contexts of individuals. Often the multiple stake-holders with different aims and interests involved in a single issue could result in their work being at cross-purposes. This kind of structuring of migrants' issues requires special skills of negotiation and cooperation. As with any other kind of advocacy, the issues are often

long term not leading to dramatic changes and it is difficult to measure the impact of advocacy. NGO advocates play an important role in advocacy. This role should, however, focus on enabling migrants to become advocates themselves.

Considerable time was spent in discussing the various ways in which to assess the impact of advocacy work. Important features of assessment would be to determine what to monitor and through what indicators – both qualitative and quantitative. Several different organizations have developed formal methods which were discussed, for example, the Oxfam method suggested by Chris Roche and the CIIR method. It was also suggested that negative impacts on other groups, as a side effect of advocacy should also be assessed.

The Intersection of Gender, Race and Class in Migrants' Advocacy

Having set the context for MHR advocacy, the second session highlighted the multiple forms of discrimination faced by migrant workers and how these can be taken up within the MHR advocacy. These were presented by Vani Dulaki of the Asia Pacific Forum for Women Law and Development (APWLD). The presentation concentrated on gender and the definition and sources of gender identity and discrimination. She drew the attention of participants to the need to identify specific gender aspects of racism and the specific problems of women migrants and to be able to gather gender-disaggregated data. She also drew attention to the fact that race, gender, class are not mutually exclusive, and she therefore stressed the need to connect the various dimensions of discrimination.

The NNSMW, SLBFE, MECC and ACTFORM present their national advocacy experiences during the panel on "Needs, Gaps and Lessons from National Policy Advocacy".

Comments from the participants covered a wide ground from the growing feminization of migration, ethical questions regarding women migrants in vulnerable jobs, the problems in linking up organizations that advocate on intersecting issues of race, gender and migration.

Needs, Gaps and Lessons from National Policy Advocacy

This topic was intensively discussed over two sessions. In the first session, representatives from the National Network in Solidarity with Migrant Workers (NNSMW, now called Solidarity for Migrants in Japan or SMJ, Japan), Raynah from Middle East Council of Churches (MECC, UAE) and Sri Lankan Bureau of Foreign Employment (SLBFE) as well as Women and Media Collective (WMC) - Action Network for Migrant Workers (ACTFORM) of Sri Lanka made presentations about their countries' experiences. The MFA Secretariat coordinator, Willie Descalzo, provided a synthesis of the discussion, suggesting that the common themes on advocacy would be the restrictions on migrants' rights and on the operations of advocates, and the linkages between advocacy groups in sending and receiving countries. He also emphasized that there has been much evolution of the advocacy responses of the MFA network members from providing emergency relief to providing welfare services to networking and broader advocacy work concerning migrants' rights.

In the next session, the conference broke up into regional groups analyzing country policy advocacy work. These workshops provided some of the input for the conference list of recommended common advocacy issues. The workshops also recommended that advocacy work needs to improve overall and it suffers from paucity of funds and workers and the systematic sharing of information and experiences. It was also suggested that we improve regional coordination and networking, make joint plans and evolve sub-regional advocacy agendas.

Participants relax during the introductory solidarity night.

The Experiences of Migrants Directly Involved in Policy Advocacy

The second day began with a focus on migrants being activists and self-advocates. Presentations were by Ipari of Joint Committee for Migrant Workers in Korea (JCMK, Korea), Coalition for Migrants Rights (CMR, Hong Kong), Saiful of Welfare Association of Repatriated Bangladeshi Employees (WARBE, Bangladesh), and Migrant Services Center (MSC, Sri Lanka). It was fruitful and inspiring hearing from migrant workers on their experiences in self-advocacy. The strategy to unionize and organize migrants themselves was highlighted and was recognized as one of the most crucial aspects of advocacy. MSC shared their experiences of organizing ACTFORM as a network of migrants' advocates that works to organize migrants together with women's groups, including participating as candidates, in elections.

During discussions, CMR, a coalition of six associations and unions of domestic workers in Hong Kong – shared their problems of networking, articulation of their problems and advocacy agenda, awareness raising, and resource limitations. WARBE from Bangladesh shared their strategies in expanding their membership, and suggested that providing focused programmes like savings groups, investments, multi-purpose cooperatives in turn help to attract membership. JCMK shared their programs for leadership training for migrants as well as their programs for training migrants to counsel other migrants. Participants discussed at length the problems of trying to reach the migrants of their countries when they are abroad, and JCMK shared their specific experiences of trying to reach migrants through the various consulates in Korea, thus touching the next topic of discussion – linking national with regional processes.

In the summing up of this session, the point was made that MFA was a unique network of advocates in that it is comprised not only of migrant support groups, NGOs and academics, but of associations and unions and migrant workers themselves. Though migrant workers do not have the right to organize in all Asian countries, the network places great emphasis on promoting migrants' role as self-advocates, as the empowerment and increased awareness among migrant workers themselves plays a tremendous role in decreasing rights violations.

Linking National Advocacy Processes to Regional Advocacy

Presentations were made by Indonesian Migrant Workers' Union (IMWU, Hong Kong), Center for Indonesian Migrant Workers (CIMW, Indonesia), JCMK (Korea). All three presented their work and suggested that cooperation and collaboration on specific projects on advocacy helps to strengthen regional ties. For example, Migrants' groups and networks in host countries including organizing, advocacy and support work on specific programs like migrant savings or alternative investments in cooperation with NGOs in sending countries. Participation on international days, e.g., International Day of Labour Solidarity, International Women's Day, also raises regional and international awareness of nations groups.

CIMW is an organization formed in 1995 providing legal and non-legal assistance, a crisis center along with research and documentation and advocacy. Spoke of their campaign against recruiting agencies in Indonesia. One of the strategies they employed was their letter campaigns to the UN Special Rapporteur and UNCHR, host governments and Indonesian embassies. They suggested that an international campaign to communicate directly with employers might also work to reduce the use of recruitment agencies. Until now, advocates normally target governments and international bodies rather that individual employers.

IMWU is a registered trade union of migrant domestic workers in Hong Kong. One of the major programmes

of IMWU is advocacy on laws and policies both in Hong Kong and Indonesia. They provide counseling referrals (but do not do case work), phone advisory, paralegal trainings for members and non-members, public discussion, publish a regular bulletin amongst other public and media campaigns. One of their major successes was their campaign against recruitment agencies charging exorbitant fees. After their campaign, the Indonesian government issued a memo requiring agencies to charge only 10% of salary as a fee. While this is not fully implemented, it was a major achievement.

The presentation of IMWU demonstrated the importance of migrant workers advocating for their own rights in host countries, and for migrants' groups to have access to NGO support services in host countries to strengthen their organizing process. The session also stressed the necessity for migrants to be working in coordination with NGOs in sending countries. In case of IMWU, the Union was established and based in Hong Kong, but much of its advocacy targeting the Indonesian government is jointly conducted with NGOs in Indonesia, such as CIMW. Hence, the importance of regional coordination through the MFA network was highlighted through the presentations of IMWU and CIMW, as two national-based groups that work together at the regional level.

JCMK pointed to the need for more effective tactics, strategies to raise consciousness amongst migrants and involving them more in actions, to integrate different types of migrants and link up with different countries that have similar situations. The difficulties lie in communication – the language gap between migrants and locals, differences in priorities between national and regional groups and the distance between sending and receiving countries to be more proactive and for more effective use of media as well as making campaigns more comprehensive.

JCMK and IMWU present on their experiences in organizing migrant workers in host countries during a panel.

Participants discuss and analyze their national advocacy issues, problems and processes during a workshop session.

The conference then broke up into regional groups (South East Asia, East Asia and South South Asia) to analyze national policy advocacy agendas and to examine which ones could be taken up at the sub-regional level. Their discussions contributed to the conference compilation of recommended advocacy issues. During discussions, it was suggested that various kinds of preparatory work is important for advocacy like a study of migrant-related laws and policies, including a documentation of best provisions, practices and frameworks. A study of the contribution that migrants make to the receiving countries would also be helpful.

The United Nations and International Advocacy

Having gone through and analyzed the advocacy issues of participants at the national and sub-regional level during the first day and a half of the Conference, the afternoon of Day 2 and morning of Day 3 focused on how national advocacy issues could be linked up to the international level, particularly highlighting case studies on the UN conventions on women and migrant workers, and the World Conference Against Racism (WCAR) process.

CEDAW and UNIFEM

Jean D'Cunha from UNIFEM started off this session by presenting a detailed discussion on the details of the UN system and its channels for advocacy for MHR. She outlined the possibilities within the UN for promoting the empowerment of women, including women migrant workers, and promoting their human rights. She described the various international conventions and protocols of the UN as having specific mechanisms for reporting and monitoring government compliance with international standards, such as committees, special rapporteurs, working groups and so on. She also outlined the conventions that she felt were most relevant to advocacy on migrant workers' rights: the Beijing Platform for Action, the ILO core conventions and ILO conventions on migration, the International Convention for Economic and Social Rights (ICESR), the International Convention for the Elimination of Racial Discrimination (CERD), and the International Convention for the Elimination of Discrimination Against Women (CEDAW).

Among these conventions, CEDAW was highlighted as being particularly useful, as all of its provisions can be applied for the promotion of the rights of migrant women. Moreover, having been ratified by over 50 governments, it can be readily used by advocates as a pressure tool. She described UNIFEM as an agency within the UN that was especially conducive to work with NGOs in empowering women migrants and promoting human rights especially through CEDAW.

Other UN Advocacy Processes Highlighting MHR

Further discussion on international advocacy continued into the next session with two case studies drawing on experiences and lessons in doing international lobbying by MFA and MRI. MFA founding member Carrie Tharan shared MFA's involvement in international fora and events, like the International Conference on Population and Development (ICPD), the World Summit on Sustainable Development (WSSD), and the Fourth World Conference on Women (FWCW) and the insights and lessons that were gained from these.

International NGO Networking for MHR Advocacy: Migrants' Rights International (MRI)

The discussion then shifted its focus to the efforts of NGOs that have been promoting international networking and advocacy for MHR. Mayan Villalba (Unlad Kabayan, Philippines) shared the experiences of the international advocacy NGO and network, Migrants Rights International (MRI), whose Secretariat is currently based in Geneva. Speaking as a founding member of MRI, she described its growth from a four-person network that emerged from the ICPD in Cairo in 1994, to an international focal point and network on migrants advocacy that now has members in Asia, Europe and

Participants brainstorm on needs and gaps within international advocacy during a workshop session.

the Americas. She described how the efforts of MFA members, such as AMC and Unlad Kabayan, were crucial to the formation of the MRI network. Ms. Villalba spoke of the importance of MRI's roles in disseminating information about UN processes relevant to migrants' rights, building the capacity of its partners and members in international advocacy, and facilitating the advocacy of its national affiliates at the UN level, and helping to bridge the gap between national and international levels. Today, MFA is the Asia focal point of the MRI network. She also stressed how important it was for the MFA network to strengthen its networking with the MRI network, as it can form the basis for international solidarity on migrants' rights advocacy. MRI can also serve as a useful intermediary between the national context of migrants' advocacy and the international UN system.

UN Migrant Workers Convention

In the following panel discussion, Sajida Ally of AMC (Hong Kong), Nanako Inaba of NNSMW (Japan), and Saiful Haque of WARBE (Bangladesh) shared their experiences on international advocacy for ratifying the UN Convention for the Protection of the Rights of All Migrant Workers and Members of Their Families (the Migrants Convention).

Some of the participants of the 7th RCM.

AMC began with an overview of the convention, its scope and contents, and the potentials and limitations of advocating for MHR with this instrument. AMC mentioned that the Migrants Convention in the most comprehensive convention to date on the human rights of all migrant workers, including undocumented migrant workers, self-employed workers and seasonal workers. It is comprehensive as it has brought together all the social, economic, civic and political rights of migrant workers that are present in the existing five core UN human rights conventions. However, as it has not entered into force (the convention needs 20 countries to ratify in order to form a Treaty Body and be enforceable as international law), there it has yet to be enforced as a binding convention. Once the convention enters into force and it is widely ratified, AMC stressed that it would stand as perhaps the most effective international advocacy tool for the promotion of MHR. Hence, AMC urged the MFA network to step up its efforts in promoting the ratification of the Migrants Convention among Asian governments. The ensuing presentations provided concrete examples of the potentials and limitations of advocating through this convention.

Ms. Naoto Higuchi of the National Network in Solidarity with Migrant Workers (NNSMW), Japan shared their experiences of the ratification campaign. Their campaign was still in an introductory stage as other NGOs in Japan are not very enthusiastic. However, they felt that participating in the region-wide or international campaign has increased the solidarity consciousness of Japanese NGOs, as previously they were very inward looking. In the discussions it emerged that there are many new and emerging issues in migrants rights which are not addressed by the convention, e.g., the issue of the social costs of migration – with broken families and homes, stateless children, paternity claims, etc.

Saiful Haque of WARBE, Bangladesh shared their experience of the ratification campaign. He said that they began the campaign in 1998 by submitting a memorandum to the government followed up by various campaign activities. Bangladesh signed the convention, but did not ratify it. After this, they changed their strategy and tried to reach out to other civil society groups to ask them to support the ratification campaign. The difficulties they faced in the campaign arouse from limited finances, the political conditions – as the elections were coming up. They also had difficulty trying to register WARBE as a trade union, as the members work in different countries.

The facilitator ended the session by commenting that though there were definite limitations in the process and impact of advocacy through UN instruments such as the Migrants Convention, it was in fact possible to use the Migrants Convention as an additional pressure tool in their national advocacy processes.

World Conference Against Racism (WCAR)

The international advocacy process for the World Conference Against Racism was continuing at the time and this

was discussed by Meera Samanthar of Women's Aid Organization (WAO – Malaysia), Sajida of AMC (Hong Kong), Mayan of Unlad Kabayan (Philippines). The WCAR identified ethnic minorities, migrants and social groups as the main victims of racism discrimination. They shared how it is difficult to formulate international and regional positions and the further problems when the NGO document is used as an advocacy tool to make changes in the government WCAR document.

Ms. Samanthar shared that involvement in the WCAR process led to their own internal self-examination – their own perceptions and racist ideas; it broadened their perspectives especially on the issue of understanding migrant workers' issues. It opened a forum for them to discuss the issue of racism in Malaysia especially in the National Eco Policy (NEP) formulated by the government as a way of balancing the various racial groups in Malaysia, though they have not been able to mobilize wider participation by NGOs in Malaysia in this process.

Ms. Villalba traced a brief history of the UN's acceptance and treatment of racism and racial discrimination and migration. She mentioned that in the first WCAR there was no mention of migrant workers. Only in the present – the third conference is there a deeper understanding of xenophobia against migrants. She described MRI's efforts on how to bring migrant advocates to Durban to intervene in the WCAR process, by providing support in terms of logistics and funding.

These presentations were followed by a discussion of the WCAR government document and changes were suggested to it to incorporate migrants' rights – ranging from the recognition of the human rights of undocumented workers to distinguishing between migration and trafficking. It was suggested that while these two processes are related they are quite distinct, requiring different responses from advocates.

Conference Conclusions and Outcome

Having completed various panels and workshops that raised common national, regional and international advocacy concerns, needs and strategies of migrant workers and advocates, the concluding session of the 7th RCM summed up the three days of Conference discussions. Most importantly, Conference participants also created and adopted a list of "Recommended Advocacy Issues". (See Appendix 1)

Recommended Advocacy Issues

To summarize the range of advocacy issues that had been deliberated during the three-day Conference and guide follow up action, participants came up with advocacy: migration laws and policies; basic MHR violations; migration process; recognition of the positive role of migrants; sub-regional advocacy agenda; and international advocacy (see Appendix 1). Some of these issues were new on the agenda, whereas others were re-emphasized for follow-up action at the national, regional and/or international level.

At the level of migration laws and policies, participants from all countries were urged to push for better legislation for the rights, dignity and welfare of migrant workers, including bilateral agreements and employment contracts that could be regulated and enforced, in part, by labour attaches based in host countries. All policies, laws, legislations and agreements had to be made consistent with international labour and human rights standards, such as the UN Migrants Convention, CEDAW and ILO migration conventions. Existing policies and regulations that were cited as particularly discriminatory included the Two-Week Rule in Hong Kong and the trainee system in Korea and Japan. Extra emphasis within advocacy efforts also had to be placed in providing legal protection for undocumented migrant workers, including granting amnesty to them.

To ensure that the overall migration process is safe, transparent, legitimate, sustainable and based on international human rights standards, the 7th RCM made several recommendations. Advocacy coordination between the national and regional levels needed to target changing the practices of brokers, intermediaries and recruitment agencies, as these were often abusive and corrupt. Many either colluded with governmental departments or officials, while others were beyond the reach of rights-based regulation. Advocacy to end abusive and exploitative immigration controls at airports was also recognized as important, particularly in the case of the proposed building of Terminal 3 of Soekarno Hatta Airport. The detention and forced deportation of migrant workers in many Asian countries reflected the gross failure of providing migrants access to a rights-based migration process, and was strongly highlighted for study, the formulation of policy recommendations and subsequent action. Participants also recommended that advocacy for the reintegration and socio-economic programmes for migrants be stepped up.

Other basic migrants' rights discussed, included rights of migrants to social services and social security, health and safety, including medical care and retirement benefits. The experiences of migrant workers in life-threatening situations, such as executions, were an area urgently emphasized for follow up action. In particular, participants urged for the development of a broad-based, well-coordinated campaign to stop the execution of Indonesian migrant, Siti Zaenab in the UAE. This campaign should eventually be extended to cover all migrant workers facing execution in the Asia region. Migrants' rights to absentee voting was also included as an issue that needs to be advocated for.

Recommendations also focused on promoting the recognition of the positive roles and contributions of migrant workers to home and host country economies, societies and political systems. Participants urged that lower status migrant workers, such as domestic workers and care-givers, be recognized as workers by labour and social welfare legislation. Governments should be pushed to recognize December 18 as International Migrants Day, and there should be large scale mobilization of advocates and migrants on the day.

Another set of issues focused on the need to develop sub-regional agenda, as sub-regional groupings had the potential to develop more comprehensive strategies, including advocacy for the recognition of MHR, implementation of support services, and linkage to regional and international networks and groups, such as MFA and MRI. For example, the formulation of a common regional migration agenda and response for migrants in the SAARC region was urgently required. The Gulf region was also highlighted for the development of more effective strategies and support services for response groups in that sub-region. Participants recommended that MFA creates a specific task force to take charge of advocacy in the Gulf. And governments in the Greater Mekong Sub-region needed to be especially sensitized to the situation of migrant workers. Towards these ends, studies should be undertaken to document and raise awareness on the problems of migrant workers in the South Asia, Mekong and Gulf regions.

The above recommended advocacy issues are largely national and regional issues, however, most can be easily linked to international advocacy through referring to key international migration-related instruments. For example, lobbying for rights-based national migration legislation can refer to the Migrants Convention, which stipulates that all governments must enact legislation that promote migrant workers' basic social and economic rights.

In addition, participants highlighted international advocacy processes that advocates should focus on. Migration advocacy within the WCAR process needed to be strengthened, particularly in the Asia-Pacific NGO process and in linking up internationally with MRI to lobby governments at the final upcoming WCAR summit in Durban, South Africa in August – September 2001. A concrete exercise undertaken at the 7th RCM by the participants was the analysis of a section of the Draft WCAR Government Programme of Action. One of the main recommendations was that "migration" and "trafficking" be treated as separate issues and sections. These changes needed to be advocated for in the final WCAR government documents. Advocates could also use the WCAR process to step up their campaign towards ratification of the UN Migrants Convention, targeting governments such as Bangladesh, Indonesia and Nepal. These efforts should come on top of a recommended intensified regional ratification campaign effort, coordinated by MFA.

Synthesis and Close

Rex Varona of AMC synthesized the three-day Conference by first stressing the importance of advocates being aware of the main actors involved in MHR advocacy: who is the target or audience of the advocacy and the intended clients or beneficiaries. Planning and assessing one's advocacy process, including understanding its impact and how to attribute advocacy results, would help towards more successful outcomes. Even more important to successful advocacy is the legitimation and participation of migrant workers as self-advocates. Migrant workers themselves fully comprehending their rights and participating in the fight against violations (as individuals and collectively) is crucial in the process of MHR advocacy. Efforts to build the capacity of migrant workers in conducting advocacy need to be stepped up to support this process. On a broader level, participants had also expressed the need to develop, improve and increase advocacy efforts and to develop more effective coordination between the grassroots, national, regional and international levels.

RCM participants meet with officials of the Indonesian Ministry of Manpower and Labour in Jakarta to lobby them to ratify the UN Migrants' Convention and stop the building of a migrant-specific Terminal 2 of Soekarno Hatta International Airport.

Mr. Varona also summarized some existing limitations to conducting effective advocacy that had been expressed by participants during the Conference. The limitation of financial and human resource to conduct advocacy and lack of systematic and comprehensive circulation of information, experiences and documentation on MHR issues and agendas were among the key issues.

During the final session, participants expressed the need to improve regional coordination and networking, including the development of joint, regional plans and agenda, to facilitate migration advocacy. The Conference closed with participants' declaration of commitment to the Conference's national, regional and international advocacy agenda. Participants came to a common agreement to take action in response – either at the organizational or at the network/regional level – to the "Recommended Advocacy Issues" of the 7th RCM. They agreed to pass on these recommendations to the MFA General Forum so that the network can strategize and advise on how the recommendations can be incorporated into a systematic "MFA Plan of Action". The MFA Regional Coordinator can coordinate between the network and non-network members present at the 7th RCM to ensure subsequent follow-up of these recommendations for the promotion of national, regional and international advocacy on migrants human rights.

After the conference, the members joined hands with the Indonesian migrant advocates and sent a joint delegation to meet with officials of the Indonesian Ministry of Manpower and Labour in Jakarta to lobby them to ratify the UN Migrants Convention and stop the building of a migrant-specific Terminal 3 of Seokarno Hatta International Airport. Both these issues were on the joint advocacy programme and it was felt that as so many members of the MFA were present on Indonesia together, some topical and local action should be undertaken to further migrant advocacy.

RCM participants meet with officials of the Indonesian Ministry of Manpower and Labour in Jakarta to lobby them to ratify the UN Migrants' Convention and stop the building of a migrant-specific Terminal 2 of Seokarno Hatta International Airport.

Recommended Advocacy Issues
As approved by the Conference Plenary
16ht June 2001; Jakarta, Indonesia

Note: Due to the particular needs and situation in each country, the following represents the range of advocacy issues, objectives and strategies recommended b migrant advocates in Asia. Each advocacy group will undertake only those issues relevant and applicable to it. Though many of the advocacy issues must be undertaken at the national level, these issues can be linked to international advocacy through reference to international instruments (e.g., the Migrants Convention) and conference declarations (e.g., WCAR Programme of Action).

Advocacy Issues	Countries Involved	Advocacy Level	Target(s) of the Advocacy	Objective(s)	Expected Result (s)	Strategies/ Tactics/ Approaches
Migration Laws and Policies	**Migration Laws and Policies**	**Migration Laws and Policies**	**Migration Laws and Policies**	**Migration Laws and Policies**	**Migration Laws and Policies**	**Migration Laws and Policies**
Better legislation for the rights, dignity and welfare of migrant workers	All	National; regional	Policy-makers	To sensitize policy-makers on the need for legislation consistent with international human rights standards	*Adoption of national protection laws for migrants consistent with international HR standards; *Improved pre-departure orientation	Tri-media, education, dialogue and consultations of government, alliance building among NGOs, POs and trade unions
Bilateral agreements; deployment of labour attaches		National; regional	Host/sending countries, particularly where there are few/ no migrant support groups, e.g., the Gulf States	Protection of migrant workers' rights	*Protection based on international labour and human rights standards	Lobby, dialogue, tri-media, education, seminar/workshop/ consultation/IOM/ SAARC
Undocumented migrant workers	All (especially Indonesia)	National; regional	Policy-makers (sending and receiving)	Promote regular migration	*Legal protection for undocumented migrants; legislation, amnesty of undocumented migrants; *Adoption of more democratic/legal/ documentation regimes consistent with international HR standards	Demonstration, media campaign, survey and study

Advocacy Issues	Countries Involved	Advocacy Level	Target(s) of the Advocacy	Objective(s)	Expected Result (s)	Strategies/ Tactics/ Approaches
Employment contract for migrants	All	National; regional	Employers; government	Promote contracts that protect migrants' rights	*Standardization based on international standards; *End contract violations, including underpayment	
Discriminatory policies, laws against migrants (e.g., 2-week rule)	Hong Kong	National; regional	Policy-makers, employers, recruiters	Abolish the discriminatory policies and laws		Survey, fact sheets, position papers, lobby
Trainee system and similar pseudo-employment schemes	Korea and Japan	National; regional	Government policy-makers, employers, small business federations, migrants	To abolish the system; recognize them as workers		Lobbying, rallying, white paper, migrants' human rights
Basic Migrants' Human Rights (MHR) Violations						
Social services/ security for migrants (medical care, retirement, education, housing)	All	National; regional	Policy-makers (sending and receiving), recruitment agencies	Enact law providing for more comprehensive social security/benefits for MWs		Fact sheets, lobby parliament, migrants speak out; dialogue, tri-media, education, seminar/workshop/ consultation
Migrants' health and safety (occupational, reproductive, physical, psychological, etc); compensation for MWs/families in case of death/ injuries	All	National; regional	Policy-makers (sending and receiving)	To provide more comprehensive, death/injury benefits for MWs; extend this to MW's families		Lobby, dialogue, tri-media, education, seminar/workshop/ consultation
Migrants in life-threatening situations (e.g., execution)	All			Campaign to release or save the migrant	*Launch campaigns for specific cases when known	Tri-media, poster and signature campaign, dialogue, lobbying prison visit; petition letter, government delegation

Appendix 1

Advocacy Issues	Countries Involved	Advocacy Level	Target(s) of the Advocacy	Objective(s)	Expected Result (s)	Strategies/ Tactics/ Approaches
Siti Zaenab campaign	Indonesian and international community	National; regional; international	Indonesia and KSA government	Intensify campaign for release of Siti Zaenab	*Justice and pardon for Siti Zaenab; release from jail	Tri-media, poster and signature campaign, dialogue and seminars, lobbying, prison visit to Siti; petition letter, government delegation, broad campaign front including trade unions
Voting rights of migrants (in home country)		National	Governments	To recognize migrants' voting rights and create effective mechanisms for such		
Migration Process						
Brokers and intermediaries	All (especially Korea, Japan, Taiwan, HK, Philippines, Sri Lanka)	National; regional	Policy-makers; government of both sending and receiving countries; employers	Abolish the practice		Survey, fact sheets, position papers, lobby, dialogue, alliance-building between NGOs and Pos, tri-media
Recruitment agencies	All (especially Indonesia, Bangladesh, India)	National; regional	Government; recruitment agencies		*Regulation or abolition of agencies *Making agencies liable for abuses on migrants *Stop excessive agency fees	
Corrupt, abusive, discriminatory practices at control points (e.g., airport, customs)	Indonesia	National; regional	Government; recruitment agencies	Stop such practices	*Abolition of Terminal 3 in Soekarno Hatta Airport	Dialogue, lobby, allies building between NGOs and Pos, tri-media

Advocacy Issues	Countries Involved	Advocacy Level	Target(s) of the Advocacy	Objective(s)	Expected Result (s)	Strategies/ Tactics/ Approaches
Migrant reintegration, savings and social enterprises, socio-economic alternatives	All	National; regional; international	Policy-makers (sending and receiving)	To advocate for reintegration and socio-economic programmes for migrants		Lobby, dialogue, tri-media, education, seminar/workshop/ consultation
Recognition of the Positive Role of Migrants						
Recognition of lower status migrants as workers, expecially FDWs, caregivers, au pairs, etc.; Recognition of labour rights	All	National; regional	Governments; policy-makers, media, general public	Advocate for recognition of their rights	*Laws/policies recognizing these workers rights as workers; *They are able to exercise their basic labour and human rights based on international standards	
Designation (by national governments) of December 18 as International Migrants' Day	All	National; regional	Governments; policy-makers, media, general public	To advocate for governments to declare Dec. 18 as International Migrants' Day	*Use this opportunity to highlight ratification *Suggest that MFA spearheads this as a specific objective/ campaign for 2001	
Sub-regional Advocacy Agenda						
Common regional migration policy for SAARC countries; work permit system for migrants in SAARC countries	South Asian countries	National; sub-regional	Policy-makers, SAARC secretariat, NGOs, migrant support groups	For migrant groups, NGOs, trade unions, advocates to study or develop proposals for common regional migration policies for the SAARC region (including concept of standard work permit) that promotes migrant human rights		Consultation of NGOs to discuss and draft proposals on the work permit system, submit a draft proposal to SAARC secretariat, dialogue of individual governments to adopt the system

Advocacy Issues	Countries Involved	Advocacy Level	Target(s) of the Advocacy	Objective(s)	Expected Result (s)	Strategies/ Tactics/ Approaches
Rights and problems of migrants in the Mekong region				Advocate for more effective actions and responses on migrants' issues / problems in the Mekong region	*Gather and circulate basic info *Sensitize relevant governments, advocates about these problems *Propose responses, strategies	
Rights and problems of Asian migrant workers in the Gulf region				Develop more effective strategies in addressing migrants' issues, including advocacy and recognition of human rights groups in the Gulf	*Recommend that MFA creates a task force to coordinate/ take charge of advocacy in the Gulf *More systematic or coordinated response from advocates across Asia *Ask UN and international human rights groups to monitor migrants' situation in the Gulf	
International Advocacy						
1990 UN Convention for the Protection of the Rights of All Migrant Workers and Members of Their Families	All	National; regional	Governments (sending and receiving countries)	Ratification		Lobby, campaign, demonstration, education, dialogue; target BA, IO, NP to ratify
World Conference Against Racism (WCAR) – governmental meeting process and NGO parallel process	All	National; regional; international		Strengthen migrant intervention in WCAR process		

Advocacy Issues	Countries Involved	Advocacy Level	Target(s) of the Advocacy	Objective(s)	Expected Result (s)	Strategies/ Tactics/ Approaches
Rights and problems of migrants in the Mekong region				Advocate for more effective actions and responses on migrants' issues / problems in the Mekong region	*Gather and circulate basic info *Sensitize relevant governments, advocates about these problems *Propose responses, strategies	
Rights and problems of Asian migrant workers in the Gulf region				Develop more effective strategies in addressing migrants' issues, including advocacy and recognition of human rights groups in the Gulf	*Recommend that MFA creates a task force to coordinate/ take charge of advocacy in the Gulf *More systematic or coordinated response from advocates across Asia *Ask UN and international human rights groups to monitor migrants' situation in the Gulf	
International Advocacy						
1990 UN Convention for the Protection of the Rights of All Migrant Workers and Members of Their Families	All	National; regional	Governments (sending and receiving countries)	Ratification		Lobby, campaign, demonstration, education, dialogue; target BA, IO, NP to ratify
World Conference Against Racism (WCAR) – governmental meeting process and NGO parallel process	All	National; regional; international		Strengthen migrant intervention in WCAR process	*Strengthen the existing Asia-Pacific migration NGO advocacy within the WCAR process *Advocate for "gap	

Appendix 1

Advocacy Issues	Countries Involved	Advocacy Level	Target(s) of the Advocacy	Objective(s)	Expected Result (s)	Strategies/ Tactics/ Approaches
					issues" (identified at Jakarta RCM) to be included into the WCAR Governmental Plan of Action *Step up ratification campaign on Bangladesh, Indonesia and Nepal coinciding with the WCAR processes	
For further study						
Migrant sex workers	Taiwan, Korea, Japan, Hong Kong	National; regional	Women's groups, migrants' groups	Protection of basic human rights		Dialogue, consultation, undertake studies
Residency rights of migrants						

Appendix 2

List of Participants

	Name	Organization	Country
	Secretariat / Organizer		
1	Bien Molina	Asian Migrant Center (AMC)	Regional
2	Rex Varona	AMC	Regional
3	Sajida Ally	AMC	Regional
4	Nurul Qoiriah	AMC	Regional
5	Avic Ilagan	AMC	Regional
6	Willie Descalzo	Migrant Forum in Asia (MFA)	Regional
7	Carla June Natan	Center for Indonesian Migrant Workers (CIMW)	Indonesia
8	Mr. Singgih	CIMW	Indonesia
9	Tiur	CIMW	Indonesia
10	Hera	CIMW	Indonesia
	Participants		
11	Naoto Higuchi	National Network in Solidarity for Migrant Workers (NNSMW)	Japan
12	Nanako Inaba	NNSMW	Japan
13	Ahn Seong Geun	Joint Committee for Migrant Workers in Korea (JCMK)	Korea
14	Lee Wan	Buchon Migrant Workers' House (BMWH) / JCMK	Korea
15	Kim Mi Sun	Medical Mutual Aide Union for Migrant Workers in Korea (MUMK) / JCMK	Korea
16	Chou Eui Pai	JCMK	Korea
17	Lee Choul Seoung	Migrant Workers' Counseling Office /JCMK	Korea
18	John Huang	Hope Workers Centre (HWC)	Taiwan
19	Mayan Villalba	Unlad Kabayan Migrant Services Foundation	Philippines
20	Inday Canete	Unlad Kabayan Migrant Services Foundation	Philippines
21	Saiful Syed Haque	Welfare Association for Repatriated Bangladeshi Employees (WARBE)	Bangladesh
22	Viola Perera	Women Media Collective / Action Network for Migrant Workers (WMC – ACTFORM)	Sri Lanka
23	H.M.K.P. Heart	Sri Lankan Bureau for Foreign Employment / ACTFORM	Sri Lanka
24	David Soysa	Migrant Services Centre (MSC)	Sri Lanka
25	Ashim Roy	Center for Education and Community Development	India
26	Salma Safiri	Solidaritas Peremouan (SP)	Indonesia
27	Meera Samanthar	Women's Aid Organization (WAO)	Malaysia
28	Sujita Shakya	All Nepal Women's Association (ANWA)	Nepal
29	Pui Hongyan	Yunnan Academy of Sciences (YAS)	Yunnan

Appendix 2

	Name	Organization	Country
30	Aewa Kim	Asian Monitor Resource Centre (AMRC)	Hong Kong / Regional
31	Amy Yeung Oi Mei	Asian Regional Exchange for New Alternatives (ARENA)	Hong Kong / Regional
32	Raynah Pasanhah	Middle East Council of Churches (MECC)	Middle East
33	Lori Brunio	Forum for the Filipino Reintegration and Savings Group / Coalition for Migrants' Rights (CMR)	Hong Kong
34	Wahyu	CMR	Hong Kong
35	Nur Safina	Indonesian Migrant Workers Union (IMWU)	Hong Kong
36	Ria	IMWU	Hong Kong
37	Sri	IMWU	Hong Kong
38	Carrie Tharan	International Organization for Migration (IOM)	Philippines
39	Ms. Lely	Canadian Human Rights Foundation (CHRF)	Indonesia
40	Fr. Paulo Prigot	International Catholic Migration Philippine Commission (ICMC)	Philippines
41	Barbara Porter	International Catholic Migration Indonesia Commission (ICMC)	
42	Marilou Suplido	International Catholic Migration Thailand Commission (ICMC)	
43	Jean D'Cunha	UNIFEM	East and South-east Asia
44	Margaretha	YMCA Salatiga	Indonesia
45	Sarah	SP	Indonesia
46	Wahyu	KOPBUMI	Indonesia
47	Khairul Alam	WARBE	Bangladesh
	Observers		
48	Devi Novi	PPPM	Indonesia
49	Esra	CIMW	Indonesia
50	Guntur	CIMW	Indonesia
51	Buti Wivawa	SBPY – Yoga	Indonesia
52	Richel Durrin	International Press Services	International
53	Ika Inggas	ACUS O with soldiers. ACILS – Solidarity bottle	International
54	Titin	Damar – PPP migrant	Indonesia

8th Regional Conference on Migration

"Migration and Migrant Workers' Health & Well-Being: Trends, Issues, Needs and Strategic Responses"

October 8-11, 2002 Dhaka, Bangladesh

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introduction

History of the Regional Conference on Migration (RCM)

The Regional Conference on Migration (RCM) is a regular conference that has been co-organized by the Migrant Forum in Asia (MFA), a regional network of migrant workers' unions, associations, support NGOs and advocates, and the Asian Migrant Center (AMC), a Hong Kong based regional migrant support NGO and an MFA founding member. The RCM has been a forum for analyzing trends, problems and issues pertinent to labor migration in Asia. It is a venue for identifying appropriate strategic responses as individual organizations and as MFA members together with other migration experts. It is different from other meetings/conferences on labor migration in that the principal voices heard are those of organized migrant workers themselves; and of those non-government organizations in the mainstream of promoting and asserting Asian migrant workers' rights and interests in various labor sending and receiving countries in the region. It also draws in the participation of migrant rights' advocates from the academe and international organizations.

Rationale for the 8th Regional Conference on Migration: The Challenge of Ensuring Migrant Workers' Right to Health and Well-being

Today, more than 15 million Asians work in countries other than their own. Even though migration has provided migrants with some level of economic and social upward mobility, labor migration has largely been characterized by deplorable conditions and circumstances. Migrant workers face multiple vulnerabilities. They are also subject to dualistic policy regimes that on one hand, encourage permanent or temporary residence of foreign professionals (referred to as expatriates, not migrants), but on the other hand refuse residency permits even temporary to economically necessary, low status, blue-collar migrant workers, thereby forcing them to become undocumented. Both the prevalent policy environment in Asia and the job types that migrants are pushed into: menial, low-paying, informal, physically demanding – leave migrants with limited or no recognition and protection of their basic human rights. Shifting policy environments, such as the intensified containment and control of migrants since September 11, 2002, intensified the use of migrants as scapegoats for social disorder, security problems and economic recessions.

Coupled with homesickness, the current situation of migrant workers in Asia, not surprisingly, has adversely affected their physical and psycho-social health and well-being. Studies have found a high incidence of mental illness, and job related accidents due to employers' failure to comply with safety standards resulting to workers' physical disability and even death. Unsafe workplaces have also led to migrants contracting lifelong (and in some cases, fatal) medical conditions such as the Stevens' Johnson Syndrome. Long hours involving physically strenuous work have also led to various ailments, e.g. enlargement of the heart, hypertension etc. Loneliness and the need for affirmation and attachment can predispose women and men migrants to enter into intimate relations, often without protection, thereby increasing risks of contracting HIV virus.

As the number of women migrant workers has been steadily increasing since the late 80's, the toll migration has taken on their health and well-being must be recognized and addressed. Women are pulled into migration partly due to the preference and demand for them in feminine, gender-stereotyped occupations such as domestic work, care giving and entertainment. The said occupations are often outside the coverage of social and labor laws thereby putting women at risk to abuse, violence and exploitation by recruiters, employers, and even by state functionaries. Gender-based forms of violence such as rape are prevalent. They damage not only women's bodies but their psyche and self-esteem as well. Post trauma stress disorder is one consequence. In many cases, violence has led to death.

In receiving countries such as Malaysia, Singapore, Thailand and Taiwan, women migrant workers are subjected to regular, mandatory pregnancy and HIV-Aids testing. If results are positive, the workers are summarily deported to their country of origin.

Because they are migrant workers in the lowest rung of the occupational hierarchy, because they are women whose labor is undervalued, and because they are undocumented, women and men migrant workers have limited, if not zero access to health information and services, and other social services in receiving coun-

tries. Employers fire them when they get sick or incapacitated. In their countries of origin, returned workers are also without any social security coverage, leaving them and their families in dire straits.

Amidst this situation, it is imperative for migrant workers and their advocates to take up the challenge of ensuring workers' right to health and well-being while simultaneously fighting against ongoing, critical concerns. It is crucial to analyze the range of issues related to health and well-being, and to strategize how migrants, non-government organizations, government and other actors can and/or should respond. Migrant Forum in Asia responded to this challenge by dedicating its 8th Regional Conference on Migration to be the venue to discuss the issues and needs of migrant workers, trends in migration and formulate strategic responses.

II. MIGRATION and MIGRANT WORKERS' HEALTH and WELL BEING: *Trends, Issues, Needs and Strategic Responses*

THE 8TH REGIONAL CONFERENCE

Regional (Asia) Conferences on Migration in Chronological Order

RCM	DATE	PLACE	THEME
1st RCM	May 1994	Hsinchu, Taiwan	Living and Working Together with Migrant Workers in Asia
2nd RCM	January 1995	Bangkok, Thailand	Asian Women Prepare for Beijing 1995
3rd RCM	August 1996	Seoul, Korea	Migrant Workers Challenging Global Structures
4th RCM	February 1998	Tao Fong Shan, Hong Kong	Regional Lobbying and Documentation Training on Migrants' Human Rights
5th RCM	December 1998	Quezon City, Philippines	"Rights and Roots" Campaign and Migrant Reintegration (Migrant Savings for Alternative Investments)
6th RCM	March 2000	Chiang Mai, Thailand	A Decade of Empowerment: Reviewing and Building Gains, Lessons, Concepts and Joint Struggles
7th RCM	June 2001	Yakoma-PGI, Jakarta Indonesia	Developing National and Regional Advocacy Agenda on Migrants' Human Rights
8th RCM	October 2002	Dhaka, Bangladesh	Migration and Migrant Workers' Health and Well-being: Trends, Issues, Needs and Strategic Responses

The history of the regional conference on migration (RCM) in Asia is closely link with the history of Migrant Forum in Asia (MFA). It was during the first regional conference on migration held in Taiwan in 1994 that MFA was formally formed. MFA was established by migrant workers' rights' advocates as the mechanism to coordinate and monitor the implementation of the conference recommendations. From being an offshoot of a regional conference, MFA became the prime mover together with the Asian Migrant Center (AMC) of the subsequent regional conferences on migration in Asia.

The confounding factors of discriminatory environment, exploitative work condition, homesickness and lack of support systems adversely affected migrant workers health. As non-nationals of the country where they are working they are not entitled to fully access the health system of the country they are in. Irregular migrants attempting to access the public health care system expose themselves to deportation or detention. Women migrant workers whose number have increased since the 80s are more vulnerable to psychosocial, physical and economic abuse, which put a toll on their health. Sick workers who chose to return to their country of

origin also find themselves without the resources to allow them to rehabilitate. This reality prompted the advocates to devote the 8th Regional Conference on Migration to discuss issues, trends, needs and strategic responses towards migrant workers' health and well-being.

Made possible through the support of Ford Foundation-Philippines and the cooperative efforts of MFA, AMC, and the Welfare Association for Repatriated Bangladeshi Employees (WARBE), the 8th Regional Conference on Migration aimed to:

1. Conduct a critical mapping of the current health and well-being situation of women and men migrant workers in Asia;
2. Develop a gendered and rights –based understanding and framework for analysis on migration and migrant workers' health and well-being;
3. Identify practical and strategic health needs of migrant workers, specially of women, on-going initiatives to respond to them, and existing gaps in responses;
4. Cull out current good practices in promoting migrant workers' health and well-being in migrant – sending and receiving countries.

CONFERENCE HIGHLIGHTS

Inaugural Ceremony

The 8th RCM formally opened with the inaugural ceremony presided by Dr. Hameeda Hossain, chair of the conference. Dr.Hossain welcomed the guests and participants and expressed his appreciation to the host organization (WARBE) and the organizers of the conference (MFA and AMC).

Greetings from the Organizers

Mr. Anisur Rahman Khan representing the host organization, WARBE, expressed pride in hosting the conference and formally welcomed all participants to the conference.

Ms. Niña Espinola of MFA welcomed the participants and introduced MFA's programs and geographical scope of its member organizations for the benefit of the non-members of the network who attended the conference. She was followed by Ms. Sajida Ally of AMC, the co-organizer of the conference who provided the overview of the conference. Ms. Ally also explained the conference objectives and processes. She reiterated the importance of addressing the issue of health, which had become a 'marginalized' issue in the past conferences amidst the myriad other problems migrant workers face. Ms. Carrie Sri Tharan of Ford Foundation, Philippines also reiterated the importance of the conference in the life of the migrant workers in Asia and expressed Ford commitment to the cause of migrant workers. The conference is the concretization of this commitment.

Bangladeshi students rendering a dance to welcome participants to the 8th RCM at the inaugural ceremony

Introduction of Participants

The 8th RCM gathered together 70 participants from 47 organizations from 13 Asian countries. International organizations and networks were also represented. Asian countries represented were: Bangladesh, Dubai, Hong Kong, India, Indonesia, Japan, Nepal, Pakistan, Philippines, South Korea, Sri Lanka, Taiwan, and Thailand. International organizations represented were: Ford Foundation, Migrants Rights International, United Nations Development Fund South East Asia HIV and Development Programme, International Labor Organizations and International Organization for Migration.

Keynote Address

Mr. Shahudul Haque, Director General of the Bureau of Manpower, Employment, and Training (BMET) was the keynote speaker for the 8th RCM. He first slated the projects and activities of BMET, among others, the registration of ¼ million returnees, granting licenses and drafting legal and administrative measures. Mr. Haque narrated the sad plight of Bangladeshi migrant workers, particularly the women, who are mostly employed as domestic workers in Pakistan and other countries in the Middle East and Asia. He outlined the responses of the Bangladeshi government to the situation in which a framework for workers protection and awareness raising had been used. The BMET has also been mainly involved in protecting the welfare of the women migrant workers. BMET is concerned about migration process and the problems they face, including health.

Mr. Haque noted that the definition of health and well-being of migrant workers remains ambiguous. According to him there is still no consensus on the primary component of well-being. Many take 'well-being' and 'health' as a fluid concept. Migrant workers have no or limited access to health care in their state of employment due to problems of discrimination, xenophobia, and exploitation, which are compounded by language and cultural differences. Mr. Haque also lamented that migration control and health screening no longer effectively address migrants' health. He recommended a rapid and efficient system to address the issue of health and well-being of migrant workers.

Special Messages from Guests

Dr. Rita Afsar, Director of the Bangladesh Institute of Development Studies shared a study of Bangladeshi migrant workers. The study participants were workers who were preparing for migration. The study, however, was complemented by secondary data. According to Dr. Afsar, of one million workers migrating each year from South Asia to the Middle East, Bangladeshi immigrant workers stand at 3.24 million (between 1976 and 2001) and they remitted US $2 billion. Dr. Afsar laid down several statistical data showing the current situation of migrant workers in Bangladesh, highlighting the fact that women earn less than men and there is wide discrepancy between contract conditions promised and the actual situation. The working conditions of migrant women workers are tight; there is no clean water, no sanitation, there is a high incidence of sickness (around 20%) including gastro-intestinal diseases, jaundice and skin diseases. There is approximately one incidence of death per day plus a high rate of suicide. She suggested a review of policies of labor exporting countries, a more efficient welfare service system, and networking with developed and developing countries with regard to Bangladeshi migrants.

Dr. Afsar, enumerated the recommendations of the study on Bangladeshi migrant workers:

1. Opening of "a help widow" at the International Airport for Bangladeshi labour migrating abroad to check their visa status, employment contract, possession of a bank account, etc., in order to save them from undue harassment, which they often experience at the airport;
2. Registration service for migrant workers to be establish by the Bangladeshi diplomatic mission in receiving countries;
3. Government lawyers will be deployed in labour receiving countries;
4. Tenure of existing Bangladeshi Diplomatic Mission in the GCC should not be renewed;
5. Government should underscore the legal protection of workers in the non-corporate sector of the bilateral agreement.

In response to the talk of Dr. Afsar, Mr. Haque of BMET added several recommendations as part of its effort to address the problem of healthcare for migrant workers. He emphasized the need for Bangladesh to forge networks with both developing and developed countries. The government of Bangladesh should exert pressure on countries of destination to review and adopt appropriate measures to prevent the excessive use of force and ensure that police forces and competent migration authorities comply with international conventions of ILO and UN relating to the decent treatments of migrant workers and their families.

Mr. Md. Dalid Uddin Mondal, Secretary-in-Charge, Ministry of Expatriates' Welfare and Overseas Employment spoke of the need to look at health and well-being on the context of its relation to broader issues, such as broader health care services. He challenged governments of migrant workers' countries of origin to address unemployment, the main reason for migration.

Regional Overview and Framework for Analysis: Migrants' Health & Well-being Rights & Issues

With Ms. Raynah Bragganzah as facilitator, discussion on the regional overview and framework for analysis of the conference started with the aim of synthesizing the views of the participants and setting up a framework for concepts on migration issues, especially gender and rights.

Mr. Choi from JCMK took off his overview of the workers' health problems from the World Health Organization's definition of health as "not merely the absence of disease infirmity but the state of mental, physical and total well-being of the individual." He illustrated the connection of the problems experienced by the migrant workers to their state of well-being.

PROBLEMS	CONSEQUENCES
Poor working conditions including long working hours, no safety measures	Industrial accidents, work related diseases
Low wages limited to minimum living cost	Ill balanced nutrition/malnutrition
No access to health information	No proper treatment
Difficulties in communication at medical institutions	Can not explain health state or disease
No maternity protection	Bad health conditions of women and children
Mandatory medical testing of pregnancy, HIV etc.	Forcible deportation
No health insurance for undocumented migrants High medical cost	Self-medication, develop diseases
Sexual, mental and physical abuses	Emotional and psychological trauma
Different social status, exploitation, working in 3D jobs	Loss of dignity, self-respect

Genevieve Gencianos of Migrants Rights International explaining the different frameworks & strategies on advancing migrants workers' health.

According to Mr. Choi, migrant workers' health care needs emerged from their living environment, working conditions, psychological state and human relations. Therefore, to solve the health and well-being problems of migrant workers, provision of medical services are not enough but their social and economic opportunities should be expanded. Ms. Upuma, Program Officer in Nepal spoke of women's issues and advocacy for health, discrimination and other concerns of migrant women workers. Ms. Upuma noted that gender-based discrimination is a big problem for migrant women, also feminization of migration. She described the major health problems of migrant women as psychological, i.e. depression, stress, loneliness, malnutrition, workplace dangers such as chemicals in factory, reproductive health problems and physical health.

Ms. Genevieve Gencianos, Migrants Rights International, Coordinator of International Networking and Advocacy to Protect/promote Rights of Migrant Workers, outlined the different international instruments that migrant workers can invoke and refer to when seeking redress for violations of their rights and in advancing their right to health.

Personal Experiences of Migrant Workers

She experienced how hard it was to have multiple jobs but worst because the money that she earned was not even enough for the needs of her family.

Migrant workers are not just statistics but real people. This fact was attested by Ms. Ma. Socorro dela Cruz (Philippines), Mr. Khan Kalabaw-no-Kai (Japan/ Bangladeshi), Ms. Ranjani, ACTFORM (Sri Lanka) Ms. Dewi Lestari, Indonesian Migrant Workers Union – IMWU/Coalition for Migrants' Rights – CMR (Hong Kong/Indonesia). The three are migrant workers who had to suffer the pain of being far from their families and home. They also experienced in different ways abuse, harassment or unfair treatment in countries where they work. Ms. Dewi Lestari shared the fate of the Indonesian migrant workers in Hong Kong.

"Being a woman is hard enough, plus being a wife and mother of six children," lamented Ma. Socorro dela Cruz from the Philippines. She experienced how hard it was to have multiple jobs but worst because the money that she earned was not even enough for the needs of her family. Her husband became a drug dependent. She has been trying to convince him to stop but without success. In the face of that situation, she decided to work abroad despite the objections of her family. It was hard to be away from her children. Her first year as a migrant worker was very difficult. She had difficulty in adapting to the community of people she served. Her employer made sexual advances to her and she tried to run away. The family convinced her to stay. It was her fondness for the children of her employer however that was instrumental for her decision to finish her contract. Meanwhile, she received news that her children back home were dropping out of school, marrying young, and engaged in trouble. She realized that there she was trying to plan for the future, "building dreams" and that was what she got. In several correspondences her mother convinced her to go back home, so she did. Her husband still was deeply addicted to drugs. She became frustrated that she decided to work overseas again, this time with a different employer. After sometime with her new employer she attempted to run away again because they locked her up every time they leave the house. She was also being shouted at. Luckily her friends helped her get a new job. The agency sent her a to new employer in another country. The new job however was more difficult: She was working with a big family in big houses with naughty children who did not show her any respect. They shouted at her, especially because they could not communicate with her well in English. She ran away for the third time and went to cross the border to Lebanon. In transit she was raped, her identification papers were taken; she was beaten and detained by authorities. When she tried to leave they kicked her, she felt like an animal. She found another employer but was beaten again. She was accused of something she didn't do. She developed allergies because of chemicals in laundry detergent. She approached her previous recruiter to complain. She was referred to a non-government organization, which helped her. She was given shelter and she became involved in the activities of the organization. She underwent the healing process and survived her experience. She still wanted to go out of the country to work again.

She decided to work in Lebanon in order to send her children to school and be able to build a house.

Ms. Ranjani came from Sri Lanka. She is a mother of two and her husband is unemployed. She decided to work in Lebanon in order to send her children to school and be able to build a house. She had to work as a domestic helper; cleaning, taking care of the kids, waking up at 4 a.m., cooking, with no day off and worst with no salary. When she asked her employer for her salary, the mistress kicked her and assaulted her. She told her she could not be rescued; she was all alone and she would be killed if she tried to escape. Six months later and no payment still, the same thing happened when she asked to claim her wages. That night, she ran away from the house, a gentleman gave her some money and helped her escape. She went to the police station. They helped her and she was taken to the embassy. There she was directed to a Sri Lankan safe house run by the Sri Lankan embassy. A catheter was inserted to her during her stay. Later the doctor and the matron demanded money in exchange for the removal of the catheter. She didn't have anything except the dress she was wearing; so other women in the safe house removed the catheter without doctor- there was a pool of blood and she fainted. She was handed over to the security personnel who turned her to the to the matron… then she was taken to hospital, and given injections. From the hospital, she was sent to an agency in Lebanon in order to find some work but again they sent her to the doctor, then to the embassy. Finally, she was left with nothing. In the safe house she had no access to health care, not much food, she discovered women were sold to men. Women were for entertainment of men. She experienced sexual harassment and she feared that she might contract HIV/AIDS. From the safe house she discovered women were sent to prison. Some were tied up and harassed. Later she was sent to a hospital and sent back to Sri Lanka without compensation. In the safe house, she was raped. She strongly recommended the following:

(i) potential migrants should be educated on their rights and how to access help;
(ii) embassy staff needs training in handling cases of migrant rights violations;
(iii) proper insurance scheme for migrant workers;
(iv) rape victims should be compensated;
(v) networking among human rights group and solidarity among organizations in sending countries are needed to strengthen migrant workers' rights' campaigns;
(vi) domestic work should be recognized as work; domestic workers to be organized as laborers and given protection accorded to workers.

He met an accident while working and that started his problems. The company did not compensate him.

Mr. Khan Kalabaw–no-Kai is a Bangladeshi migrant worker who used to work in Japan. Married with a 6-year old daughter, he went to Japan to find a better work. He met an accident while working and that started his problems. The company did not compensate him. He talked with Mr. Karabukai and explained his problem. The company didn't have insurance he was told. Mr. Karabukai however vowed to help him access the insurance. He sought help again and somebody helped him to get compensation. In 2001, Japan's Ministry of Labor Welfare promised to compensate him. He was compensated but he could not be productive after the accident. His compensation however was not enough to cover his medical needs and he believes that he should be compensated for the loss of his ability to be productive again. Bangladeshi doctors suggested sending medical documents to the Ministry of Labor and Welfare in Japan in order to seek payment for the loss of his productive years. He sent appeal and the documents but has not received any response yet.

MAPPING of Migrant Workers' Health & Well-Being: Needs, Issues & Responses

After a brief introduction about the workshop by Ms. Sajida, the participants were divided into sub-regional groups (South Asia, Southeast Asia, East Asia). The main objective of the workshop was for each group to be able to identify and discuss the migrants workers' critical health & well-being problems, issues & practical/ strategic needs and the Government health policies (that prevent, inhibit, or facilitate the assertion of migrants' right to health & well-being) of sending/receiving countries.

Workshop Outputs

SOUTH ASIA

Each group presented the results of their workshop, starting with the participants from South Asia that summarized the critical health problems of migrant workers as malnutrition, overwork, no access to mental health (for both documented and undocumented), mental health, trauma, accidents, sexual harassment/abuse, broken health, and suicides. Other problems identified include illegal and exploitative recruiters, vulnerability, different health requirements, HIV/AIDS, unhealthy living and working conditions, inhumane treatment of diplomatic officials, contractual violations (all countries), trafficking/deception, family welfare and government focus on remittance. Main recommendation presented by South Asia was the need to change the attitude of people in the host countries so that there will be programs to respect the rights of migrant workers and no arbitrary laws will be enforced. The need to sensitize diplomatic officials on the rights of migrant workers was also cited and the formation of a Task Force to monitor the health situation of migrant workers' and members of their families.

SOUTH EAST ASIA

Participants from the Southeast Asia (Indonesia, Philippines and Thailand) noted that their problems and needs were no different from those presented by South Asia group, they therefore opted to discuss other issues. The group proceeded to discuss the medical policies and regulations of both sending and receiving countries. Medical policies and regulations were seen at two levels:

1. The level of diagnosis where migrant workers were subjected to medical examinations upon leaving the country of origin and upon embarking on the receiving country. The issue was not on the medical examinations per se but in the way these examinations were being handled. In most cases, there was a breached of confidentiality and migrant workers were stigmatized.
2. The level of access to medical resources and benefits by migrant workers in the receiving countries. Other concerns raised by the group were:
   (a) limited access of migrant workers to medical resources and benefits either due to lack of knowledge or because they are not entitled to free access;
   (b) Undocumented workers fear to avail of public health facilities and yet they cannot afford private health clinics making them vulnerable to precarious health situations;
   (c) the new policy of shipping companies which stipulates that seafarers are entitled to claim benefits for direct work related accidents or death (when seafarer died in his sleep during of duty inside the ship he can not claim employment compensation; the group contends however that even if the seafarer is asleep as long as he is inside the ship, he should be considered in duty);

(d) among the health problems of migrant workers, mental health problems are almost always overlooked even if migrant workers are vulnerable to these problems due to stress, abuses and other factors.

EAST ASIA

For the East Asia group, the lack of health insurance is a major problem for migrant workers more so for undocumented workers. Migrant workers are prone to malnutrition because often employers do not provide enough and good food. Occupational safety is also a problem; so many migrant workers get injured. Alcoholism, drug addiction, physical abuse and sexual violence (rape) were also mentioned as major health hazards for migrant workers. The group also stated a number of good and bad practices by receiving countries as follows:

1. Taiwan - there is health insurance, but mandatory health testing;
2. Korea - undocumented migrant workers can access small trainings but are generally excluded from public health services;
3. Japan - some local governments subsidize medical/hospital treatment if migrant workers are unable to pay but excludes them from the public medical insurance system;
4. Hong Kong -there is free legal aid for documented workers but discriminatory policies are present.

During the open forum, the issue of mandatory testing was taken up. The participant from Taiwan pointed out that they have stopped mandatory testing and pregnancy ban will be lifted in September. Another participant said that testing is not actually negative. The issue is that no one should be discriminated against. Hence they are not against testing but only against discrimination/stigmatization that pose a problem for migrant workers.

The Open Forum Capped Day 1 Activities

Mapping out Migrant Workers' health and well-being

- Discriminatory and restrictive laws on immigration and migrant workers
- Job insecurity and occupational hazards
- Harsh and slave-like working and living conditions
- Mental and psychological distress
- Violence against women
- Insensitivity of diplomatic officials from both sending and receiving countries
- Unhealthy working environment

DAY 2: October 10, 2002 Day 2 of the conference started at 9 in the morning with a recapitulation of the previous day discussions. Host organizers made some announcements after the recap. Thematic presentations that covered the issues of occupational health and reproductive health followed.

Thematic Presentations
A) On Occupational Health

The presentation of Mr. Sanjiv Pandita of the Asian Migrant Resource Center (based in Hong Kong) commenced with the breaking question: "What is occupational health?" He then presented the International Labor Organization's study that every year there are about 1.2 million workers who die from accidents or diseases at work. The figure can even be modest as reporting practices vary and are often unreliable. Ms. Sanjiv continued that there is an urgent need to know the different aspects of health and safety. She added that the hazards at the workplace could be grouped into 3 types: (i) physical (injuries, accidents, noisy place could affect hearing, high temperature), (ii) chemical, and (iii) biological. She lamented that despite the gross situation of migrants in the Asia Pacific with regards to occupational health and safety, legislations in various countries are not implemented. Although there exists legal remedies, most of them declarations of ILO conventions, the problem is "who implements?" Many of those who met occupational related accidents are not attended to, either because the government is not efficient, or because the workers themselves are reluctant to come out especially those who are undocumented as this could mean losing their jobs. Mr. Sanjiv concluded her presentation with a statement that ILO seems to be a paper tiger because its convention declarations have not done much on the ground.

Father Peter of the Hope Workers Center, in his report, laid down statistical indicators to show the situation of migrant workers in Taiwan. He pointed out the sad fact that caregivers, around 110,000, and domestic workers, around 10,000, are not recognized as workers in Taiwan. Among the health issues faced by migrant workers in Taiwan are psycho-social and mental health risks due to stress and loneliness, physical exhaustion and unsafe working conditions. Many women workers in factories have also been subjected to sexual and physical abuse.

Hope Workers Center responded to the problems of migrant workers in Taiwan by counseling, empowering the migrant workers through education sessions, and lobbying. Father Peter cited a notable initiative of the Hope Center, the Communication for Action on Labor Legislation (CALL) lobbying that have won gains to alleviate the situation of migrant workers in Taiwan. Moreover, through documentation on violations of migrant workers' rights, networking with other advocates and even with government people, and organizing the Occupational Health and Safety memorial day, Hope Workers' Center was able to call attention to the plight of migrant workers.

Met Tuico of the Coalition for Migrant Rights (CMR) and Asian Domestic Workers Union (ADWU) spoke of the situation of migrant workers in Hong Kong. Ms. Tuico cited a baseline research conducted by CMR last 2000, which revealed many cases of verbal and physical abuse, including sexual violence against migrant workers in Hong Kong; majority of them are domestic workers. She noted that most workers are under poor living conditions and are subjected to mental pressure and stress, have poor occupational safety, and are vulnerable to sickness such as stomach ulcers and kidney stones.

The CMR has pushed for several measures to improve the situation of the domestic migrant workers in Hong Kong like the standardized contract conditions, salary, insurance, and free legal aid

A case study about a Thai migrant worker in Taiwan was presented to the conference to give a picture of the real situation of migrant workers in the country. Thaka Sai, 28 years old went to Taiwan to work as caretaker but ended up as factory worker. After meeting an occupational accident, his employer refused to give any compensation but with the help of Hope Workers Center, he was able to force the employer to pay him. This experience made Thaka Sai realize it is unbelievable how employers violate migrant workers rights.

B) Reproductive Health & Sexuality

Ms. Carrie Tharan of the Ford Foundation presented an overview and framework on reproductive health. She apprised this topic as an extension of the definition of health and defined it as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. She asserted that reproductive health should be viewed as a human right and that it is no more and no less important than social and economic rights.

Ms. Tharan laid down the elements of sexual and reproductive rights, which was the product of a Philippine research group. The group compressed the 13 elements of reproductive and sexual rights into 4 principles of a feminist ethical perspective: bodily integrity, personhood, equality of access to services, and diversity. Ms. Tharan asked the question why migrant workers are vulnerable to abuse and suggested that looking at sexual abuses is one aspect of trying to understand this problem. She pointed out that the world has gradually come to realize that HIV/ AIDS can only be addressed by also addressing sexuality. The same case with the abuse of migrant workers. Sexuality is linked to women's rights, intersects with other human rights, and intersects with social discrimination.

Dr. Mari Marida of the Diabetic Association of Bangladesh, in her talk regarding perinatal care, stated that the definition of reproductive health includes many component, including reproductive health care. She outlined the migrant workers needs as prevention and treatment of STIs, family planning services, safe abortion services, infertility treatment and IEC on human sexuality. Dr. Marida also expressed concern over the fact that many undocumented workers prefer not to seek care for fear of being caught. She cited the data showing 50% of HIV/AIDS victims in Bangladesh are migrant workers. There is a need to strengthen the capacity of health care providers and the community regarding STIs and HIV and program managers need more orientation on how to carry out the program regarding sexual health. At the same, there should be a proper system and tools to monitor health care services delivery and this should be made accessible to migrant workers.

During the open discussion, the panel was asked by participants to elaborate on how to protect migrant workers on the aspect of reproductive health and sexuality. On the question of forced pregnancies, the panel reiterated the importance of prevention, meaning safe sex, and awareness raising of migrant workers. A participant pointed out that male sexuality should also be attended to as there are certain societies, for example, in India and Pakistan, where male sexuality situation is very oppressive. Ms. Tharan answered and agreed that male sexuality is a very important area and that we should definitely do more. There are support groups for men in the area of VAW, and for HIV/AIDS, they definitely bring men in order to change this.

C) Trafficking of Women and Children from Bangladesh

Mr. Shahidul Haque of the International Organization for Migrants spoke of the nexus between migration and trafficking. He noted that in focusing on migration and health, one needs to distinguish between documented and undocumented migrants. He asserted the link between trafficking and labour migration despite the confusion and ambiguities about migration-trafficking nexus. Mr. Haque mentioned that migration is a broad phenomenon, of which trafficking is a subset. There are typologies and interrelated causes of migration on a continuum from seeking opportunity to forced migration.

D) Medical issues of undocumented migrant workers in Japan

Ms. Aiko presented statistical data on migrant workers in Japan noting that only 15% of them have health insurance. Among the many problems faced by undocumented migrant workers in Japan are high medical cost, language barriers, and lack of information. Many have also avoided treatment for diseases such as AIDS, TB and other contagious diseases.

The responses proposed by Ms. Aiko were the provision of medical insurance for all, access to interpreters, education and medical information, free check-up and consultation to help prevent disease transmission. She cited the Minatomachi Medical Center which have responded to the problem by linking with NGOs and international groups.

E. Issues & response for migrants in detention and deportation process

Professor Rajmah of the Mindanao State University in the Philippines narrated about the influx of deportees from Malaysia in Tawi-tawi and other areas in Mindanao. Health-related problems among these deportees were documented, which included limited access to health services (woman lost baby due to whipping), no protection of their basic human rights, physical abuse, malnourishment and pregnant women were denied maternity rights. The responses included collection of donations, prayer rally and community assistance while the national government remained inefficient in providing help. Professor Rajmah asked the question: what can we do to improve the health situation of the deportees and what extent have the government addressed in these problems?

During the open forum, it was clarified that TB is a disease related to working conditions. It was also pointed out that often migrants become scapegoats for bringing in the HIV disease. On the issue of trafficking, it was brought out that there is a debate on the policy level as some countries in the region (Europe) do not agree that migration is a human right. A participant also suggested that IOM/MFA send delegation to ask Bangladesh to ratify Migrant Rights convention and enforce it.

F) Health Issues of Families of Migrant Workers

Ms. Afsana Wahab of the Center for Women and Child in Bangladesh cited several cases showing the psychosocial effects of migration on the family of the migrant worker. Counseling facilities for the families should be installed. Ms. Wahab assailed that many well-educated people have devoted time to study the economic aspects of migration but failed to examine at the social costs. In Bangladesh, no study has been done on the social impact of migration. Ms. Wahab expressed hope that the conference will help participants formulate responses to the social problems caused by migration and which they can apply to their respective countries.

Questions and comments from the participants were welcomed on the floor. One commented that Bangladesh government could actually do quite a lot, such as keep a register of men working abroad and implement a monitoring program for the families while they are gone, then keep track when they returns and follows up after that. Social education, and not mere education related to literacy or mathematic skill, is what is needed to correct the problems revolving on the effects of migration on the family, for example, broken marriages.

G) Social costs of Migration and Long-term impact on Migrant and their families

Nellie Sotto of KAKKAMPI (Philippines)

Ms. Nelli pointed out that migration becomes an endless cycle in search of money in which one leaves to work abroad then spends his earning at home then leaves again to work abroad.

In the ensuing discussion, a participant commented that the weakening of the family can be viewed as both a cause and a consequence of migration. While migration does put pressure on marital relationships, it is also not fair to put full blame on it. Before thinking whether a family is weakening or disintegrating, we should learn about the decision-making process regarding the decision to migrate. There was a study which found that women gained more power in the family's decision-making process upon their return, so they had more power regarding controlling resources.

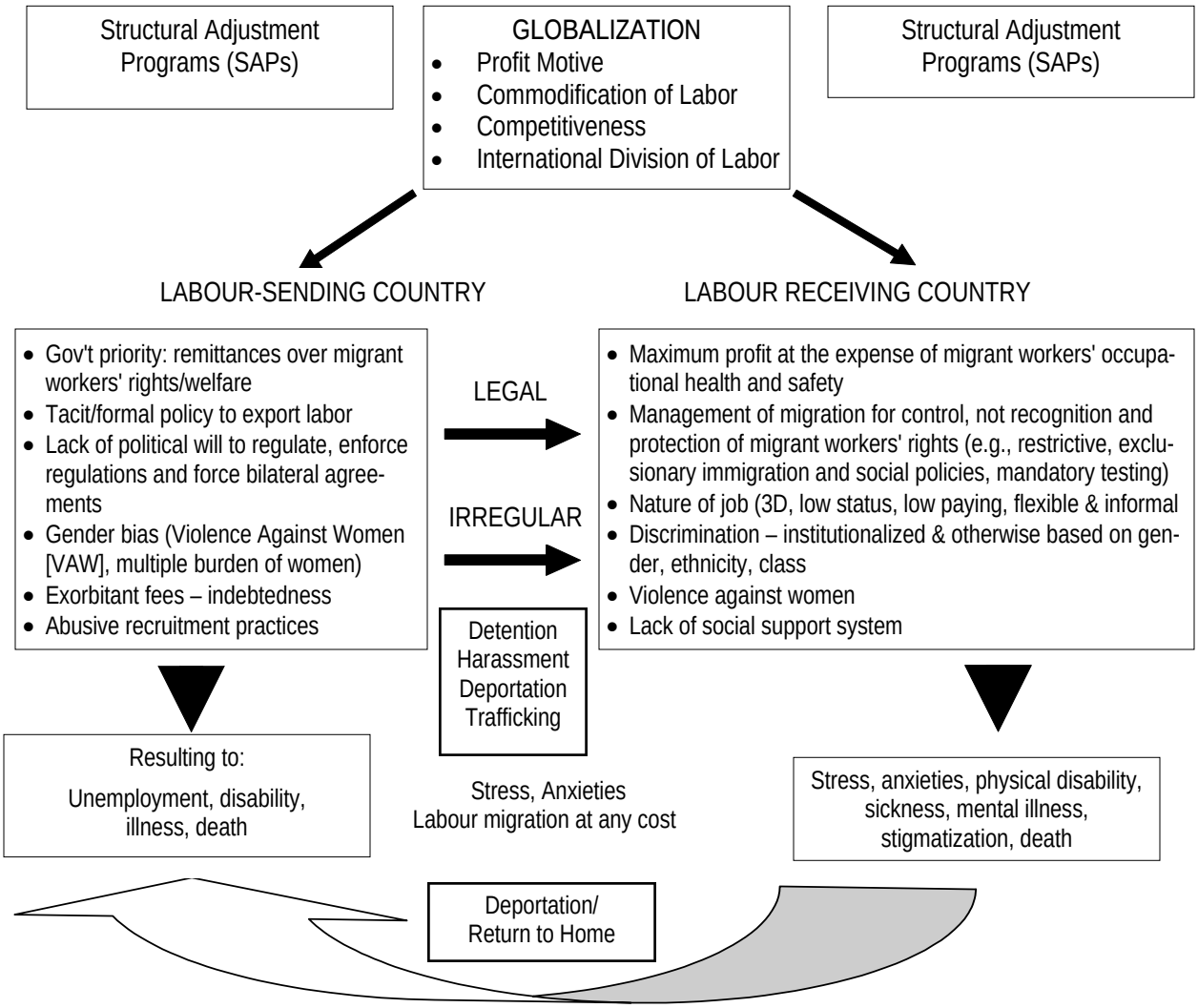
`In the short summary of the presentations, the facilitator asked the participants were asked to note that the people involved in the MFA were already married to migrant concerns and migrant workers; that they are not constrained by laws, and are always open to new approaches. They continuously advocate at the local government level in order to get immediate responses. MFA works towards community empowerment. The presentations were merely indicative of the things that are coming out – they are getting more and more creative as policies towards migrants are becoming increasingly restrictive.

Responses and Good Practices for Migrant Workers' Health and Well-being

Mr. Dudley Wijeseri of the Migrant Services Center in Sri Lanka, Rev. Choe from Korea, Ms. Malou Alcid of the Kanlungan Foundation in the Philippines and Mr. Naoto Higuchi of the National Network in Solidarity with Migrant Workers in Japan shared their experiences in promoting migrant workers' health and well being. Mr. Wijeseri discussed on the pre-departure and reintegration: health education and services in Sri Lanka. It was in 1995 that the Migrant Services Center started its pre-departure training for migrants. In 1997, Sri Lankan government made training mandatory for all migrants.

Malou Alcid from Kanlungan Foundation shared on how their organization organized and sensitized the families of migrant workers who came home suffering from psycho-social trauma to provide the necessary attention and seek appropriate services. They have also mobilized the local government and other members of the community to be responsive to the needs of these suffering migrant workers. Ms. Alcid also presented a diagram showing the context and risks to migrant workers' well being.

CONTEXT AND RISKS TO MIGRANT WORKERS' HEALTH AND WELL-BEING



Mr. Naoto Higuchi described their work in lobbying for the inclusion of migrant workers in the national health programme. He shared the case of an undocumented Filipino migrant worker whom their organization helped to access the national health insurance system.

To make health services accessible to migrant workers, especially the undocumented ones, the Joint Committee for Migrant Workers in Korea organized the Medical Mutual –Aid Union for Migrant Workers in Korea known as MUMK. The main features of the health care scheme were shared by the representative from MUMK.

During the open forum, other participants shared their experiences on the provision of training and education for migrants. One cited her experience in the formation of a migrant's savings program. The program sought to empower women economically. Someone noted that NGOs oftentimes forget to consider migrant workers as partners. She urged advocates to remember that migrant workers should be prepared to eventually managed programs and services for themselves as part of the process of empowerment. The value of education for the migrant workers in order to avoid exploitation was reiterated by one participant. NGOs can spearhead the education and trainings in order to lead the way for the government.

DAY 3: October 11, 2003

Regional Advocacy Initiatives for Occupational Health and Safety

Mr. Sanjiv Pandita of the AMRC shared the aims and projects of the Asian Network for the Rights of Occupational Accident Victims (ANROAV), a coalition of migrant workers who met work related accidents. Its members include those from Cambodia, Hongkong, India, Indonesia, Japan, Korea, Nepal, Pakistan, Sri Lanka, Taiwan, and Thailand. ANROAV allied with other labor groups. ANROAV aims to be a venue for sharing of experiences on occupational health and safety, resources and expertise. It is actively campaigning for the recognition of health as an important issue as it forges solidarity among its networks in Asia. It targets its campaign on the International Labor Organization because ANROAV members have the opinion that ILO does not give importance to health issues. During the open forum, a participant underscored the importance of establishing a database on factories with dangerous chemicals and machines. Mr. Sanjit answered that there were already websites that provided data on dangerous chemicals and machines together with diseases/injuries caused by them. Migrant workers can go over these websites for references she said.

Intergovernmental Mechanisms Relevant to Migration and Health

Ms. Genevieve Gencianos of the Migrant Rights International reminded the participants of the interconnectedness of each other's programs and initiatives – work at the grass root level feeds into what is going on at the international level. Information and data from the ground are needed to get attention at the international level and put pressure on the concerned governing bodies.

She enumerated the committees that have been created to monitor the UN Conventions that parties have signed on to. She said that these committees could be accessed by migrant workers and their advocates to monitor violations. Non-conventional mechanisms such as UN charter-based bodies can also be mobilized. Ms. Gencianos recommended to link with other human rights concerned organizations. There should be cooperation among NGOs to maximize the ability of NGOs to form cross-sectoral coalitions and participate/work with the government she suggested. NGOs should also maximize the use of information and communication technology to exchange information and develop innovative projects. Working with non-traditional potential allies was also recommended.

Building HIV Resilience for South East Asia

Ms. Marleen Van der Ree of UNDP discussed about the challenge posed by the dynamics of the HIV epidemics in South East Asia. To meet this challenge, UNDP, according to her, embarked on a two-phase program: a)

Phase 1 (1999-2001) – exploratory and advocacy stage; b) Phase 2 – an on-going phase which concentrates on a three pronged tracks namely: (i) promoting an enabling policy environment; (ii) capacity building for multi-sector development approaches which impact on mobility systems; and (iii) building community resilience.

Questions raised during the open forum:

1. What is UNDP doing about the stigmatization of persons with HIV/AIDS? The reality is that migrant workers who are HIV/AIDS positive are discriminated by employers.
2. How can UN force certain states which are non-signatories to some important UN conventions to respect the rights of persons with HIV/AIDS?
3. How can UN work in certain states which deny the occurrence of HIV/AIDS even if in reality it is existing?
4. Can a non-government organization without consultative status with the United Nations intervene if individuals are discriminated like persons with HIV/AIDS?

Responses from the Panel of Reactors

Panel of reactors asserted that the challenge to the problem on HIV /AIDS is enormous. Even if people understand technically how HIV/AIDS can be transmitted, i.e., through sexual intercourse still persons with HIV/AIDS are discriminated and shunned. One reactor noted that since many countries in Asia are not signatories to the ILO convention they felt that they are not liable for failing to comply with the provisions of the conventions. A participant from India asked the panel to draw attention to the problem of database as data is very important especially in cases such as in India where the incidence of HIV/AIDS is high. She suggested that there should be a mechanism where all regions are equally covered and data shared. As to the question of what UNDP was doing on the issue of discrimination of AIDS victims. The panel clarified that NGOs have an important role in pushing UN to urge governments to do something on the issue of HIV/AIDS. NGOs can advance migrant workers' right to health at different levels: grassroots, regional and international. Being a part of an international network like the Migrant Rights International can forge success for the migrant workers' rights campaigns.

Venues to pursue the international campaigns for the advancement of migrant workers' right to health were enumerated as follows:

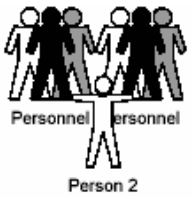
(i) the World Conference Against Racism;
(ii) campaign for Ratification of UN Migrants Rights Convention;
(iii) the December 18 campaign; and
(iv) HR Mechanisms with Special Rapporteur on Migrants.

Conceptual Framework on Migrant Workers' Right to Health and Well Being: A Synthesis

Mr. Rex Varona, Executive Director of the Asian Migrant Center presented the conceptual framework based onthe discussions of the past 3 days. He enjoined the participants to give their comments to improve the presentation. He noted that the concept of the conference of health for migrants is the integrity of the migrant together with the family and community. What need to be answered is how migrants end up at the bottom without health. In the chart illustrating the issue, Mr. Rex Varona explained that human rights, migrants' right to health, the original holistic right, is gradually reduced to nothing as migrants are considered merely as economic tools and commodities.

Conceptual Framework on Migrant Workers' Right to Health

MWs' right to health is a fundamental human right::



* right to health is underpins the right to life;
* right to health is universal, inalienable, indivisible;
* international standards recognize and protect this right;
* right to health encompasses economic, social, cultural as well as civil-political rights and needs.

* it is multi-dimensional: physical/medical health; social, mental, emotional, psychological; reproductive, sexual and sexuality.
* preventative and curative
* both the migrant workers and his/her family are entitled to it
* health is not only the absence of disease; it is an internal condition as well as an external environment that ensures a person's whole well-being and dignity.

* encompasses personal and community safety, security, including job security;
* enabling and enriching condition/environment

Contexts, risks, vulnerabilities, particular characteristics of migrants:

- Underlying exploitative logic of labour migration = labour trade, commodification of labour;
- Gender, class, race oppressions;
- Single-person migration;
- Structural and systemic vulnerabilities: oppressive and discriminatory laws,
- Nature of jobs (3D), situation where migrants are forced into or end up in:

Discrimination, exclusion, marginalisation, oppression, exploitation
*gender, class, race/ethnicity/culture

Violations; denial, reduction, degradation of human rights:

1. 'non-essential' rights are targeted/stripped:
   *right to health is usually the first casualty
   *stripping of family, social, labour, political rights
2. discriminations, oppressions reinforce, repeat, magnify, universalize — gender, class, race
3. new oppressions, vulnerabilities also arise — visa status, health status, family status, maternity status; migration/ national security, public safety controls;
4. MWs are stripped to the bone — health, wellbeing, personal dignity, humanity, social/ family/ com munity support removed; gender, etc. rights denied; exploited as economic production tool

Rex encouraged the participants to give their suggestions for the enhancement of the conceptual framework. It was suggested that the 7 Macro Forces affirmed in the 7th RCM be added to the conceptual framework. The summary presented by Mr. Rex Varona capped the morning session.

Workshop on the concretization of the responses followed using the following guidelines:

- Priority strategic and critical issues for interventions/responses;
- Specific initiatives/programmes/areas of cooperation? (e.g. training & capacity-building, documentation)
- Organizational needs to implement these programmes.

Rex asked the participants to make their suggestions strategic, not necessarily detailed as these concepts and recommendations will not only be taken by the conference but will be brought to other organizations for action.

These would be adopted by the RCM conference and presented to, built upon & followed-up by MFA, participants, & other networks.

There was a proposal for the conference to participants to make unanimously a statement of commitment from the participants, which they can bring back to their respective organizations. The conference participants agreed that a statement of commitment should be made.

Participants to the 8th RCM in Dhaka, Bangladesh commit themselves to pursue and implement either as individual organization or as a network the conference declaration and recommendations, which they adopted on October 11, 2002.

CONFERENCE DECLARATION & RECOMMENDATIONS

We are 60 delegates representing migrant organizations, NGOs, trade unions, networks, international agencies, migration experts and advocates from 13 countries. We have gathered for the 8th Regional Conference on Migration (RCM) to specifically discuss the issue of "Migration and Migrant Workers' Health and Well-being." We are deeply concerned about the health and well-being of migrant workers and their families in Asia and in other parts of the world.

For many decades, migrant workers have made significant contributions to their own countries as well as the labour receiving countries – without which the economies of many sending countries would have collapsed, and those of the receiving countries would not have attained their impressive economic performances.
These significant roles and contributions have been made at an enormous cost to the life, health and well-being of the migrants and their families.

The present mode of mass labour migration is premised on single-person migration, and the trade and commodification of human labour – treating migrants as mere economic tools, separating them from their families, uprooting them from the support systems of the family and the community, and negating the wholeness of their humanity. The types of jobs that are open to migrants are mainly the '3D' (dirty, dangerous, disdained) types. Because of these, the migrant workers suffer physical, mental and psychological ill-health. Foreigners, especially migrant workers, coming from poor countries are often subjected to various forms of discrimination, racism and xenophobia, and to multiple types of oppressions (class, gender, race). Women migrant workers in particular, are faced with added vulnerabilities to all forms of violence against their bodily integrity and personhood.

The present political turmoil particularly in the Middle East and within the context of the US-led anti-terrorism campaign puts migrants at the greatest risk to their life and security.

We, the participants of the 8th RCM, express grave concern over the continuing denial and erosion of the rights of migrant workers, particularly to life, health and well-being, as evidenced by the recent summary deportations and mass expulsion of migrants (e.g. Malaysia); the increasing incidence of HIV/AIDS; the high rates of occupational accidents and work-related diseases; the steady stream of migrant deaths; the high incidence of mental, emotional and psychological stress and distress; and the disintegration of many migrants' families.
Initiatives and efforts to address these health concerns have been inadequate and ad hoc. As a matter of justice, governments of both receiving and sending countries must now respond to the health and well-being of migrant work-

ers and their families, and mobilize and allocate all the resources needed.

We call on the governments to fulfill their obligations to the Universal Declaration on Human Rights and various international human rights covenants. These international instruments set the basic standards in upholding migrants' health and human rights. We renew our long-standing call on all governments to ratify the *1990 UN Convention on the Rights of All Migrant Workers and Members of Their Families* – which now have 19 State-parties, and will become an international treaty after the 20th ratification. We specifically met in Dhaka to call on the Bangladeshi government, which has already signed the convention, to become the historic 20th State-party and pave the way for the treaty's entry into force.

The right to health is the right to life. No migrant worker and migrant family should be deprived of this.

We further commit ourselves, and call on other supporters and advocates, to undertake the attached recommendations on strategic areas of action.

Adopted by the 8th Regional Conference on Migration, 9-11 October 2002 Dhaka, Bangladesh

Organizers:

Migrant Forum in Asia (MFA, Philippines; regional),
Asian Migrant Centre (AMC, Hong Kong; regional),
Welfare Association of Repatriated Bangladeshi Employees (WARBE, Bangladesh)

Participants:

Action Network for Migrant Workers (ACTFORM, Sri Lanka)
Ain-o-Salish Kendra (ASK, Bangladesh)
All-Nepal Women's Association (ANWA, Nepal)
Asia Monitor Resource Center (AMRC, Hong Kong; regional)
Asian Domestic Workers Union (ADWU, Hong Kong)
Asian Network for the ICC (ANICC, Bangladesh)
Asia-Pacific Forum on Women, Law and Development (APWLD, Thailand; regional)
Bangladesh Women Migrants Association (BWMA, Bangladesh)
Center for Education and Communication (CEC, India)
Center for Indonesian Migrant Workers (CIMW, Indonesia)
Coalition for Migrants' Rights (CMR, Hong Kong)
Community Advancement and Research Initiatives (CARI, Bangladesh)
Hope Workers Center (HWC, Taiwan)
Individual participants from the Middle East and international agencies
Indonesian Migrant Workers Union (IMWU, Hong Kong)
Joint Committee for Migrant Workers in Korea (JCMK, Korea)
Kanlungan Center Foundation (Philippines)
Kapisanan ng mga Kamag-anakan ng Migranteng Manggagawang Pilipino (KAKAMMPI, Philippines)
Khan Foundation (Bangladesh)
Medical Mutual Aid Union for Migrants in Korea (MUMK, Korea)
Migrant Forum (India)
Migrant Services Centre (MSC, Sri Lanka)
Migrants' Rights International (MRI, Geneva; international)
Minatomachi Medical Center (Japan)
National Network in Solidarity with Migrant Workers (NNSMW, Japan)
Qudwatun Nisail Muslimat (QUDWA, Philippines)
Refugee and Migratory Movement Research Unit (RMMRU, Bangladesh)
National Network in Solidarity with Migrant Workers (NNSMW, Japan)
Qudwatun Nisail Muslimat (QUDWA, Philippines)
Refugee and Migratory Movement Research Unit (RMMRU, Bangladesh)
Seoul Migrant Worker's Center (SMC, Korea)
Solidaritas Perempuan (SP, Indonesia)
Solidarity Center (SC, Sri Lanka)
Solidarity Foundation (SF, Bangladesh)
UNDP South East Asia HIV and Development Programme (Thailand; international)
Unlad Kabayan Migrant Services Foundation (Philippines)
WOREC (Nepal)

II. PAPERS PRESENTED

Migration and Migrant Workers Health and Well-being: Trends, Issues, Needs, Responses and Strategies

By: **Shahudul Haque**
Director General, Bureau of Manpower, Employment and Training
Government of the People's Republic of Bangladesh

Introduction

Manpower Export is one of the most significant sectors in the economy of Bangladesh for enhancing socio-economic development through employment generation and poverty alleviation.

Overseas Employment

Bangladesh started exporting manpower in 1976 with a figure of 6078 in 1976 which was limited to the middle Eastern countries only. Towards the end of 1980, the extent of migration took significant shape to 30,073. The figure of migrants in 2001 reached 1,880,965. Presently Bangladesh is exporting its manpower to more than 20 countries. Total export of manpower from 1976 to July 2002 stands at about 3.40 million. In the year 2000 Bureau of Manpower Employment and Training (BMET) arranged registering of the data of returned migrants through its 42 district level offices. About a quarter million returnees have been registered in the database so far which is now being computerized.

The Recruitment procedures in Overseas Employment

Bureau of Manpower Employment and Training (BMET) performs the duty of monitoring overseas employment by issuing licenses to the recruiting agents, giving recruitment permission and emigration clearance. It takes legal and administrative measures against malpractices under the Emigration Ordinance of 1982. The Director General of BMET is the protector of emigrants as described in the ordinance.

The migration of female workers is negligible which is roughly 0.22% in the total flow of migration. As a result, despite being most vulnerable to abuse and exploitation they remained neglected. The main receiving countries of the women workers are the Gulf states, particularly Saudi Arabia and Kuwait, Malaysia and Brunei. A large number of Bangladeshi women are also working as domestic labor in India and Pakistan.

Though facing abuse, insult and exploitation in different form, Bangladeshi women workers have continued to show their keen interest about overseas employment. It is often regarded as a family survival strategy. Social causes like illiteracy and unemployment, reluctance towards agricultural work, poverty at family level, limited employment opportunity in formal employment market and low wages push the rural capable female to temporary labor migration. In absence of legal papers and contract providing categorical details about the working condition, the workers are denied of the minimum legal protection and basic human rights. Thus the unabated exploitation and abuse multiply.

Presently, government allows migration of domestic workers only if the employers belongs to any of the following: 1) Bangladesh embassy staff, 2) financially solvent Bangladeshis such as doctors and engineers etc. and foreign passport holders Bangladeshis. A Bangladeshi expatriate worker can take up to five workers abroad without prior permission of BMET. Official record indicates that between 1991 to 2002 altogether 16,500 women have migrated through official channel.

Though ban exists presently on domestic workers, the demand for Bangladeshi workers in the Middle East and other Muslim countries is still very high. The ban has made the trade even more profitable for the dishonest recruiting agencies and their agents. The trade being illegal, there is no process of accountability. No job contracts and insurance guarantee is given. The government is now seriously considering to lift the ban as it will reduce the cost of migration for female workers.

The female workers are also employed in hospitals, hotels and garments factories and shopping centers. After allegations of gross molestation and torture on female domestic workers, the Bangladesh government imposed a ban on the migration of female workers as domestic help. Similar ban was also imposed on sending nurses abroad. However, the government later lifted the ban on nurses. The main cause of multifarious abuse and cheating of female workers are:

(i) Ignorance about the proper migration procedure;
(ii) Absence of written contract between the recruiting agents and the migrant workers; and
(iii) A tendency to believe in false assurance about jobs and working conditions from friends and relatives abroad.

Recent Steps to Improve Migration Process/Well-being of Migrant Workers

Government has given emphasis on overseas employment ensuring the Welfare of the Bangladeshis working abroad to establish a congenial atmosphere in the field of development of export of migrant workers. In this connection a separate ministry named Ministry of Expatriates Welfare and Overseas Employment has been created to expedite employment abroad and enhance the welfare of the Bangladeshi migrant workers.

With a view to accelerating the current trend of export of manpower and also to extend more services to the expatriates the following measures have already been taken:

1. Arrangements are being made to keep the job seekers in a single complex to facilitate recruitment, issuance of passport, medical test, purchase of air ticket and skill- testing to reduce strain on the out-going workers. In this regard, a hostel complex is being constructed at Dhaka to provide them "One Stop Service."
2. A computer data base network is being established at 42 district level offices and BMET headquarters with connection at the Ministry, airport and BAIRA office. Compulsory registration for all types of job seekers with the nearest DEMO is being started and recruiting agencies will collect job seekers from amongst the registered candidates. The recruiting agencies will be allowed to recruit workers only from the data bank.
3. Awareness campaign:
   a) Pre-departure briefing: The workers selected for overseas employment are briefed of the terms and conditions of their services, job contract, language, culture, local laws, working atmosphere of the labor receiving country, service charge, examining of travel documents etc. with the aid of electronic media. The briefing covers vulnerability to HIV/ AIDS and other diseases, consciousness of reproductive health, occupational safety, etc.
   b) Welfare-desk Billboard: Officials in two welfare desks, one at the Arrival Lounge and other in the Departure Lounge of the airport are made responsible to examine travel documents and assist out-going workers and returned migrants. Billboards with instructions are displayed in the different visible spots at the airport for the awareness development of the workers going abroad.
   c) There are buses arranged by BMET for the out-going and returned migrants and instructions through cassette are relayed to the out-going and returned migrants.
   d) Awareness campaign for the migrant workers are publicized through newspapers, radio, television etc.
4. Information centers are being established in District Manpower and Employment Office to make aware the prospective migrant workers through modern electronic media. District Manpower Offices are being made key information center to disseminate information to the job seekers at the grassroots level.

Conclusion

Migration of workers has become inevitable phenomenon for both the sending and receiving countries for its considerable contribution towards personal improvement and national economic development. We have to think more about the welfare of the earners of foreign currency. It is necessary to ensure their future prospect, economic security, social benefits, and last but not the least their health. I hope this seminar will contribute a lot through exchange of views amongst participants on the well-being of migrant workers. The deliberations and ultimate resolution will be helpful to formulate future plan of action.

Globalization, International Labour Migration and Women's Empowerment and Well-being

By: **Rita Afsar**
Research Fellow, BIDS, Dhaka

Contextual Facts

- Total population more than 130 million
- Population growth rate 2% / year
- Labour force growth rate 3% / year
- Higher unemployment among women
- Chronic history of trade deficit
- Size of the remittances is around 2 billion dollars

Introduction

- 1 million workers emigrate each year from South Asia to the Middle East
- Magnitude of Bangladeshi immigrant workers stands at 3.24 million (between 1976 and 2001) and they remitted US $ 2 billion
- 80% of them went to the Middle East
- There is a highly ambivalent feeling about benefits and costs of labour migration to the Middle East.
- There is no systematic study

The paper addresses the crucial question:

- whether migrants are chasing after perilous illusions and
- type of policies needed to protect the interest of migrant workers

Data and Methods

Three surveys were conducted under the study:

1. Pre-migration household survey in 3 Thanas: N= 75
   - ð Keraniganj Thana under Dhaka District
   - ð Fatikchari Thana under Chittagong District
   - ð Chatkhil Thana under Noakhali District
2. Random destination based survey of migrant workers from the UAE (N= 78 Men and 41 Women)
3. Trace survey of migrants' households from 25 Thanas
   N= 64:30 male and 34 female migrants' households

Background Information

- Predominance of youth in the migration stream
- Women are younger
- Nearly 40% of the youth male migrants either students or unemployed
- 85% of the women migrants were employed in the RMG sector prior to migration
- For men it was direct migration and for women it was step migration
- Early 70% of the men and women migrants were ever married
- On an average they have 7 and 5 years of schooling
- 2/3 of male migrants has secondary and/ or post secondary level of education
- 37.5% of women migrants had similar level of education

Consequences of Overseas Migration

Empowerment vs. vulnerability
- Wages and entitlement
- Living and working conditions
- Intra-household decision making

Measuring well being of a migrant's family
- Economic well being
- Non-economic dimension of well being

Wages and Entitlements- RMG

Empowerment	Vulnerability
• Wages rate $7.7/ day	• Blatant gender discrimination
• Overtime $ 2.5/ day	• Unauthorized deductions, delayed payment
• Remit $150/ month	• Employees mistrusted
• Relatively better wage	• Discrepancy- contract and actual wages
• Increase saving ability	

Working & Living- RMG

Empowerment	Vulnerability
• Better working	• Unfair work regulation condition
• 4 times higher wages	• Maltreatment, verbal and physical abuse
• Free accommodation	• Arbitrary extension / cancellation of visa
• Relief from heavy domestic burden	• Cooking added to workload
	• High room crowding and congested
	• Poor food quality

Costs

- On an average a migrant worker spends around 30% of their income for self- maintenance
- Food alone consumes 41% of their total expenditure. It also added to their existing workload since a large majority work more than 10 hours/day
- Expenditure patterns varies depending on their entitlements which often differ according to their nature of job
- Workers of RMG sector, construction and informal services live in high room crowding (8-15sq. feet/ capita)
- They often had water and sanitation problem
- They often lack adequate ventilation and air-conditioning
- Incidence of sickness is very high: around 20% and found among all categories
- According to the Labour Attaché there is almost one death everyday. Rate of suicide is also very high.
- 62% of the workers did not have written contract prior to migration
- Often final contract is given after their arrival in the host country
- Those who had the contract prior to migration found discrepancy between what is promised and what is given with regard to wages and working conditions.
- 90% of the respondents were not aware of the labor laws of the host country
- 80% had no idea about Bangladeshi Diplomatic Mission
- it indicates lack of knowledge and unbridled fraudulent practices by private recruiting agencies

Consequences

Well-being has multi-dimensional connotations of both subjective and objective nature. As a result it is difficult to measure and more difficult to come to a uniform consensus on the indicators.

In this study, economic and non-economic wellbeing of the migrant's family are measured. In the absence of information on non-migrants, before and after approach was used to examine the impact.

Income and expenditure pattern and

Economic costs at the family level

- A typical migrants spend around Taka 95,000 to migrate to the UAE
- 95% of this cost is incurred to obtain work permit and to finance air ticket
- Under the existing law of the land, employers are supposed to bear these costs
- Official recruiting agency (BOESL) charges around Taka 12,000-15,000
- Thus private recruiting agencies in collusion with the employers of the host country and not infrequently along with Bangladeshi Diplomatic Mission exploit a large majority of immigrant labour.
- In order to meet this huge migration cost migrants' families adopt multiple strategies

Economic Benefits

- With the help of inflow of remittances, benefit-cost ration is estimated at 2.88 and 1.63 for male and female migrants
- Migrant increases the level of household income substantially (the change between the pre and post migration income level is estimated at 55%)
- Remittances become a dominant source of household income by contributing around 2/3 to the household income
- There is positive and statistically significant co-relation between duration of migration and size of remittances
- Women who migrated for less than two years on an average sent lesser remittances than men. Thus, their households had:
  - ð 15% increase in the income level
  - ð Remittances contributed around 46% to the income of those households
  - ð Remittances play an important role in the alleviation of poverty. Moderately poor households declined from 21% to 7%.
- Household's expenditure pattern reveals:
  - ð Expenditure share on food item declined by 5%
  - ð Costs of Medicare have doubled
  - ð Cost of education increased significantly particularly in the case of female migrants' households.
- Male and Female Migrants' households are now able to save Taka 25,000 and nearly 8,000
- With regard to land related assets male migrants' households gained marginally in terms of their land values by 5%

Speech of Md. Daliluddin Mondal

Secretary-in-Charge, Ministry of Expatriates' Welfare & Overseas Employment on

The Impact of Migration on Migrant Workers' Health and Well- Being

Mr. President,

Migrant Forum in Asia and Asian Migrant Center of the 8th Regional Conference, the office bearers of MFA, distinguished guests, participants and delegates and media men, ladies and gentlemen, Assalamu Alaikum.

It is a great pleasure and pride to have this special distinction of being invited here in this August gathering. I would like to avail this opportunity of expressing my heartfelt thanks and gratitude to the President and Secretary General of MFA, AMC and WARBE, for arranging this conference and inviting me here in your midst. I feel specially honoured in coming here because I am very deeply concerned with migrants of Bangladesh in particular and the migrants of other countries of the world in general.

Ladies and Gentlemen.

Migration is defined as any change in residence. It involves the detachment of an individual from the organization of activities at one place and the movement of the total round of activities to another. International Migration is if, the change of such residence outside one's own national boundary i.e. the state of origin.

Migration across international border is very stressful in accommodating to a new culture, languages, being dominated by different religion, adjusting to different sets of social expectations and obligation. Migration may result in stress and disorganization of daily life.

Migration among many other things disrupts the ties with families and stable neighborhood net works, deprives the traditional solace for person's loss, the sacrifice of physical closeness with loved ones.

Ladies and gentlemen.

Bangladesh has a large number of migrant workers in different labour importing countries. In Bangladesh, nearly 35 million people are unemployed. Government cannot provide employment this huge number. Naturally, migration outside Bangladesh comes as a first option for solution of unemployment. This is why the simple and homesick Bangladeshi are migrating to other countries for employment. Bangladeshi has got an important position in the list of labour exporting countries. Every year, thousands of Bangladeshi youths line up for migration. The remittance of these migrant workers constitutes the largest portion of foreign exchange earning. We must continue it. But the urgent thing is that, we must be more and more sensitive to the welfare and well- being of the migrant workers. We are already working hard to:

- Regulate the activities of the recruiting agents
- Scrutinise Emigration of the workers
- Activates the labour wings in the respective foreign missions of Bangladesh.
- Allocate fund for the welfare support of Bangladeshi Expatiate workers abroad

We are also facilitating the remittance of expatriate workers by sending Bank Representative in the mission, making Bank alliance with the host country, introducing the system of speed cash.
Inside the country for the outgoing workers we are:

- Running briefing centres
- Maintaining welfare desks in airport
- Supplying vehicles for movement

We have also plan to build welfare infrastructure like hostels, hospitals for expatriate workers and their families. We are also going to provide legal assistance to the family of the expatriate workers when they are in problems regarding the security of the family person and properties. We are also trying to bring accountability of the recruiting agents and establish transparency in their activities. Present government has shown the most appreciable interest in the welfare of the expatriate workers. The creation of separate Ministry of Expatriate Welfare and Overseas Employment is a physical example of the goals commitment to the welfare of expatriate workers.

It is very much pertinent to point out here that even after arrival from abroad, the Govt. takes some welfare and promotional steps for the migrants. With the intention to find out the different skills they have brought in the country so that they may be helped and guided to fully utilize their skill and resources. The Govt. is trying to chalk out a comprehensive plan for the full and meaningful re-integration of the returned migrants.

Ladies and Gentlemen

Since HIV is spreading from country to country through the migration of man, sometimes, migration is also blamed. Therefore, it is mainly through the labour migration that Bangladesh has been exposed to the HIV infection. The migrant workers are a vulnerable group, because they are:

- Separated from families and partners
- Unknown and anonymous in his surrounding
- Extra freedom from social control
- Exposed to risky sexual behavior

So we are earning foreign exchange. We are importing HIV infection. But this does not mean that we should aban-

don the system and practice of exporting our manpower.

But to speak the truth, this labour migration and spread of HIV are the natural effects of globalization. Because of the severity of the disease, it has created a terrible panic among the people of all countries.

But long before the globalization of market, the globalization of disease started. Syphilis once was terrible disease. It originated among the Mongols, from there it went to Middle East, from Middle East it moved to Europe. But disease has got its strong limitation of movement and survival, some tropical diseases cannot survive and spread in extreme environments as in desert areas or in extreme cold countries. But serious diseases like syphilis or AIDS are very much universal in character. They can survive and spread in any environment and infect both white and black people. At least it has no racial discrimination.

Ladies and Gentlemen

So AIDS has become the biggest health menace of the modern world. It devastates the life of the victim, damages his family, and terrifies his surrounding society. The stigma associated with HIV infection was initially accorded when the virus was thought to be transmitted to primarily through unprotected homosexual behavior or contaminated needles shared in intravenous drug use. HIV just does not affect individuals. It affects society. It engulfs the person with the fear of loosing precious social relationships after others learn of the result of the diagnosis. So combating AIDS poses the greatest challenges to the world community. We must do everything to make adequate encounter for it.

One think, I would like to mention here that these disease have some cultural barriers. In a traditional society where people have puritan values and where polygamy is strongly discouraged the disease cannot easily spread. In this respect we must consider ourselves lucky. We are sending our workers in the conservative, traditional societies of Middle East, and the country like Malaysia, Brunei in the Southeast Asia. Barring few countries like South Korea and Singapore where the society is open, other countries give negligible chance of physical mixing leading to the change of HIV infection. Perhaps that may be the reason where the number of HIV patients is less in Bangladesh.

Ladies and Gentlemen

On the other hand, Bangladesh so far, has not sent the female workers. Because of our strong cultural and traditional attitude and sense of special care and respect for women our people do not like to send the female workers abroad of just for earning. This has also lessened our vulnerability to HIV infection and the absence of any abuse of female workers.

HIV positive cases in Bangladesh are estimated to be 13000. But a great number of them are injecting drug users. In a country of 130 million it does not appear to be a big figure.

Our danger lies somewhere else. The young people in 10-25 year of age constitute nearly one 3rd of the total population i.e. 43 million of 129.2 million. A great portion of them are vulnerable to potential HIV infection.

It is noteworthy that among Bangladeshi workers there has been found a low prevalence of HIV. This has always been positive point for Bangladeshi workers to the employers in international markets. We should keep up this low prevalence of HIV to increase the marketability of our labor force. For this purpose, we should try our best to expand our activities in prevention of HIV. Any expenditure in this sector will benefit us as a profitable investment.

Ladies and gentlemen

AIDS is a different and difficult type of problem. It needs a different approach, not traditional one to solve the problem. One thing must be borne in mind as regards HIV and AIDS is the culmination of HIV. Till to day AIDS is

not found to be curable. You can keep from getting it by learning about how it is spreading and then avoiding the behaviour that might allow you to be infected. Moreover it is very hard to catch, because it is not transmitted through the food, water and air.

As regards the case of migrant workers, the receiving countries to take the responsibility of the health of migrant workers, take special care for prevention of HIV infection in them. It is infected through contact. Now the question is how to avoid the contact. It is not only hard to avoid, but it is near impossibility. Because, human passions are not always controllable. Rather the human behaviour is guided and driven the passions. It is better to regulate human behaviour and adjust it with the need of human society and welfare.

Addressing these problems requires a combined national and international effort. As a Ministry of Expatriate Workers, our foremost duty is to find out solutions and engage in the efforts possible with national range first and then join the International Co-ordination.

Nationally before sending the workers we:

- Check the selected workers medically.
- Brief the selected workers to sensitive them against the possible hazards including HIV infection.

Moreover, time to time we also avail the opportunity provided by different seminars and workshops organizes by both Govt. and NGOs to raise awareness against HIV.

But as regards the welfare of returned migrant workers, we should also add the programme of medically checking the migrant workers with a thrust to find out the HIV infection, if any.

If detected they may be treated medically and socially looked after for their adjustment in the society. It is true we have a lot of works to do. As a democratic Govt. we are highly sensitive to this issue of the welfare of migrant workers including the returned ones. We like to work for this in close alliance with the International Organizations NGO's to combat at this growing menace.

Ladies and Gentlemen

Finally, I would like to express my deep sense of satisfaction and gratitude to the authority who have organized this seminar. It is a brilliant reflection of their profound commitment to the migrant workers who constitute a great fragment of worlds working humanity. They deserve the best of our Sentiment, best of our feeling and finest of our endeavours. Here I cannot check the temptation of expressing my profound feeling of compliments to the media people in Bangladesh. They have always been in the forefront march in transforming the people's attitude and prepare them for new trends and ventures. I hope they will continue their endeavour and contribute to the building of a happy prosperous Bangladesh. Therefore, I also thank them from the core of my heart. I feel it a proud job to join here with this great minds dedicated to peace and well being of mankind.

Thank you.

Regional Overview of Migrants' Health & Well-being Situation

by

Joint Committee for Migrant Workers in Korea (JCMK)

for the 8th RCM, 9-12 October 2002, Dhaka, Bangladesh

I. Right to Health - Basic Human Rights

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO definition of health)

To extend the WHO definition of health, right to work, a decent living for all workers and their families, safe and healthy working conditions, rest, leisure and reasonable limitation of working hours and periodic holidays with pay etc. are recognized as inherent human rights or economic, social and cultural rights.

However, the migrants' right to health are not fully recognized as basic human rights in everywhere.

II. Health and Well-being Situation of Migrant Workers

Problems	Consequences
Poor working conditions including long working hours, no safety measures	Industrial accidents, work related disease
Low wages limited to minimum living cost	Ill-balanced nutrition, malnutrition
No access to health information	No proper treatment
Difficulties in communication at medical institutions	Can not explain health state or disease
No maternity protection	Bad health conditions of women and children
Mandatory medical testing of pregnancy, HIV etc.	Forcible deportation
No health insurance for undocumented migrants, high medical cost	Self medication, developing disease
Sexual, mental and physical abuses	Emotional and psychological trauma
Different social status, exploitation, working in 3D jobs	Loss of dignity, self-respect

III. Migrant workers' health care need

Migrants' health care need is emerged in their living environment, working conditions, psychological state and human relations. Therefore to solve the health and well-being problems of migrant workers is not only limited to increase the medical services but to extend the social and economic sphere.

Followings are some new trends of migrants' health care need in Korea.

1) Increasing of health care need of migrant workers

As the length of migrants' staying in labor hosting county becomes longer, their basic need for health care is increasing. They are increasingly well adapted to the host society and have a living basis. When they have a family in the host society, childbirth needs more health care than before.

New group of migrants from Central Asia, Latin America or Africa (previously most migrants from Southeast Asia, South Asia) also call our attention to the new disease or medical support.

2) Increasing of health care services for migrants

Even if migrants' status is illegal, their health care needs cannot be neglected. Therefore free medical services for migrants are increasing. The government also provides some basic health service for migrants to prevent infectious disease to the locals.

3) Need for knowledge of HIV/AIDS prevention

Increasingly, foreign migrant workers especially undocumented migrants become a suspicious group of HIV carrier in threatening of public health. Knowledge about HIV/AIDS is not only needed to migrants but also to migrant support groups and public so that they can have right information. HIV/AIDS prevention education needs to be conducted with local organizations. Humanitarian treatment and support for infected migrants is also needed. But most host countries expel them when they found HIV infected. Same condition of test (anonymous testing) and basic treatment for migrants same as locals should be raised by migrant support groups and medical personnel.

4) Increasing of chronical disease

Increasing number of patients who having chronical disease can be analyzed as revealing of potential patients when they have access to the health care system. At the same time, since their staying gets longer, their illness which have not been well managed become worsened.

If they cannot access to the health care system, more and more chronical disease will be found among migrant workers and it will need costly treatment. Therefore providing health education and systematic health care program for migrants are much needed. Early detection of disease, regular medical check-ups, self-examination and health care should be introduced as disease prevention measures.

5) Need for concern and support for women migrants

Women migrants working in manufacturing sector experiencing long working hours and low wages. When they are pregnant it is hard to get proper maternity protection. Women in service sector are also facing sexual harassment and exploitation. Unwanted pregnancy and illegal abortion affect women's health state. Therefore, sex education and contraception information is needed to avoid unexpected pregnancy.

6) Mental health problem

Migration itself becomes a big stressful factor for migrants. Need for finding well- paid job to support family pushes them to migrate. But new society with different language, culture and system threaten their mental health. Such stress developed into alcoholism, drug addiction etc. Providing programs to eliminate feeling of isolation, strengthening unity are needed.

7) Migrants' mutual-help system

Various forms of migrants' community based on their nationality can play a role as a social network and psychological support unit. It can also be a problem solving mechanism to help each other.

IV. Necessary Responses

1. Recognition of health rights as basic human rights.
2. Basic health care system and information for migrants in labor receiving country.
3. Medical support system between migrant support groups in labor sending and receiving country (esp. returned migrants who having infectious disease).
4. Application of existing health related laws to migrants.
5. Rejecting human rights violating mandatory medical testing to migrants.
6. Making safe working environment for workers.
7. Humanitarian services for migrants who are in detention center or their cases are in the court.
8. Maternity protection for women migrants and necessary health care service for migrants' children.

Regional Overview of the Migrant Worker's Health And Well-Being Rights and Issues: A Gender Framework with Focus on Migration and Health Issues

by
Upama Maila
Women Rehabilitation Center (WOREC), October 2002

Introduction

Globalization of market policy, poverty, unemployment, forced displacement at one hand and the demand for cheap and unskilled/skilled labor on the other hand are some of the reasons to increase migration regionally and globally. Nepal is not an exception. External migration process started in Nepal 184 years ago when hill people were recruited in the British Army after the end of the Anglo –Nepal war in 1918. This trend continued even today, though at significantly reduced level. A large number of Nepalese have migrated primarily to India to work as farm laborers and industrial workers. Migratory movements of Nepalese workers have grown rapidly in the last two decades. Today Nepalese migrated to around 48 different countries. According to the data from the Department of Labor, from the year (1991-2001) within a span of ten years approximately 222,000 migrated, where as in the year 2000-2001 alone approximately 85,000 migrated through individual initiatives and employment agencies. In Asia alone within 1995-1999, 2.6 million migrated for work.

The countries in South Asia have used migration of its citizens as a major strategy for foreign exchange earning. Poverty is widespread in Nepal with 49% of the Nepalese living in absolute poverty. So the government of Nepal has adopted foreign employment policy as an opportunity to provide alternative employment to its people. In the year 2000-2001, the remittance amounting to Rs. 74 Billion (1 Billion US $ approximately) entered into Nepal.

The migrant workers now include a large percentage of females. The countries like Indonesia, Philippines and Sri Lanka constitute 60-80% of the migrant women workers (MWWs). More and more Nepalese women are also migrating for work.

But we often come across migrant workers who have gone through basic human right violation, tortures, deaths, etc. Therefore, an attempt is made to highlight the problems these migrant women workers are facing in the sending, transit and receiving countries.

Problems of Migrant Women Workers in the Receiving Countries

- Limited opportunities: To understand the health issues of the migrant women workers, it is very important to explore the nature of jobs they enter. Due to the limited education opportunities, lack of information, the work options for women are also limited. Hence, the migrant women workers often find jobs as factory and agricultural workers, and in the garment industries.
- Gender selectivity in job recruitment: Also the gender selectivity in the recruitment of women workers has placed them in the isolated and individualized work situations as domestic helper, entertainers and helper in restaurants, sex workers or in other menial jobs. Such jobs however are unprotected and informal with less social support because in many countries it still does not have legal status.
- Access to health care: Migrant women workers do not have access to health care unlike the citizens of those countries. If the workers have illegal status they are more in vulnerable position.
- Discriminatory health policy: Health policy in some of the receiving countries is discriminatory to migrant women workers. It is mandatory for workers to do medical test. In Singapore, migrant women workers are deported back to their source country if they are found ill or pregnant.
- Attitude of the employers: The attitude of the employers is such that they do not realize that migrant women workers are human beings just like them. Due to this attitude, migrant women workers are treated as their

property, underpaid, overworked, not fed properly, and are battered.

- Violence in receiving country: Because of the nature of the job, migrant women workers are in a vulnerable position more than men migrant workers. Cases of verbal assault, molestation, emotional blackmail and rape are highlighted through media frequently.
- Exclusion from legal protection: Receiving countries are interested to pay wages for their work but not interested in giving legal protection.
- Globalization of service sector: Health services are becoming more expensive due to privatization of such sectors and increasingly inaccessible to the migrant workers.

In the above context, the prominent health issues confronted by the migrant women workers are listed:

- Psychological problems like depression and stress are the outcome of loneliness in the absence of family support, new cultural/lingual/social environment, less social support, round the clock on duty (domestic workers), physical mobility restricted by the employers, verbal assault, deprivation in terms of the private space etc. Cases of returned migrant women workers suffering from mental illness where as they had not shown any sign and symptoms before points out that they are not treated well in the receiving countries.
- Malnutrition: A majority of the migrant women workers are found to be suffering from malnutrition. The domestic helpers are totally at the mercy of their employers who give them less food and make them work longer hours.
- Chronic diseases: Tuberculosis, cancers of the breasts and the uterus are caused when exposed to certain chemicals in the factory.
- HIV/AIDS and other sexually transmitted diseases are found in the migrant women workers because of less use of contraceptives like condom due to less bargaining power.
- Self-induced abortion: In some countries of the Gulf Region, women get death sentence or a large number of whippings if caught as pregnant. Pregnancy means loss of job and deportation for the migrant women. So migrant women workers either goes ahead with self-induce abortion or are compelled to do abortion like in sex workers. This put the health of women at risk.
- Disablement or injury: Violence on the migrant women is common. Their health and also the control over the decisions regarding their body are affected by the social attitude of their employers. They are exposed to physical beating, molestation, sexual harassment and rape, as a result of which they are disabled or injured.
- Access to health care services is less because of their restrictive mobility, lack of information and sometimes illegal status.

The World Health Organization (WHO) has defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. While contemplating at the above health problems we have strong reasons to worry about the serious human right violations of the migrant women workers.

Suggestions to address the problems of migrant women workers in sending countries.

- Advocacy for flexible migrant policies: Advocacy should be done to lift ban for women to go to specific countries (e.g. Gulf countries for Nepal) because surveys have shown that ban has not reduce the number of women going to Gulf countries.
- There should be bilateral agreements between sending and receiving countries to facilitate legal migration, increase government's responsibilities, reduce vulnerabilities and give redress in case of human rights violations.

Migrants' Right to Health: Identifying Frameworks and Strategies

Presented by
Genevieve J. Gencianos, *Migrants Rights International*

I. International Instruments on Migration and Health

- Overarching Framework: Right to health is a basic human right, enshrined in the following international law instruments:

A. The International Bill of Rights

1) Universal Declaration of Human Rights, *adopted and proclaimed by the General Assembly on 10 December 1948 provides:*

Art. 22: Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Art. 25(1): Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Art. 25(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

2) International Covenant on Economic, Social and Cultural Rights (ICESCR); *Adopted by the General Assembly on 16 December 1966; Entry into force 3 January 1976, provides:*

Art. 2(3): Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Convention to non-nationals.

Art. 9: The State Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

Art. 12(1): The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Art 12(2): The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
b. The improvement of all aspects of environmental and industrial hygiene;
c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
d. The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.

3) The International Covenant on Civil and Political Rights; *Adopted by the UN General Assembly on 16 December 1966; Entry into force on 23 March 1976, provides:*

Art. 6(1): Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

B. International Convention on the Elimination of All Forms of Racial Discrimination; *Adopted on 21 December 1965; Entry into force on 4 January 1969, provides:*

Art. 5: In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: [...]

Art. 5(e)(iv): Economic, social and cultural rights, in particular the right to public health, medical care, social security and social services.

C. Convention on the Elimination of All Forms of Discrimination against Women; *Adopted on 18 December 1979; Entry into force 3 September 1981, provides:*

Art. 11(1): States Parties shall take appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights in particular: [...]

Art. 11(1)(e): The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old ages and other incapacity to work, as well as the right to paid leave;

Art. 11(1)(f): The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

Art. 11(2): In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties take appropriate measures:

Art. 11(2)(a): To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;

Art. 11(2)(b): To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;

Art. 11(2)(c): To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;

Art. 11(2)(d): To provide special protection to women during pregnancy in types of work proved to be harmful to them.

Art. 12(1): States Parties shall take appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Art. 12(2): Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

D. Convention on the Rights of the Child; *Adopted by the General Assembly on 20 November 1989; Entry into force on 2 September 1990, provides:*

Art. 24(1): States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health services.

Art. 24(2): States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;
(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on

the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
(d) To ensure appropriate pre-natal and post-natal health care for mothers;
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents and family planning education and services.

Art. 26(1): States Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.

Art. 26(2): The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits by or on behalf of the child.

E. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; *Adopted by the General Assembly on 18 December 1990.*

- Right to health is accorded to both documented and undocumented migrant workers and their family members.
- However, additional health rights are accorded to documented migrant workers and their family members.
- Migrants' access to health, though reiterated in basic human rights instruments including the UN Migrants Convention, remains subject to national laws and domestic schemes.

For all migrant workers and members of their families:

Art. 25(1)(a): Migrant workers shall enjoy treatment not less favorable than that which applies to nationals of the State of employment in respect of remuneration and other conditions of work, that is to say, overtime hours of work, weekly rest, holidays with pay, safety, health, termination of the employment relationship and any other conditions of work which, according to national law and practice, are covered by these terms;

Art. 25(3): States Parties shall take all appropriate measures to ensure that migrant workers are not deprived of any rights derived from this principle by reason of any irregularity in their stay or employment. In particular, employers shall not be relieved of any legal or contractual obligations, nor shall their obligations be limited in any manner by reason of such irregularity.

Art. 27(1): With respect to social security, migrant workers and members of their families shall enjoy in the State of employment the same treatment granted to nationals in so far as they fulfill the requirements provided for by the applicable legislation of that State and the applicable bilateral and multilateral treaties. The competent authorities of the State of origin and the State of employment can at any time establish the necessary arrangements to determine the modalities of application of this norm.

Art. 27(2): Where appropriate legislation does not allow migrant workers and members of their families a benefit, the States concerned shall examine the possibility of reimbursing interested persons the amount of contributions made by them with respect to that benefit on the basis of the treatment granted to nationals whore are in similar circumstances.

Art. 28: Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused by them by reason of any irregularity with regard to stay or employment.

Additional health rights for those documented or in regular situation:

Art. 43(1)(e): Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to access to social and health services, provided the requirements for participation in the respective schemes are met.

Art. 45(1)(c): Members of the families of the migrant workers shall, in the State of employment, enjoy equality of treatment with nationals of that State in relation to access to social and health services, provided that requirements for participation in the respective schemes are met.

Art. 70: States Parties shall take measures not less favorable than those applied to nationals to ensure that working and living conditions of migrant workers and members of their families in a regular situation are in keeping with the standards of fitness, safety, health and principles of human dignity.

F. The International Labor Organization's Convention on Migrant Workers

- C97 lays the basis for the medical check-ups for migrant workers to ensure that they are in "reasonable health."
- C97 provisions on access to health are limited only to migrants in regular situation ("lawfully within the territory") and are subject to national laws and schemes.
- C143 focuses on measures to control and suppress illegal employment and clandestine movements. In line with C97, it provides access to health to migrant workers in regular situation but subject to national laws and domestic schemes and without prejudice to State measures to control movements of migrants for employment.
- These two Conventions, C97 and C143, are supplemented in detail by a number of non-binding ILO Recommendations.

1) C97 Convention Concerning Migration for Employment, (Revised), 1949, provides:

Art. (1)(b): Each Member for which this Convention is in force undertakes to apply, without discrimination in respect of nationality, race, religion or sex to immigrants lawfully within its territory, treatment no less favorable than that which it applies to its own nationals in respect of social security (that is to say, legal provision in respect of employment injury, maternity, sickness, invalidity, old age, death, unemployment and family responsibilities, and any other contingency which, according to national laws or regulations, is covered by a social security scheme), subject to the following limitations:

Art. (1)(b)
(i) There may be appropriate arrangements for the maintenance of acquired rights and rights in course of acquisition;
(ii) National laws or regulations of immigration countries may prescribe special arrangements concerning benefits or portions of benefits which are payable wholly out of public funds, and concerning allowances paid to persons who do not fulfill the contribution conditions prescribed for the award of a normal pension.

Art. 5: Each Member for which this Convention is in force undertakes to maintain, within its jurisdiction, appropriate medical services responsible for-
a) ascertaining, where necessary, both at the time of departure and on arrival, that migrants for employment and the members of their families authorized to accompany or join them are in reasonable health;
(b) ensuring that migrants for employment and members of their families enjoy adequate medical attention and good hygienic conditions at the time of departure, during the journey and on arrival in the territory of destination.

Art. 8(1): A migrant for employment who has been admitted on a permanent basis and the members of his family who have been authorized to accompany or join him shall not be returned to their territory or origin or the territory from which they emigrated because the migrant is unable to follow his occupation by reason of illness contracted or injury sustained subsequent to entry, unless the person concerned so desires or an international agreement to which the Member is party so provides.

2) C143 Migrant Workers (Supplementary Provisions) Convention, 1975, *provides:*

(pp): Considering that further standards, covering also social security, are desirable in order to promote equality of opportunity and treatment of migrant workers and, with regard to matters regulated by laws or regulations or subject to the control of administrative authorities, ensure treatment at lease equal to that of nationals.

Art. 9(1): Without prejudice to measures designed to control movements of migrants for employment by ensuring that migrant workers enter national territory and are admitted to employment in conformity with the relevant laws and regulations, the migrant worker shall, in cases in which these laws and regulations have not been respected and in which his position cannot be regularized, enjoy equality of treatment for himself and his family in respect of rights arising out of past employment as regards remuneration, social security and other benefits.

Art. 10: Each Member for which the Convention is in force undertakes to declare and pursue a national policy designed to promote and to guarantee, by methods appropriate to national conditions and practice, equality of opportunity and treatment in respect of employment and occupation, of social security, of trade union and cultural rights and of individual and collective freedoms for persons who as migrant workers or as members of their families are lawfully within its territory.

II. International Mechanisms on Migration and Health

A. Intergovernmental Mechanisms Relevant To Migration and Health

1. The UN Treaty Bodies (Conventional Mechanisms)

Utilizing their reporting mechanisms and complaints procedures:

(i) Human Rights Committee
(ii) Committee on the Elimination of Racial Discrimination
(iii) Committee on the Elimination of Discrimination Against Women
(iv) Committee on the Rights of the Child
(v) Committee on the Rights of Migrants (coming soon)

2. The UN Charter-based Bodies (Non-Conventional Mechanisms)

The thematic mechanisms:

(a) At the Commission on Human Rights

1. **Special Rapporteur on the human rights of migrants-**
   The mandate was renewed by CHR Res. 2002/62 for 3 years. She is Ms. Gabriela Rodriguez Pizarro (Costa Rica)
2. **Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health -**
   The mandate established by CHR Res. 2002/31 for 3 years. He is Mr. Paul Hunt (New Zealand).
3. **Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance-**
   The mandate was renewed by CHR Res. 2002/68 for 3 years. He is Mr. Doudou Diene (Senegal).
4. **Special Rapporteur on violence against Women, its causes and consequences-**
   The mandate was renewed in 2000 for 3 years. She is Ms. Radhika Cumaraswamy (Sri Lanka).
5. **Independent Expert to examine the question of a draft optional Protocol to the International Covenant on Economic, Social and Cultural Rights-**
   The mandate was established by CHR in 2001, the duration of which is not specified. He is Mr. Hate Kotrane (Tunisia).

(b) At the Sub-Commission on the Promotion and Protection of Human Rights

1) Special Rapporteur on the Rights of Non-Citizens-

The mandate was established through a Sub-Commission
Resolution, asking the special rapporteur to make a study on the rights of non-citizens. The final report I due in 2003. The special rapporteur is Mr. David Weissbrodt (USA).

3. The World Health Organization (WHO)

Links their work to include access of migrants to health. III. Civil Society Responses
Increasing movements, international forums, and current trends promoting migrants' rights to health:

- **Campaign for Regularization.**
  In Europe, with the move of European Governments to establish a common immigration and asylum policy, NGOs are responding by campaigning for regularization of irregular migrants. E.g. PICUM, GISTI, Collectif Sans Papiers, etc. In the US, national groups are calling for regularization of irregular migrants to strengthen protections, recognition of migrants economic contribution, and humanitarian reasons, particularly in light of the impacts of September 11.
- **International/Regional Forums and Movements focusing on Migrants' Right to Health**
  Third European Symposium on Migration and Health, 24-25 October 2002, Paris – led by Migrations Sante (Sante) and the International Centre for Migration and Health (Switzerland). Objectives include collecting evidence on the health and social situation of migrants, identifying factors and barriers to migrant access to health, and exploring opportunities for intervention.
  - *8th Regional Conference on Migration of the Migrant Forum in Asia, Dhaka, Bangladesh, 9-11 October 2002-* Theme: "Migrants' Health and Well-being."
  - *The International Federation of the Red Cross and Red Crescent Societies-* priority on health care for migrants; this policy is outlined in the Berlin Assembly Program of Action in April 2002.
  - *Prospect to hold a Panel Discussion on Migration and Health among Geneva NGOs (tentative)*
- **Global Campaign on the UN 1990 Migrants Rights Convention**
  The establishment of international law foundation specific to migrants.
- **Combating Racism, Racial Discrimination and Xenophobia**
  Following the commitments and recommendations of the 2001 WCAR Conference, highlighting how migrants are denied of their right to health as a manifestation of racism and xenophobia and embarking on measures to address this.

IV. Conclusion

1. International human rights instruments guarantee the right of all peoples to health. Certain instruments provide specific guarantees for access of migrants to health yet these are subject to national laws and existing domestic schemes, and often limited only to migrants in regular situation, or "are lawfully in the territory" of the State of employment.
2. Inter-governmental mechanisms are available for the promotion and insurance of this right. These mechanisms were established in line with the principles of human rights, including the human right to health.
3. Nevertheless, migrants, particularly women, children, and those undocumented or in an irregular situation, are continuously deprived of this right to health and access to health services.
4. Civil society organizations are increasingly focusing attention to this problem through coordinated national, regional and international cooperation, strategies and approaches.

V. Recommendations

- Continue to bring the discussion of migrants' human right to health as a critical issue in the international agenda.
- Build on the principle that human rights, including the right to health, are fundamental to and inherent in every human being. These rights are indivisible from each other, such that the right to health cannot be separated from the entire body of human rights, and must always be linked to other civil, political, economic, so-

cial and cultural rights in the analysis of issues and the formulation of policy and other recommendations for action.
- Maximize, and in some cases strengthen, existing national, regional and international protection and promotion mechanisms with regard to the right to health and the human rights of migrants.
- Support and enhance the role of civil society organizations towards advocacy, networking, information and skills-sharing, delivery of support services, and awareness-raising.

Finally, some points to ponder on factors that contribute to the success of NGOs in international work. (Contributions from Schechter, M., "Making Meaningful UN-Sponsored World Conferences of the 1990s: NGOs to the rescue?" in Schechter, M. (Ed.), UN-Sponsored World Conferences: Focus on Impact and Follow-up, United Nations University Press: Tokyo, New York, Paris, 2001).

Key factors for NGOs' success:

1. The cooperation amongst NGOs;
2. The ability of NGOs to form cross-sectoral coalitions;
3. The ability of NGOs to participate and work with government delegations;
4. The ability of NGOs to identify like-minded intergovernmental organizations which they can coordinate actions;
5. The intensity of networking amongst NGOs;
6. Exploiting of communication technologies to facilitate exchange of information;
7. The development of innovative projects;
8. The willingness of NGOs to work with non-traditional potential allies.

Occupational Health and Safety of Factory and Construction Based Migrant Workers in Taiwan

by
Rev. Peter O'Neill - *Hope Workers' Center, Taiwan*

Introduction

As of August 2002 of the 311,464 migrant workers in Taiwan 162,912 are factory workers and 27,149 are construction workers. About 110,000 are caregivers and 10,000 are domestic workers. (The government has no exact figures for these workers because they are not classified as workers in Taiwan.) The breakdown of nationalities of the total number of migrant workers is as follows:

Thailand: 121,747 (39.09%)
Indonesia: 98,766 (31.71%)
Philippines: 69,630 (22.36%)
Vietnam: 21,286 (6.83%)
Malaysia: 35 (0.01%)

The majority of construction based migrant workers are from Thailand. These workers are predominantly farmers and are use to working outdoors in the heat of the sun. They are hard working and extremely reliable. The largest number of factory based migrant workers are also Thai with the second largest being Filipino. Most of the Vietnamese are factory workers with a few Indonesians. The majority of Indonesians are caregivers and domestic workers. The majority of factory workers are male.

Major Occupational Health and Safety

There are both health and safety issues for factory and construction based migrant workers in Taiwan. I will first highlight those issues that are common to both sectors.

Like all migrant workers the workers in these two sectors suffer from **psycho-social/mental health problems such as stress, loneliness and homesickness.** During the initial stages for some workers these problems can lead to more serious psychological problems. They find it difficult adapting to working overseas in a foreign country away from the support system of their families as well as coping with the many stresses in the work place. All migrant workers

are under the stress of having to pay their broker's fee and for many to pay back the money they borrowed to pay their placement fee.

Physical exhaustion due to excessive working hours is a common health problem among these workers. Many workers are forced to work long hours out of fear of being repatriated if they refuse not to. They may work between 12 to 16 hours a day. Their contracts state they must live in accommodation provided by their employer. This makes them vulnerable to be forced to do overtime at any time. With the huge broker's fee hanging around their necks they push their bodies to the limit so they can earn as much money as possible in the shortest amount of time in order to pay back both their debt and the interest on their debt. Some seemingly healthy workers have died suddenly
of heart attacks due to exhaustion and stress.

In order to keep up this unhealthy pace of work some workers turn to **drugs** to give them that extra push. They become addicted and need to work extra hours in order to pay for their addiction. It becomes a vicious cycle. Drug gangs have been formed in particular among the Thai workers. Just recently in Taiwan two Thai workers were murdered by fellow Thais in gang related incidents.

Many of the male migrant workers turn to **alcohol** as a way of coping with psycho-social/mental health problems. Excessive use of alcohol is a major concern among the Thai workers. There are at present around 20 Thai workers in the Taipei prison. For the majority of these workers their crimes were committed while under the influence of alcohol.

Workers in these sectors are often forced to carry heavy loads beyond the legal safety limit. They end up suffering major **back problems.** It is extremely difficult in Taiwan to have back problems recognized as a result of an occupational accident.

In both sectors the workers suffer from **unsafe working conditions.** Employers are unwilling to spend extra money and time to make sure the work environment is safe. Many family owned businesses are still using outdated equipment which has been banned by the government. Safety nets are not put up on some construction sites. In such working environments migrant workers are vulnerable to **occupational accidents**.

Factory workers may suffer from major **health related issues** such as **exposure to chemicals and dust**. It is extremely difficult in Taiwan to have such exposures, which cause diseases to be recognized as occupational accidents. In the mid-90s around 40 Filipinas who worked at the same Philips' plant in Taiwan were all diagnosed with the Steven Johnson Syndrome. The government refused to recognize their disease as an occupational accident.

A few of them died as a result of the disease. Many female migrant workers in computer companies suffer from **eye sight deformities** due to constantly looking through microscopes.

Migrant workers in factories are also vulnerable to **sexual and physical abuse** in the work place. The Hope Workers' Center (HWC) in 2000 assisted 23 workers (12 Filipinos; 6 Thais; 5 Indonesians) who were victims of sexual and physical abuse. 14 of these workers were factory-based workers and 9 were domestic workers and caregivers. In 2001 the center assisted 20 workers (11 Filipinos; 1 Thai; 6 Indonesians; 2 Vietnamese) who suffered from such abuse. 12 of these workers were factory-based workers and 8 were domestic workers and caregivers. (The large number of domestic workers and caregivers work in Taipei City. The HWC is situated in Taoyuan county about 40 minutes south of Taipei. The largest number of factory based migrant workers are in this area).

Responses

Responses on several levels are being undertaken to address these issues. At the HWC the staff of ten people with social workers from Taiwan, Indonesia, the Philippines, Thailand and Vietnam offer **counseling** to migrant workers who are suffering from psycho-social/mental health problems. The center organizes **peer counseling seminars** to train migrant workers on how to empathetically listen to the problems and concerns of their fellow migrant sisters and brothers. The workers are trained on how to help workers who are suffering from stress, loneliness and homesickness.

The center offers **educational seminars** on a wide range of issues that are related to occupational health and safety and their related causes. Migrant workers are unaware of the laws that protect them especially if they have an occupational accident. We educate them on Taiwan's Health and Safety Law; on how to demand safe working conditions from their employers; the importance of wearing safety equipment; on reporting any unsafe working conditions to either our center or local authorities; what to do in the event of an accident; and the protection they receive under the Health and Labor Insurance Laws. All factory and construction based migrant workers in Taiwan are to be covered by health and labor insurance.

The center **empowers migrant workers** who are victims of occupational accidents to negotiate with their employer for compensation in addition to what is owed them from their labor insurance. The social workers act as the worker's legal aid in these negotiations. An example is the case of Nolasco Lintag. Nolasco is now blind as a result of an occupational accident he suffered while working on a construction site building a tunnel. He was working with dangerous chemicals to blast rock. On several occasions he insisted that his employer provide him with safety glasses. The employer said it would cost too much money to buy safety glasses for all the workers. One day the chemical Nolasco was using exploded and went it to both his eyes. He received only NT$633,600 (US$18,630) from his labor insurance. The HWC acted as his legal aid at 9 negotiation meetings with his company and their lawyer. Finally the company agreed to pay NT$2 million (US$59,000) in compensation. While in Taiwan Nolasco's third daughter was born. He has never seen her beautiful face.

Good Practices and Policy Recommendations

The HWC belongs to the Taiwan Catholic Migrant Advocates Association, which consists of five Catholic migrant workers' centers/offices. We also belong to the Committee for Action on Labor Legislation (CALL), which is comprised of local unions and NGOs. The major **lobbying group** for specific issues related to migrant workers is the Catholic Migrant Advocates Association. We have been **lobbying the government** for years with regards to health issues/problems and needs of migrant workers. For instance, a series of four meetings called by the new Minister of Labor with labor officials, the Catholic Migrant Advocates Association, scholars and representatives of broker agencies started in September 2000. The migrant advocates proposed an 11-point list of recommendations on how to improve the conditions of migrant workers. The list contained suggestions on how to protect the health and safety of migrant workers; on the abolition of the pregnancy and marriage ban; the mandatory medical check-ups; the possibility of live out arrangements; the demand for domestic workers and caregivers to be covered by the Labor Standards Law; on how to stop the workers from being overcharged by the brokers; on the forced savings; and tax deductions.

At these meetings we lobbied the government once again to **introduce a policy** whereby a factory needs to be **inspected** if a migrant worker has an occupational accident. (According to Taiwan's Health and Safety Law if three or more workers are injured as a result of an occupational accident the employer is to notify the local labor bureau within 24 hours). The employer is to be banned from employing migrant workers until the factory has passed a rigid health and safety check-up. If the employer refuses to follow the instructions of the government then all the migrant workers in this factory are to be transferred and the employer is to be banned from ever employing migrant workers again.

So far our lobbying on this issue has fallen on deaf ears. We continue to accompany migrant workers who are victims of occupational accidents to the Council of Labor Affairs so they can see these workers in person and witness the horrors of their injuries. The struggle continues.

At these meetings we brought forward the issue of migrant workers falling victims to **false medical check-ups**. In Taiwan it is mandatory for migrant workers to undergo medical check-ups within three days of arrival and then bi-annually. Migrant workers are tested for TB, HIV/Aids, Hepatitis B, intestinal parasites, pneumonia, any sexually transmitted diseases, drugs and a pregnancy test. Brokers and employers use the **mandatory medical check-ups** as a way of repatriating migrant workers. Some corrupt Taiwanese medical personnel will accept bribes from

brokers to falsify migrant workers' medical examinations. Migrant workers are not entitled to a second consultation. Only the first test counts. The results of a retest are not accepted by the government. Sometimes brokers and employers threaten the workers that they will retaliate through the medical check-up of they don't cooperate.

Case documentation on migrant workers abuses is required when lobbying the government. Through our **networking** with Kanlungan in the Philippines we received two case studies with regards to false medical check-ups. The **first case** was that of a Filipina who was repatriated on January 20, 2000 because the result of her first bi-annual HIV test was "indeterminate". After returning to the Philippines, over a period of four months she went to three major hospitals in Manila for an HIV test. Each test was non-reactive. The **second case** was that of five Filipinos who in October 1999 were falsely diagnosed with Hepatitis B when undergoing their first bi-annual medical check-up. They had refused to pay their exhorbitant brokers fee. The other 17 workers who had paid their brokers fee passed their medical. The Philippine government office in Taipei requested that the workers have a second medical check-up at another hospital. The results were negative. The workers were allowed to continue to work.

We brought these two case studies to the meeting with the government to verify our position. As a result of our lobbying, since November 2001 hepatitis B is only tested upon arrival but not during the bi-annual check-ups. If a worker is found to have intestinal parasites s/he is allowed to stay and take medication. After 30 days the test is repeated. We will continue to lobby for the complete ban on mandatory medical check-ups.

At the first meeting we had with the Minister of Labor she said within one month the **bans on migrant workers becoming pregnant and marrying** will be lifted. Two years later they are just being lifted. It was only on October 2, 2000 that the CLA announced that these bans will come into affect as of November 9, 2002. However, this new regulation will only apply to migrant workers who enter Taiwan after November 9, 2002. Migrant workers who entered before this date will still be subject to deportation if they become pregnant.

A major impetus in lifting the pregnancy ban was the HWC's **networking** with Verite, an NGO in the U.S. Members of this NGO visited the HWC a number of years ago. I spoke to them about the numerous abuses suffered by migrant workers in Taiwan. One of them was the mandatory pregnancy test and immediate repatriation if tested positive. Verite wrote this in their report. Their report landed in the hands of the U.S. media. The Taiwan government lost some face over the issue and vowed to do something about it.

According to Article 15 of the Regulations on Employment and Management of Foreign Nationals migrant workers, prior to and after their arrival, will still be required to undergo medical check-ups for the purpose of maintaining national quarantine safety. **Pregnancy is classified under "national quarantine safety".**

Pregnant migrant workers employed under the Labor Standards Law, i.e., factory workers, will be allowed to switch to jobs with less work load. The status of domestic workers and caregivers, to whom the Labor Standards Law does not apply, would be determined by their employment contracts, if they become pregnant. Employers would be permitted to terminate contracts if the worker is unable to perform her duties due to pregnancy. In such cases a severance fee must be paid, in accordance to the Labor Standards Law. We will continue to lobby for domestic workers and caregivers to be covered by the Labor Standards Law so they can receive better protection.

Each year the HWC participates in the **Taipei City's memorial day** for local and migrant workers who have died as a result of an occupational accident. This event receives very good media coverage.

In preparation for any action with regards to occupational health and safety of migrant workers the HWC has a **photo album of migrant workers who are victims of occupational accidents**. Each page of the album consists of a photo of the worker; a description of how the accident happened; and the response the HWC gave to the worker. We show this album to any visitors to our center. On each occasion we first ask for the permission of the worker to take their photo and to use it for education.

Advocacy for Migrants' Access to Health in Japan

by
Naoto Higuchi, *National Network in Solidarity with Migrant Workers*

1. Introduction

Because Japan is a welfare state with comprehensive social security programs, the most important issue to promote the migrant's health issues is inclusion into and exclusion from social security. If they are included, most of the health problems are solved. So the problem is whether there is discrimination based on nationality or legal status.
In reality, foreigners were excluded from most of the welfare provision until the 70s. Such a situation changed since the 80s, both positively and negatively. Today, I will first schematically review social security policy and policy advocacy for migrants' health access in Japan. Secondly, I will describe our advocacy strategy to achieve short- and mid-term goals. The point is the change of our activity from reactive to proactive and from single-issue to comprehensive advocacy.

2. Four phases of social security policies and advocacy for migrant workers

The 1980s achieved abolishing nationality clauses. Since the ratification of international convention on human rights in 1979 and the refugee treaty in 1981, nationality clauses on social security were abolished. Long-term residents are basically qualified for same rights as Japanese nationals.

But the influx of migrant workers in the late 1980s changed the situation. On the one hand, the Ministry of Health and Welfare issued official announcements to exclude undocumented migrants from national and social insurance in 1992. On the other hand, activities of NGOs remained reactive, that is, they were overwhelmed by emergency rescue of migrants and did not have the capacity to promote policy advocacy. Though we still have many tragic cases, problems were most serious in this period.

In the late 1990s, NGOs began more proactive activities. While emergency rescue was still crucially necessary at that time, migrant support groups began exhausted with these reactive measures since migrants were still excluded from social security. Since several NGO networks are established, some specialized groups including those concerned health and medical issues also began to lobby. But in this period, the target of lobbying was local government, not the Ministry of Health and Welfare.
The second tactics of policy advocacy is lawsuit. So far we brought three cases of national health insurance to court, of which we won one case and the other two lost. The issues at stake are whether undocumented migrants have formally recognized address, which is the requisite to apply national health insurance. Since we won one case, the case of a Filipina and her son living thirteen years in Japan, we could slightly open the door to apply national health insurance for undocumented migrants. Since 2000, the Network for Medical Care and the Lives of Migrant Workers was established and has been negotiating with the Ministry of Health and Welfare to improve health coverage for them.

3. Good practices

Before going to the strategies to achieve goals, let me introduce a good practice of Brazilian migrants. By the revision of the Immigration Law in 1990, Japanese-Brazilians can stay and work in Japan with a very privileged visa status. Now the number of Brazilian nationals counts nearly 270,000, the third largest population group next to Koreans and Chinese. Most of them work in factories as temporary workers. Since their employers are reluctant to pay for their social insurance, most of them are excluded from social insurance though they are qualified.

Usually those who are not applied social insurance are eligible for national health insurance. However, local governments with much Brazilian population rejected Brazilian applicants, insisting the principle the principle that employees should be applied social insurance. That is why majority of Brazilians are excluded from public health insurance.

In 1997, a Brazilian catholic group based on Hamamatsu city submitted a petition to apply national health insurance for Brazilians, with signature of 5,000 people. It had great impact on the Hamamatsu city government.

Since then, the group repeatedly negotiated with city officials. The achievement of a series of policy advocacy by the groups is twofold:

First, the attitude of the city government has changed and it organized a conference with twelve local governments with much Brazilian population in 2001, in which presented a declaration that urges the national government to resolve the health insurance problem. National governmental officials, including managers from the Ministry of Labor, Health and Welfare, were also invited to the second conference held in November 2002, in which they were criticized their ignorance of the problem by the delegates of local governments.

Secondly, officials of Hamamatsu city government informally decided to ease the requisites to apply for national health insurance in 1997. Though the problem is not yet solved, Brazilian policy advocacy gained a remarkable achievement in these five years. But it is evident that local governments should have never responded positively if undocumented workers had claimed for national health insurance. This is the limit of this case study. So we have to construct strategies in a very long term.

4. Strategies to achieve short- and mid-term goals

It takes time to change structural-institutional aspects of governmental policies. So we have to combine strategies to achieve goals in short-term (one to three years) and mid-term (five to eight years). Short-term goals can be achieved by negotiations with local and national governments without modification of legislation or ordinance. We are now urging equal treatment in terms of child and maternity health, or public hygiene.

Mid-term (five to ten years) goals include revision of health insurance system and life protection law, to cover whole of the migrant workers. Since these cannot be achieved by negotiations with ministry officers, we have to bring the matter to MPs and parties. For that purpose, we have published a book titled "Proposal for Comprehensive Policies for Foreign Residents". The proposals in this book are so idealistic that it is difficult to realize in policies in a few years. But, we can take the book to party secretariats and urge them to formulate their policy scheme. Generally, parties welcome this kind of proposals, since they began to get interested in migration issues and regard it constructive suggestions from civil society.

5. Lessons of Japanese Experience

Lessons of Japanese experience can be summarized as follows:

(1) Though the case of the Brazilian group is exceptional, organized migrants can have leverage to change policies.

(2) I don't know whether it is applicable to other countries or not, it seems more effective to present policy proposals than to go direct actions in Japan. And networking of domestic NGOs is also essential to formulate comprehensive policy proposals. Since 90 organizations are affiliated with the National Network, about fifty persons including lawyers, social workers, unionists, medical personnel and researchers joined the working group.

(3) It will be more effective if organized actions of migrants and specialized policy proposals are combined. Japanese support groups are still on the way to organize migrant workers. Maybe what is most lacking in our activities is the real solidarity with migrant workers, though we have some experiences for lobbying by our-

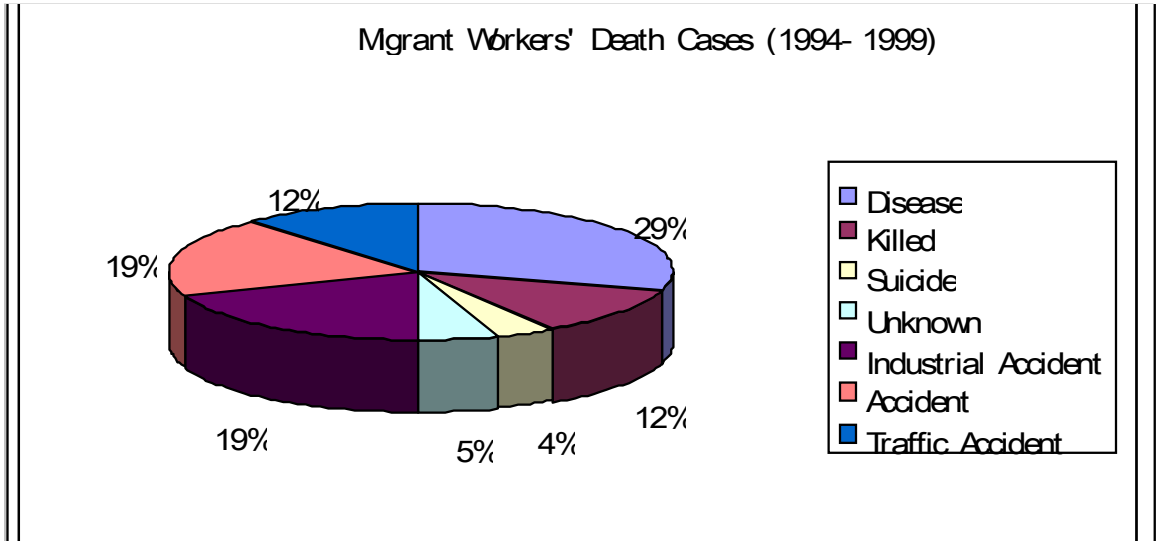
'Akihiro Okawa, "Gaikokuseki Shimin to Shakaihosho Fukushi Seido," (Foreign Residents and Social Security and Welfare Programs), in National Institute of Research Advancement ed., *Tabunka Shakai no Sentaku* (Choosing Multicultural Japan), Tokyo: Nihon Keizai Hyoronsha, 2001.

A New Collective Trial for Migrants' Health

By
Kim Mi-sun
Coordinator, Medical Mutual Aid Union for Migrant Workers in Korea (MUMK)

Many migrant workers in Republic of Korea work in poor conditions, as they are employed in so called 3D jobs – dirty, dangerous, and difficult. They are classified into two groups, legally documented and undocumented. Legally documented workers are professionals and trainees while the undocumented are some trainees who have low wages and some overstaying foreigners.

According to previous survey, migrant workers suffer from various diseases ranging from disc to cancer and HIV/ AIDS, which are not very different from local people. Medical insurances are covering the documented migrants workers but not the undocumented migrant workers. This makes it difficult for undocumented migrant workers to have proper medical care and have to bear the medical costs, which is three to four times higher than with other workers with medical insurance. This is the major problem for migrant workers - accessibility to medical care service. So, some migrants just suffer with illnesses until it turned out to be fatal and sometime lead to death.



Source: Analysis of 80 migrant workers' death cases (1994-1999) by causes, Report on the Health of the Migrant Workers in Korea, 2001.

Having such cases, some migrant counseling centers started to set up medical mutual aid system in mid 90s. But, as the number of undocumented migrants increased, medical related counseling cases have also increased. Migrant counseling centers reached a consensus to establish a collective medical mutual-aid system. In early 1999, members of Joint Committee for Migrant Workers in Korea (JCMK) in Seoul and Kyunggi region started to organize it. The Medical Mutual-Aid Union for Migrant Workers in Korea (MUMK) was officially launched on 21 September 1999.

From individual Experience to a Collective System

At the beginning, the most important thing was to market the system with the three major parties. The first major party are the migrant workers. They have to apply for membership and pay monthly fee of 5,000 Korea Won (about 4 US$). These collective fees are used for the members' medical costs. The second major party are

the hospitals. They provide discounts to the union members at an agreed rate. The last but not the least are the migrant counseling centers. They manage memberships and provide information about associated hospitals.

By the end of August 2002, the Medical Mutual-Aid Union has 10,314 members, 489 clinics, 65 general hospitals and 119 pharmacies are associated, and 33 counseling centers involved. From 2000 to end of August 2002, total 256,935,714 Korean Won (about 214,113 US$) was spent for 628 medical cases. 1/3 of the cases are pregnancy and delivery cases.

Providing medicines to the free clinics for migrants, examination fees and maternity protection project (including providing new born baby goods) are not included in direct medical cost support.

The features of the members' benefits are as follows:

Benefits for members

A. For all Members (upon payment of the fee)

a. 60-70 percent discount at designated/associated private clinics.
b. Same treatment as Koreans will be given in public health centers.
c. 40 percent discount at designated/associated general hospitals.

B. Full Rights and Benefits (three months after being a regular member)

In addition to the benefits stated in A, 50% of medical expenses are reimbursed to members who had an operation, hospitalization or in emergency case. One member can get maximum of 4 million Korean Won (about 3,125 US$) for medical cost support.

Need for more Participation from other Sectors

Given the first year in operating the system, problems being encountered are : the designated hospitals are too far from where the members are living, misunderstanding about the system, so does not pay for membership fee after reimbursement of expenses, some hospitals do not want to cooperate because they do not have the assurance about system, as MUMK is just a NGO. On the other hand, other members think that MUMK should help them in everything even without following the principles in the system.

The major tasks of the MUMK are fund raising, negotiate with hospitals, and provide necessary education for members. Its additional sources of funds are from Community Chest of Korea, Ministry of Administration and Home Affairs, and Ministry of Gender Equality that support migrant women's maternity protection project.

Having operated almost three years of MUMK, it gained more credibility from members and hospitals. But, still need more active participation from migrant communities, as they are the major beneficiaries and contributor to the system. Continuing participation and commitment of doctors and other communities are also necessary to optimize the support to the migrants.

However, establishing and implementing an adequate migration policy is the first priority to let migrant workers live and work safely here in Korea.

Migrant Workers in Pakistan: Magnitude, Health Issues, Problems, and Responses

by
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Program Officer (Lawyers for Human Rights and Legal Aid , (LHRLA-Pakistan)

In the year 2001, Pakistan had an estimated population of 145 million. In 25 years, it is estimated that the population will double, increasing the strain on the infrastructure and resources. The low GDP growth, inflation coupled with recessionary trends in the economy has frustrated the people pushing them to move out of the country.

About 80% of the country budget is spent on debt servicing and defense expenditure. With other liabilities the government is left no money for development programs to uplift the condition of the masses.The gulf between the rich and the poor is widening day by day and in such frustration people are willing to work as waiters, drivers, peons and even as laborers outside the country but feel humiliated if they have to perform such tasks in their own countries.

The level of unemployment is expected to increase even more in the coming years. The high rate of population growth, accelerating unemployment rate, and economic conditions in the context of globalization make leaving the country a viable and often preferable option for many Pakistanis.

At the same time as citizens are leaving the country's borders in search of work, citizens of other countries are entering the country with the same objectives, as well as to seek refuge from difficult situations in their own countries.

According to the Figures of the Protector of Emigration Karachi

- in 1998 total 15,530 people were registered out of which 39 were female;
- in 1999 total 12,525 people were registered out of which 42 were female;
- in 2000 total 17,633 people were registered out of which 50 were female;
- in 2001 total 19,461 people were registered out of which 90 were female;
- in 2002, till September, total 12,876 people were registered out of which 93 were female.

In Pakistan usually people are using four channels to go abroad; Bureau of Emigration & Overseas Employment, Overseas Employment Corporation, Private Sector and Direct Sector.

According to official statistics, about 1,08,984 Indian Nationals arrived here from 1996 to April 2002 and about same number left Pakistan during this period. About 40,000 Bengalis came to Pakistan through legal channels and left the country in same period. The number of other Asian nationals who came to Karachi, Pakistan and left is 24,949. According to a rough estimate, more than 20% of the population of Karachi comprises those who have either come in to work from other provinces or are illegal migrants from Afghanistan, Bangladesh, Burma, Philippines and the Central Asian States. This illegal workforce has an impact on the weak domestic economy and also challenges the social structures of the society. In order to analyze the demographic impact and the social change of internal and international migration on a developing state like Pakistan it is necessary to measure its influence on the resident population. Lack of data on internal migration and the illegal workforce has created difficulties in identifying and measuring the challenges posed.

- They come from as far as Burma, Iran, India, Bangladesh, Sri Lanka and Philippine.
- Most of these illegal migrant workers from Bangladesh are working in the carpet weaving and fishing industries.
- Bangladeshi women are working as domestic servants.
- Because of their subordinate status both as migrants and as women, female migrant workers are highly vulnerable to exploitation and ill treatment.
- Many migrant workers work without official work contracts, or if such contracts exist, they are on unfavorable terms - low salaries, no insurance, and no control over working hours.
- In some cases, the migrant workers passports are withheld by the employer, which represents a restriction of their freedom of movement.
- Migrant women are also particularly vulnerable to psychological stresses; divergent sets of cultural expectations, marginalization in the host society and in the labor market and the double burden of family and work are but a few examples.

- In addition, migrant women are particularly susceptible to physical and sexual abuse during travel, in camp situations, or in the countries of destination.
- Many women who migrate for promised jobs in domestic service, catering or entertainment find themselves tricked into prostitution.
- Since they are often illegal or undocumented immigrants, these women are vulnerable to abuse.

Health Perspective

Lack of Awareness

A vast majority of migrant workers who, including those leaving and entering and those returning to their country of origin, are unskilled and uneducated workers. They are employed for manual work, including for jobs such as factory workers, taxi drivers and domestic staff. Even if they possess some basic literacy skills, by and large their level of education and awareness is low. This leaves them open to the risk of contracting infections and being carriers of certain inherent and endemic diseases without any possibility of seeking medical recourse to prevent the risk of spreading those diseases both locally and regionally. The risk factor therefore is maximized by their lack of awareness and failure to consider the health aspect seriously. In the case of HIV/AIDS, for example, many may dismiss their risk of contracting the infection without a true understanding of the actual risk and vulnerability they may have.

Diseases Inherent or Localized in Pakistan

Many diseases are particular to certain geographical regions. Poor water supply, nutritional deficiencies, climatic conditions and other such factors may be the reason for such poor health outcomes. As a result, migrant workers may be in poor health at the start of the migration process.

Mental Health Aspect

Migration brought on by the quest for a more lucrative livelihood and the stresses associated with adjusting to a new cultural, political, legal, linguistic, professional and social environment takes a toll on the mental health of migrant workers. There is also the added pressure of earning enough to remit back to families in their home country as well as maintain standards of survival in a foreign country. The mental health aspect of the migrant worker is a very neglected sphere.

With illegal migrants, levels of stress can be even higher as the threat of being discovered and deported is a constant fear they live with during their stay. Exploitation by overseas employers and a step brotherly attitude add fuel to this burning frustration and state of powerlessness the migrant workers have no choice but to contend with.

If the concern and safety nets for nurturing the physical health of migrant workers are inadequate then it may be safely speculated that those available for the mental well-being and psychological health of this uprooted workforce are next to non-existent. There is no provision for counseling, no availability of mental health professionals or even awareness amongst the migrant workers themselves of the need for such treatment and medical aids to ease adjustment and make their transition smoother. It is suggested that this particular aspect of mental health commonly known, as depression should not continue to be ignored and appropriate measures be taken to allow the migrant workers to constitute associations and unions to share and express their concerns and also to protect their rights. Appropriate measures by the employer/employing organizations also ought to be taken for their counseling if and when required.

HIV Vulnerability

High stress and lack of avenues for mental support have caused a substantial number of migrant workers to turn to drugs for temporary relief. The most obvious danger of such addictions or even occasional use of drugs is the physical and mental dependency on the substance used. Additional side effects include a loss of appetite resulting in weight loss, decreased concentration and lethargy. From the financial point of view, a continuous use of drugs burdens the already scarce resources, and in turn, this adds to stress levels. Migrant workers using drugs are therefore caught in a cyclical state of mental anxiety and pressure, which already increase their vulnerability to practice high-risk behaviors. Those who are using injecting drugs are clearly at an even higher risk of vulnerability to HIV infection.

Living conditions for migrant workers can also be difficult. They often live in cramped quarters, share limited living space with workers from similar backgrounds and are of the same sex. As a result of loneliness, alienation and the close quarters living conditions, sexual relations between men do occur. The main advantage and therefore attraction of this is the fact that this mutual sexual relief comes for free compared to that offered by brothels and professional sex workers. The cultural conditioning of these workers is also a factor in their choice for homosexual relationships. They may for example feel that to indulge in a heterosexual sexual relationship would be cheating on their spouses left behind and is

morally more wrong than homosexual relationships.

In tribal culture such as that prevailing in the northern areas of Pakistan, women are symbolic of a man's honor, be it their father, brother, husband or son. Therefore to have extramarital or premarital sexual contact with a woman is encroaching on another man's symbol of honor. Often if found out the price for such an offence is very severe and may in fact be the death of two individuals involved. This mental conditioning makes it more 'acceptable', 'free of danger' and 'guilt free' to turn to members of the same sex for sexual relief.

In all of the above scenarios, the use of protection during casual sex is rare if not absent altogether. Lack of education, the impulsive nature of the sexual encounters and the cost and perhaps embarrassment of purchasing contraceptive devices are the major contributing factors.

The result of indulgence the availability of casual sex both of a heterosexual and homosexual nature, visits to commercial sex workers, drug use all without any concern or use of precautionary measures seriously heightens the risk of sexually transmitted and other diseases, including HIV.

Sex with Multiple Partners

Amongst migrant workers sexual promiscuity is a dominant contributing risk factors to HIV/AIDS. Most of the migrant workers are single men and most belong to a healthy and reasonably young age group. Most of them do not travel with their families, and are away from home for a long time as travel is an unaffordable luxury and leaving for a short period may even cost them their jobs.

These workers therefore are very lonely and in the absence of their spouses or being bachelors seek sexual relief. They visit brothels and indulge in careless sex. Even those who live with families and have wives habitually visit brothels. The cost of this casual sex increases the chance of contacting sexually transmitted diseases, which include HIV/AIDS.

Homosexuality

Many migrant workers owing to the physical proximity, sheer availability and advantage of free sexual relief succumb to having casual sexual relationships with each other. The main advantage and attraction of this kind of relationship is the fact that this mutual sexual relief comes for free compared to that offered by brothels and professional sex workers.

Drug Use in Migrants

On account of the stress, lack of avenues for psychological help and mental support the migrant worker experiences frustration and a substantial number of them may turn to drugs for temporary relief. The most obvious danger of such addictions or even occasional use of drugs is the physical and mental dependency on the substance used. Followed by a loss of appetite resulting in weight loss, decreased concentration and lethargy. From the financial point of view as well maintaining drug use burdens the migrant workers already scarce resources adding to his stress levels. He is therefore caught in a cyclical state of mental anxiety and pressure. Moreover sharing of needles has been known as a very common way of contracting AIDS/HIV amongst the migrant workers.

It is therefore essential to take information from Potential migrants about their level of knowledge, provide them sufficient information and share the experiences, life histories of Returnees who wants to migrate again and who return to stay.

As the country facing high economic transition at different level, masses are forced to migrate different places for the better life of their families. In their own native country they face different kind of problems, though they have been deprived of basic information but yet, other economic and social problems forced them to migrate within and out migration. The factors involved in this process can be various but leading contributing factors are as follows:

- Lack of education (among elders and children)
- Lack of employment and better earning opportunities
- Lack of sharing from returnees
- Bad recruitment agencies
- No regulation/ law enforcement
- Lack of governance and social control
- Lack of knowledge sources with communities.

The Pakistani Government Established National Aliens Registration Authority (NARA)

Under this scheme an illegal alien can become a legal resident by paying a paltry amount of Rs. 1000, and by paying Rs. 5000 more he or she can get a work permit.

The National Aliens Registration Authority established by the Pakistan government started registration of aliens by the end of February this year and about 18,600 aliens have so far been registered. These include mostly Bengalis, who work as domestic workers, in hotels, factories and in fishing sector.

LHRLA Work

- Trafficking of women & children
- Review of laws
- Assist the government in making & implementation of laws
- Research with migrant workers on HIV/AIDS
- Community development center
- Awareness raising campaigns on health, law and protection
- Documentation of cases

Responses

- Positive government response
- Government's approach to involve civil society
- Expansion of civil society organizations
- Positive response by the urban masses towards civil society initiatives
- Recognition of the importance of human rights in every day life
- Government's initiative with regard to trafficking and migration issues

Migration and Migrant Workers Health and Well Being: Issues, Needs, Responses and Strategies (Gulf Region)

The gulf region is host to a large number of migrant workers. However outreach to these workers is limited to charity organizations or prayer groups based in the various churches; clubs and associations based on regional lines. Besides the embassy, these groups conduct free medical check-ups either in labour camps or elsewhere occasionally. Health access is limited because workers at the lower end of the scale are not covered by insurance and if they are provided with medical aid , it is deducted from their wages. Thus little documented information is available about their health issues. A brief look at the kinds of problems encountered:

Domestic Workers: Physical and sexual abuse, high workload, insufficient food, pregnancies. They are not covered by the labour law but by the Sharia law .

Fish Workers: (Quatar, UAE, Oman …Indians and Bangladeshis) work related injuries, many can't swim so drowning at sea, killed by pirates (Iranis) attacking their boats (Quatar), general disease, stress related disease, infections… Fishermen have been promised insurance schemes for years.

Factory Workers. While a large number are legal many because visas have not been stamped or extended, become illegal. NO medical aid provided for. Earlier because of health card (which employer has to pay for but instead is deducted from workers), they could access free medical treatment and medicines from the public hospitals. From may 2001 no more such facility and they have to pay for medicines, treatment, etc… less if have health card but high rates without. Also as these factory workers live in labour camps, which are not conveniently located close to medical centers, they have no access to medical help, as they can afford neither the transportation nor the high cost of medical help or medicines. Most resort to 'panadols' or aspirins, which come in bulk from home countries. (Medicines for personal use can only brought as stock for 3 months…)

Construction Workers. Work in most cases without safety equipment. The work in the heat (temperatures up to 45 degrees centigrade in the summer cause a number of accidents and heat related illnesses. A similar problem is faced by others in outdoor work like gardeners, those involved in roadworks, etc.

Qatar has health care center, as it is difficult to get them to hospitals. Embassies are more of a hindrance than help (esp. Indian)… Hospitals are no longer free. The counseling center at the church provides help to migrant workers and their children with psychological problems, depression, the victims of physical and sexual abuse, drug and alcohol addictions…

Bahrain has a unique problem of free visas… These are cases where a visa can be bought from sponsors and then they work in the free market. The sponsor then refuses to acknowledge their responsibility vis a vis the workers health, injury, and even repatriation of the body in case of death. (Bahrain…Bangladeshis according to the embassy staff, 90% of approximately 40,000 expats are casual workers in the agricultural, construction and household fields.). In Bahrain the Coordination commission of Indian Associations has started an insurance scheme, where for BD 1 per year, major injuries are covered. Covered and a 350BD compensation is provided for injury and death and repatriation of the body.

Oman has some groups that provide transport to and from labour camps for workers who need regular tests for blood pressure, sugar, eyes and breasts. Attempts are being made to identify people in parishes (doctors, nurses), etc, who would volunteer to provide services to workers who have no access to medical aid.

Most of the Gulf countries have prison visits by church groups which provide minimal assistance for financing the treatment, surgery, medication etc….on a case by case basis. Most because they have to report to their jobs, no access to leave, medical allowances, etc, either do not access medical help or leave with minimal help irrespective of whether a complete cure has been achieved.

Major concerns:

- Limited access of workers to medical help as most (especially low income groups) are not covered by insurance or covered partially. Medical help is expensive.
- Sponsors have the responsibility according to law to provide medical help but majority do not or only provide partial assistance. There are very few, if any, mechanisms to monitor whether employers provide the services they have to, and still fewer measures to ensure they do.
- Families of workers who accompany are rarely covered and so medical expenses are a major burden.
- Outdoor workers like construction workers, gardeners, fish workers, etc suffer severe problems in the summer because of the extremely high temperatures and are prone to accidents and injuries because of unsafe working conditions.
- Assistance provided by embassies and consulates is limited

In the gulf region, thus the efforts of reaching out to migrants health concerns is a developing area. The major cause for this is because all groups addressing the issue are charity based, volunteers with no legal standing. At minor levels some groups liaise with embassies and consulates to provide assistance. An effort is being initiated to document cases being assisted. We hope to collate this information at the regional level to push for better services from consulates.

Confusion and Ambiguities about Migration Trafficking Nexus: Is Conceptual Clarity Possible?

by

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"The problem of Trafficking and the web of human right violations it embraces present some of the most difficult and pressing issues on the international human rights agenda. Complexities include different political contexts and geographical dimensions of the problem: ideological and conceptual differences of approach … link between trafficking and migration presents another complexity presenting both political and substantive obstacles to resolutions of the trafficking problem."

UN Secretary General's Report on 'Trafficking in Women and Girls' presented at the 58th Commission on Human rights (2002) in Geneva.

Introduction

Migration and trafficking are two different but inter-related phenomena. Migration is a broad general concept and trafficking is only a sub-set or category of the broader concept. Migration is the movement of people from one place to another (in case of international migration one country to another) in order to take up an employment or establish residence or to seek refuge from persecution. It applies to various types of movements guided by diverse causes. International migration (i.e. migration across borders) in particular is a complex and multidimensional phenomenon. The dynamics of international migration is often explained or measured in relations to (either alone or in combination) citizenship, residence, time or duration of stay, purpose of stay or place of birth etc. On the other hand, a "Migrant worker" is a person, who is to be engaged, is engaged or has been engaged, in a remunerated activity, in a state which, he or she is not a national . This definition also includes undocumented workers who would also, under this Convention, be entitled to a certain rights. Trafficking is the movement (either internally or internationally) of a person under a situation of deceit, force, threat, debt bondage etc. involving exploitation and violation of human rights of the person. Trafficking in person generically included smuggling plus abusive exploitation and human rights violations. That means facilitating illegal employment does not come within the scope of smuggling. But, studies have suggested that a person by placing himself/herself in the hand of smugglers, albeit voluntarily, often lose control of his/her fate and freedom becoming a trafficking victim. (The issue of assisting a person in an illegal broader crossing for non- profit purpose is not discussed here).

IOM Overview of , Overview of International Migration, Migration Management Training Program, April `97, Geneva
Article 2 (3a) of International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.

For details see Ahmed, Syed Refaat Ahmed, Forlorn Migrants: An International Legal Regime for undocumented Migrant Workers, 1999, UPL Dhaka.

4Smuggling is a situation when a person places himself/herself to facilitate his/her border crossing in a irregular manner is exchange of financial or other material

IOM, Migrants Trafficking and Human /smuggling in Europe: A review of the evidence with case studies fro Hungary, Poland and Ukraine, Geneva, 2000.

Harm" is the undesirable outcome that places a person in a situation whereby, the person finds him/herself in exploitative and dehumanizing conditions. Often beaten up, sexually and psychologically abused. Made to work long hours without remuneration. Freedom of mobility and choice are non-existent. The "harm" results from a situation of forced labor, servitude and slavery- like practices in which a person is trapped/ held in place through force, manipulation or coercion for a given period o time.

Conceptual Ambiguities and Limitation

Within the field of migration and trafficking, there is no consensus on how to refer to those who migrate in ways that contravene national laws and involve the facilitation by others for profit. Various terms are used, some of the most common are: "alien smuggling"; "trafficking of aliens"; "illegal immigrant smuggling"; "human trafficking"; "trade of human beings". Many researchers and advocates prefer the more neutral terms of "irregular migrants" or "undocumented workers". At the same time, these terms disguise the kinds of exploitation that much organized trafficking involves. Particularly the "harm" situation that the trafficked victims end up in eventually. These complexities make both researches difficult. Moreover, there is not enough clarity about what should constitute 'voluntary' prostitution and the range of ways in which sexual exploitation takes place, and how to name those who profit from this trade in women. The best we can do is to be aware of the debates, and be clear about which term and language we used in our researches.

It is difficult to ascertain differences between migration and trafficking, as the demarcation between the two phenomena is often apparent and a question of perception. Attempts to draw a clear line between the two concepts are described as working in "terminological minefields". Sometimes attempts, though wrong, are made to distinguish smuggling as a migration issue and trafficking as a human rights issue. Again, any generalization in identifying the difference between the two concepts can be misleading because both the concepts are overlapping, contextual and time bound. In simple terms, the difference could be as follows:

- Normally, smuggled migrants are aware of the conditions of the travel and voluntarily engage themselves in the process of illegal migration. Victims of trafficking are seldom aware of the entire process. Even if they submit themselves freely to the traffickers, they can not consent to the human rights violations they will be subjected to.
- While smuggling of persons indisputably involves international cross-border movements trafficking could also occur within national borders, although the vast majority happens across international borders.

Expert opined that, clear distinction between smuggling and trafficking could be difficult to establish particularly in analyzing real cases. Smuggling may contain elements of deception and/ or coercion as well. Both smuggled and trafficked (and even migrants) persons incur into debts with the intermediaries, and the abuse of human rights may occur during the time of smuggling operation. There is often a gray area in practice and it is not realistic to discuss smuggling without trafficking.

There is however, a similarity as both trafficking and smuggling threaten States and Security because of the presence of organized crime, irregular migration and violation of national legislation in both the processes. But, threat from trafficking in persons on state security is much higher as it concerns human security and basic human rights of the citizens. States need to provide protection to the victims of smuggling and trafficking in terms of return, reintegration, medical, psychological, counseling and legal support.

Although the main purpose of migrant smuggling might be to facilitate the illegal entry of the migrant into another country, there are many cases in which smuggled migrants are exposed to violation and exploitation either during transportation to the destination country or on arrival.

It is obvious from the above discussion that ascertaining a clear distinction between migration, smuggling and trafficking is extremely complex. They are inter-twined and an integral component of the population movement process- both conceptually and operationally. It could be rather realistic to conceive all the three concepts as part of a dynamic "population movement scenario". People on the move could be placed in the boxes (net page) depending on their legal and human rights status.

Kelly, Liz,. " Conducting Research on Trafficking: Guidelines and Suggestions for Future Research" a report prepared for IOM, 2001.

Skeldon, Ronald, "Trafficking: A Perspective from Asia" in Reginald Appleyard and John Salt edited, perspectives on Trafficking o Migrants, 2000, IOM, Geneva.

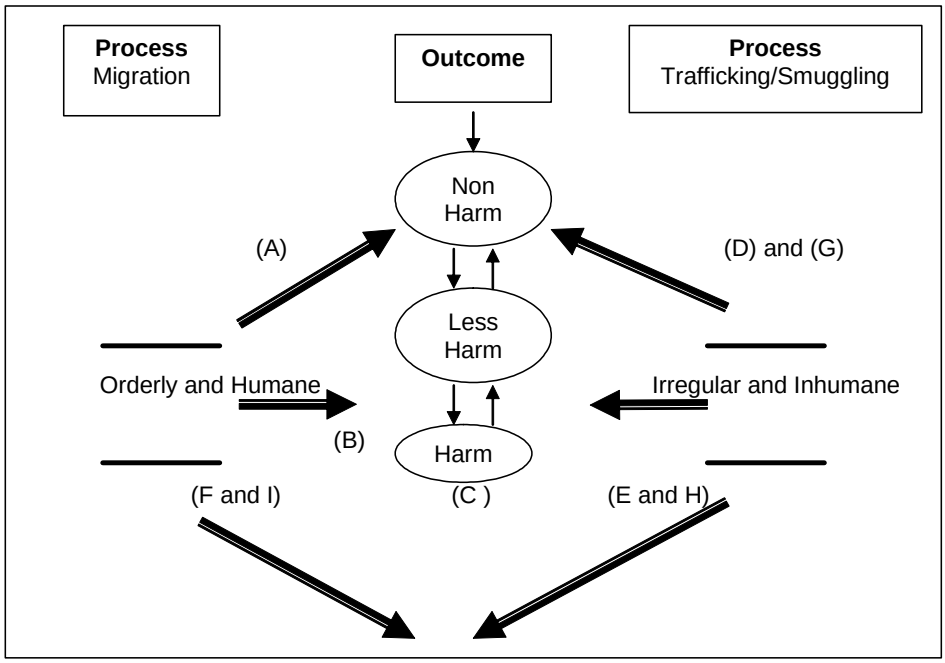
IOM, Migrant Trafficking and Human Smuggling op.cit.

Ibid.

Salt, John. " Trafficking and Human Smuggling: A European Perspective "in Reginald Appleyard and John salt edt. Perspective on Trafficking on Migrants, 2000. IOM, Geneva.

Movements back and forth along the two processes could also be possible. Often that is the case. Migrants in an orderly and humane situation could be placed as part of the left processes and trafficked/ smuggled persons on the right process of the diagram in the following":

Dynamic of Population Movement in a Process – Outcome Scenario



(A) A person who has been migrated to another country with legal documents (orderly process) and is in a "non-harm" working situation (humane outcome).

(B) A person who has been migrated to another country with legal documents (orderly process), but its in a "less- harm" situation (exploitative outcome).

(C) A person who ahs been migrated to another country with legal documents (orderly process, but is in a "harm" situation (inhumane outcome).

(D) A person who has been smuggled into another country (irregular/ in orderly process) but is in "non- harm" working situation (humane outcome).

(E) A person who has been smuggled into another country (irregular process), and is in a "less-harm" situation (exploitative outcome).

(F) A person who has been smuggled into another country (irregular process), and is in a "harm" situation (inhumane outcome).

(G) A person who has been trafficked either within his or her own country through a forced, deceptive and abusive process (irregular process) but is in a "non-harm" situation (humane outcome).

(H) A person who has been trafficked either within his or her own country or another country through a forced, deceptive and abusive process (irregular process) but is in a "less-harm" situation (exploitative outcome).

(I) A person who has been trafficked through a forced, deceptive and abusive process (irregular process) and is in a "harm" situation (inhumane outcome).

"Freedom to choose" which is vital in determining migrant status (i.e. where he/she is migrant or trafficked person).

There are overlapping approaches to analyze trafficking. First, economic perspective that considers trafficking as an economic activity and secondly, legal perspective that considers trafficking as a criminal activity. Economic approach places trafficking in broader concepts of migration as a business in which agents/ institution seek to make profit. Some analysts have suggested that trafficking should be viewed as a consequence of the "commodification" of migration process that generates profit out of peoples' mobility.

On the other hand, legal approach considers trafficking as a violation of legal provisions of State and violation of human rights. Criminal networks have emerged involving trafficking in persons, which provide labor to the "hidden economy" illegally. The main weakness of the two perspectives is neither of the two focuses on human rights violations of victims. Therefore, there are discussions on construction of "humanitarian perspectives" to analyze trafficking. Moreover, there is no theoretical construction, which could deal trafficking within the broader migration dynamics taking into account in the process and outcome of trafficking.

Placing trafficking only in economic and/or legal bounds makes it difficult to identify those elements of movements (migration) that are associated with quasi-legal or quasi- economic issues. The ambiguities in theoretical understanding of the migration- trafficking nexus often lead to unavailability of adequate & reliable statistical data. The researchers face difficulties in choosing appropriate method of data collection and analysis. The inadequate data in turn imposes two types of "limitations" on the researches, first, over dependence on subjective interpretation, which could be biased and marred by individual perceptions. And, second, adoption of "adhoc methods" which sometimes could lead to distorted analysis and outcomes.

Since trafficking and irregular migration take place within broader socio-economic space, there is a need to be careful in choosing right terminology in describing the processes. The elements of population movement/ mobility can be described or conceived in terms of paired aspects. A non- exhaustive list of such paired aspects might be as follows:

Concerns and Conclusions

Over- emphasizing trafficking as a migratory and "mixing" it with legal migration would not be productive in combating trafficking and making migration safe. Some of the destination countries sometime use trafficking and smuggling as excuses to develop more restrictive approaches to migration. They also argue that "trafficking in migrants" is a criminal act and needs strict crime prevention strategies to tackle it. They deliberately "mix" up the issue of migrants human rights with that of human rights of trafficked or smuggled persons. Therefore, for the purpose of Thematic Group exercises, w may use the term "population movement/ mobility" rather than calling the trafficking process as migration. It is a generic term, which is applied to the whole spectrum of human migration and displacement.

- **Internal/International:** This element of population movement has to do with territorial parameters and the limits of state sovereignty. Internal migration often takes the form of economically and/or non- economically (civil strife, natural disasters and environmental degradation) motivated rural-urban migration. International migration, in many ways, a more complex issue than internal migration as it activates the sovereign rights and responsibilities of States. Sovereign states are vested with the right to regulate the admission of non- citizens into their territory.
- **Legal/Illegal:** This element of population movement has to do with whether movement takes place within existing legal frameworks. Legal (regular) migration can involve short to medium-term workers (for example professional intra- company transferees and skilled or semi-skilled contract personnel) as well as permanent migrants (persons accepted without a limit on the duration of their stay, whether for business or family migration or even refugee resettlement). Illegal migration is generally discussed in the context of international migration.

Voluntary/Forced*:* This element of population move-

Discuss based on IOM publication on Migrant Trafficking and Human Smuggling in Europe op.cit.

Salt. J. Stein, " Migration as business: The case of trafficking" International Migration, 35(4).

This discussion is based on IOM-UNHCR joint Discussion Paper on " Population Movements: Their Nature, Causes and Consequences: present at a Expert Meeting in Bangkok, July 1997.

ment relates to the motives of the persons moving. It is usually difficult to identify any single cause for a population's departure from their country of origin as host of social, economic, political & culture factor influence people to move. Self-interest, which may be considered to underlie most voluntary movements, and self- preservation, which is behind most forced movements, blends into one another. While distinctions are not easily made, it is often said that economically motivated movements are generally voluntary and that humanitarian movements, in cases where they are based on fear, are forced (involuntary). It is however, possible to conceive of situations in which persons are "compelled" to leave their homes or countries for reasons of economic survival or security related reasons not simply economic betterment. In any case, while a single case, highly visible catalyst to flight may exist deeper set of root causes generally underlies these events. Thus, while famine, persecution or armed conflict may be apparent cause of forces population movement; amore thorough investigation will often reveal a complicated mixture of causes, which have precipitated the decision to flee.

INDONESIAN MIGRANT WORKERS UNION

Dhaka, October 2002

I. Introduction

Hong Kong is one of the promising regions for foreign migrant workers such as Philippines, Thailand, Nepalese, Indian, Indonesia, etc. So far the number of the Indonesian migrant workers in Hong Kong is one of the greatest populations after Filipino migrant workers, it is 75, 0000 and all of them are women. Since the prolonged of economic crisis in Indonesian it is causing huge number of unemployment every month and migration is become popular and best choice to settle unemployment problem.

In Indonesia itself the number of workers sends abroad both documented and undocumented are rising dramatically every month. At the end of 2000, the number of Indonesian migrants send abroad was estimated at 4 million and 70% of them are women and working as Domestic Workers. Also most of the Indonesian migrants are working in the 3D area (Dirty, Danger, Demeaning) like a domestic helper, plantation workers and factories workers.

Since they are working in this 3D area, usually they are in bad health condition and no human right protection both from the Indonesian government and the host countries.

Problem of the Indonesian Migrant in Hong Kong

The most common problem faced by Indonesian migrant workers in Hong Kong are:

a. Underpayment. (The HK regulation for all foreign domestic workers minimum wage was HK$ 3670 but most of the Indonesian domestic helpers get an average wage HK$1800-2000/ month)

b. Excessive placement fee HK$ 21,000 more+ interest if we pay them late.

c. Renewal Contract Problems. (Overcharging fees) between HK$ 5000-9000.

d. Contract Violation. (No proper food, accommodation, underpayment, working in other places out of contract).

e. Lack of protection fro the government to migrant workers. (Until now the Indonesian government did not make new regulation to protect Indonesian migrant workers).

f. Lack of information about the regulation in Hong Kong.

g. Sexual and physical abuses.

h. No temporary shelter for migrant workers who has labor cases.

i. No accommodation for us to hold the training for migrant workers.

j. Risk to be terminated by the employer any times.

STAGE	PROBLEMS
Recruitments and Pre-departure (Regular and Irregular)	1. False Medical Test 2. No proper shelter while migrants workers are waiting for their departure such as: • No enough food • No mattress for sleeping • Too long waiting and staying in the agencies shelter • Not allow to communicate with the family's members or communities outside the shelter. • No medical treatment • Not enough clean water, etc.
Arrival and Reception	1. In some countries the migrants have to do the medical test (In Taiwan some migrants are forced to do medical test in the airport), in Malaysia many Indonesian women were forced to do HIV test and STD. 2. While they are waiting in the Agencies shelter: • Many Indonesian migrants are forced to do illegally work • The agencies also doing physical and oral abuses toward the migrants. • No medical treatment • Not enough food, etc.
Work place	1. Not enough food 2. No proper accommodation 3. No proper medical treatment 4. Rape (STD or HIV), physically abused 5. Not Allowed to communicate with the families in Indonesia 6. Many Indonesian migrants in Hong Kong are not aware about STD or HIV disease by changing partners easily.
Re-Entry	1. Some of the migrants whoa have deported back to Indonesia they were being raped an in this situation they are on the risk health condition. (See Deportation from Malaysia to Nunukan-east of Kalimantan, Indonesia) 2. Un-human detention camp (in Malaysia many migrants died in 1998 while they were waiting in the detention camp to be de-ported back in Indonesia. 3. The migrants who were prisoners in some Arab countries or in Malaysia are in bad health situation.

II. IMWU and Other Migrants Grass Root Respond

IMWU was conducted many activities to respond the above problems:

1. Training (Paralegal, gender, leadership etc.)
2. Advocacy
3. Lobbying
4. Publication
5. Reintegration
6. Social and Cultural Work

Migration Plan of Action for REACH

Why Migration is on our Agenda?

- Felt needs of participating countries – South Asia is a region on the move
- Inter-country, cross border and overseas migration taking place all over the region.
- Migration in the presence of poverty and absence of information, choice and rights make people vulnerable to HIV.

Some initiatives undertaken so far:

1. Facilitation of a Regional Migration and HIV strategy through involvement of all key stakeholders from South Asia: Governments, CSOs, research institutes, UN, bi-/ multi- lateral agencies etc.
2. Multi-centric pilots

   - Coverage: 3 countries (India, Pakistan, Sri Lanka)
   - Areas: Urban slums (Delhi)
     Open Labour Market (Turbha Naka)
     Garment Production Centres (Tirupur)
     FTZs (Byagama, Katunayake)
     Inter country migration hub (Karachi)
   - Methods: Involvement of Trade Unions
     Peer groups for awareness/ support
     Operations research
     Linkages with referral systems (voluntary & municipal doctors)

3. Action research to assess causes of out migration & related vulnerabilities
   - 3 villages of Kalpakkam
   - potential migrants, spouses, returnees
4. Action research to assess special vulnerabilities
   - Calcutta Port Area
   - Comparison of migrant: non migrant youth
5. Major findings: Majority migrate in search of a better livelihood;
   Foremost requirement of migrants: survival
   Women who migrate, whose partners migrate both vulnerable.
   Those settled for longer time: less vulnerable
   Younger migrants: peer pressure, early initiation into sex
   Strengthened social capital enable safe mobility

Lessons learned which will shape future strategies

The following lessons have emerged in implementing migration and HIV initiatives through partners in Bangladesh, India, Pakistan, Sri Lanka and Nepal:

- Need for strengthened data and empirical knowledge base on vulnerability factors among migrants and response strategies required at policy and community levels.
- Lack of disaggregated information on the universe of mobile populations and related strategies, i.e. economic migrants, transport sector workers, students, armed forces, displaced people, trafficked persons etc.
- Specific needs of overseas, trans-border, intra-country migrants as well as documented and undocumented migrants, legal and illegal migrants and those trafficked among them. Linkages between migration and trafficking and overlaps.
- Absence of national, regional networks or organizations working on migrant issues in comprehensive manner at source, transit and destination areas
- Lack of advocacy, support and commitment from governments within the region and recognition of the social and economic identities of migrant workers.
- Dearth of multi-sectoral and integrated responses addressing the wider context of livelihoods, poverty and mobility.

Plan of Action

- ***Advocacy with Government for committed responses***: Mobility and migration are not being adequately addressed by many governments of the region and where they are being addressed government is not adequately informed in the absence of concrete data and analysis of key issues. An advocacy strategy to generate greater commitment and involvement of governments is required.

  Proposed immediate action: Meeting of Heads of National AIDS Prevention Programmes from all South Asia countries for advocacy on migration and HIV. Learning and sharing of experiences and identifying areas for capacity development. Objective: to strengthen government support to CSOs working on migration and HIV/AIDS in the region.

- ***Tools***: In addition to absence of data there is an absence of tools that can facilitate migration and HIV initiatives. But what kind of tools are required?
  Proposed immediate action:
  - facilitate development of Code of Conduct for the Recruitment Agencies within South Asia. A Pilot initiative with Recruitment agencies in Pakistan and Sri Lanka to take this forward. Also collate and disseminate best practices in the area of migration and HIV.
  - development of advocacy and mainstreaming tool for linking migration and HIV with broader issues of poverty and livelihoods.

- ***Interfacing Migration and trafficking***: The most common entry points for linking trafficking and migration initiatives lies at the source areas where unsafe mobility results in trafficking.

  Proposed immediate action: build in safe migration component into the trafficking project being implemented at the source communities.

- ***Addressing special needs of special population groups- women affected by migrants***: Women who migrate alone, those who migrate with their spouses and those whose spouses migrate have all known to be vulnerable to several risk factors including HIV/AIDS. Have the special vulnerabilities of women migrants to sexual exploitation and to being trafficked been addressed adequately by migration organisations? Women migrants need greater preparedness and safety nets to reduce these risk factors.

  Proposed action: Develop a strategy to reduce the vulnerability of women migrants in partnership with other key players in the region including IOM, Care South Asia etc. This could include pilot initiatives with women migrants at source, transit and destination locations. Also include Forum of sending countries to raise concerns related to exploitation, mandatory testing, discrimination, sexual abuse etc.

- ***Developing effective and operational model(s) for action***: Good operational models need to be developed within the region for replication and for upscaling. A 'source to destination' pilot to be implemented with migrants in their transit and destination areas and their families in the source areas is being proposed.

  Proposed Immediate Action:
  - A 2 year pilot 'source to destination model between India and Nepal to be initiated before the end of 2002. Beginning at the Destination (New Delhi) and identifying Source communities in Nepal.
  - A multi-site, multi-country project to be implemented in Bangladesh, India, Nepal, Pakistan and Sri Lanka. Proposal ready for implementation before end of 2002. Focus on involvement of Trade Unions for reaching out to workers in the informal sector, looking at different typology of migrant groups at source and destination areas. Involving a nodal organisation linking with NGOs in each o f the implementing countries.

- ***Facilitating Operation research***: An applied research to disaggregate 'vulnerability' will enhance understanding of what specific issues or areas need to be addressed and who among the migrant communities are more vulnerable.

  Immediate proposed action: a research in West Bengal on the migrant populations' vulnerability to Injecting Drug use followed by a drug rehabilitation initiative reaching out to migrant communities.

- ***Innovative use of technology for strengthened responses***: Community kiosks in source and destination areas can facilitate better linkages between the migrant and his/her family, can provide easy access to relevant information regarding livelihood options, HIV/AIDS etc. How can ICT facilitate knowledge networks between the different country programmes and NGOs for easy sharing and learning.

Proposed immediate action: The Orissa model: from source to destination. Converting community kiosks into activity centres. Developing packages to facilitate database of outgoing migrant workers through involvement of Panchayats.

- ***Forming and operationalizing a Regional migration network***: No network of migration organisations exist in the region. Often NGOs that work with migrant communities do not see them as migrants but as urban or rural poor communities.

  Proposed immediate action: A public trust called Voice of Migrants, involving more than 10 migrant organisations has been facilitated in New Delhi on an experimental basis. The process will be documented and shared for replication in partner countries.
  A network of committed practitioners linked through e-workspaces as a Community of Practice, providing concrete inputs into on-going initiatives, identifying emerging needs and areas of work etc.

- ***Upscaling for wider coverage***: At present some good examples of mobility and HIV pilot initiatives exist within the region. For impact wider coverage and sustained responses are crucial. A resource mobilization strategy has been evolved to take forward the implementation of the modular regional strategic framework for action within all countries of South Asia through a cluster country approach. UNAIDS is a key partner supporting this process. Linkages with governments for ongoing support and partnerships with private sector, including the Business Trust Fund of CII in India are being explored. Committed responses need co-ordinated efforts.

  Proposed action: the possibility of setting up a steering committee consisting of representation from the key agencies, Government, CSO and private sector who were involved in developing the regional strategy are being explored. This committee will develop guidelines for systematic implementation of the strategy involving "buy ins" from the different partners, including other UN agencies.

Overall Guiding Principles

- Making responses rights sensitive with commitment to peoples' right to move.
- Building strategic partnerships for multi-sectoral responses
- Strengthened linkages between national, regional and global programmes.
- Greater involvement of migrant workers in decision making from planning through implementation and monitoring stages.

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Dhaka, Bangladesh

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