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Gender, Migration and HIV – Impact on Women in the Context of International Political Economy

Feminisation of migration has taken place. The UNFPA State of World Population report in 2006 stated that almost half of migrant workers worldwide are women constituting about 95 million women migrant workers. In fact Asia women migrating from countries like the Philippines, and Sri Lanka outweigh the volume of male migrants. Great majority of those who migrate are from developing countries taking up unskilled jobs[1] and a great majority of labour migrants in Asia move to countries within the region.[2] Women become extremely vulnerable as they seek income in environments influenced by the Asian gender construct. These environments are heavily influenced by patriarchal system and conservative religious and cultural values. It is also weak in legislation and policies protecting the rights of women.

Asian women primarily migrate alone within the region to countries in the Middle East, East Asia and South East Asia (Malaysia, Singapore and Thailand). Women migrating for work take up jobs as domestic workers, care workers and in the service and informal sectors. Women are also moving across borders as migrant brides and trafficked victims.

The unprecedented intensity and diversity of human mobility is influenced by material and non material causes, voluntary and non voluntary circumstances. The "push" factors for population mobility in the developing world are well-documented. Migration is not only a livelihood choice for people who wish to better their economic circumstances. Migration has become a byproduct of economic and political globalisation it occurs under circumstances of poverty, unemployment, underemployment, economic and political instability, landlessness or the deterioration of the environment. These circumstances lead to exploitation and further impoverishment of migrants throughout the migration process.[3]

Political and economic globalisation as it stands does not allow developing countries and its poverty stricken communities to compete on a fair and equitable level playing field. Trade liberalisation and the burden of debt caused the breakdown of domestic industries and the reduction of social and fiscal expenditures. Declining living standards and increasing unemployment rates are key outcomes of neo-liberal policies forcing poor populations to seek work opportunities abroad.[4] Political and economic globalisation encourages asymmetrical development and widens socio-economic inequalities between countries and regions.

The restructuring of production and pressures to reduce labour costs has led to forced migration, labour flexibilisation and has induced temporary labour migration. All three are key characteristics of contemporary migration. Business entities hire on a short term contractual

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[1] CARAM Asia programmatic areas focus on the health rights and wellbeing of Asian labour migrants.
[2] HIV/AIDS and work in a globalizing world, International Labour Office, 2005, pg21.
[3] How Does Poverty Affect Migration Choice?, A Review of Literature, HUGH WADDINGTON and RACHEL SABATES-WHEELER, *Institute of Development Studies, Sussex*, December 2003
[4] Donald P. Chimanikire, 'African Migration: Causes, Consequences and Future Prospects and Policy Options', paper presented at the UNU-WIDER conference on Poverty, International Migration and Asylum, Helsinki, 27–28 September 2002. http://www.wider.unu.edu/publications/pb8.pdf

basis based on a set of requirements most suited for the company. This in turn creates loss of job security, labor rights and benefits.

Those in favour of liberalising labour movements see migration as a huge financial benefit and as a tool for development. However these players are less engaged with the actual negative socio-economic effects of temporary migration. CARAM Asia has studied some of the negative impacts of migration. Major gaps and concerns include social exclusion of migrants in receiving countries, violations against women migrants, disintegration of family units, poor social and economic reintegration and deteriorating health outcomes of migrants. Utilisation of migration for "development" and for financial benefits implies the perpetuation of conditions for cheap labour and exposes the fact that neo-liberal globalisation has not brought us closer to the eradication of global poverty and unemployment.[5]

Commodification of labour is taking place. In sending countries active labour export promotion policies are implemented in order to gain benefits for foreign debt servicing and foreign exchange earnings through remittances. Filipino migrants sent U.S$ 8 billion dollars home in 2004 and Indonesian migrants remitted U.S$2 billion the same year. [6] In order to raise resources required for migration marginalised communities in home countries are forced to sell their land. Creating communities who are dispossessed of land and means of production.

Neo-liberal globalisation has led to the creation of a labour underclass. The capitalist movement intensifies its exploitation through labour flexibilisation resulting in migrant workers not benefiting from basic conditions enjoyed by other work classes.[7] Depressed wages, absence of benefits, bad working conditions, abuse, lack of access to free health services and no social services creates a labour underclass. Women caught in the nexus of globalisation and migration are confronted with the most severe degrees of marginalisation.

The protagonists propagating temporary labour migration and labour flexibilisation are the global neo-liberal institutions (WTO, World Bank, IMF etc.) and economic powers, their client states and the profit driven private sector. All three have perpetuated the weakening of social and labour contracts and encouraged protectionist and "value driven" policymaking which fail to protect the rights of women migrants. States and neo-liberal structures have also increased dependencies on remittances for development which have overtaken Official Development Funds (ODA). Remittances are not only larger than official ODA but also more predictable and stable source of income compared to either FDI or ODA. [8] These players have contributed to creating an enabling environment for the trading and outsourcing of labour. Women are most at risk by the labour migration agenda both as individuals crossing borders for livelihood and as a family member and/or spouse left behind.

Migration and Health

Public health care systems in developing countries are crumbling. The burden of debt repayments imposed by IFIs compounds the negative consequences of economic globalisation. It ties up fiscal expenditure required by developing countries to expand and improve education, health services and social-economic conditions of the marginalised. Faced with shrinking public health budgets and privatisation of health care, medical professionals in developing countries are migrating or transferring to the private sector.

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[5] Sison Jose Maria, International League of Peoples' Struggle, ILPS, Statement On The Global Forum on Migration and Development, International League of Peoples' Struggle, July 4, 2007.

[6] Human Rights Watch, Asian Women's Labor Migration, December 2005, http://hrw.org/reports/2005/singapore1205/2.htm

[7] Tuhan, Antonio, Globalisation, Crisis and Migration, Presentation made at the CARAM Asia Migration, Health and Globalisation Workshop, Kathmandu, Nepal, June 2007.

[8] UNFPA, State of World Population, A passage to hope, Women and Migration, 2006, http://www.unfpa.org/swp/2006/english/chapter_1/harnessing_hope.html

The increased global transmission of HIV the past two decades has coincided with rapid economic globalisation a process spearheaded by liberalisation of international trade, markets and services. The negative health impact and quality of life of migrants as a result of globalisation policies resulting from multilateral platforms such as the WTO are regressive in nature. It does not promote human rights and global health which is a prerequisite to socio-economic progress. It also leads to a reduction in access to healthcare and HIV treatment for the poor. The shrinking budgets in health care inevitably leads to lack of access to sexual and reproductive health and rights (SRHR) information and treatment. This increases the risk of women working abroad and returning from migration contracting HIV/STIs and developing various sexual and reproductive complications.

CARAM Asia believes that the health status of migrant workers serves as one of the most important and tangible indicators of a migrant's well being. However migrant health concerns are often sidelined and fail to look beyond the medical paradigm to consider the larger social, cultural, political and economic contexts in which health issues are embedded. Furthermore to the detriment of migrants' health rights and wellbeing health concerns of migrants in particular HIV and AIDS are increasingly dealt with as part and parcel of foreign and security policies which restricts liberty of movement and does not include a public health and rights perspective.

Abuse, Discrimination and Exploitation of Migrant Women: HIV Vulnerability Issues.

The UNAIDS has estimated that in 2006 Asia had between 2.8 and 9.8 million people living with HIV. The UNAIDS report also stated that women constituted between 1.4 and 3.9 million women living with HIV in Asia. Although migrant workers have been recognised as a vulnerable population in the UNGASS Declaration of Commitment June 2001 there is still a huge vacuum in terms of epidemiological studies and data available on HIV and migrant workers let alone gender segregated data on HIV and migration. CARAM Asia through its work with partner CBOs and NGOs have identified institutional, social and cultural barriers which make women in migration susceptible to violence and HIV.

All migrant workers are vulnerable to HIV. However women whether as migrants or spouses left behind are more vulnerable biologically, socially, economically and culturally as compared to male migrants. The following are ways in which gender differences related to migration and HIV has made women migrants more vulnerable to abuse, discrimination, exploitation and HIV:[9]

[9] The Forgotten Spaces, Mobility and HIV in The Asia Pacific, CARAM Asia, 2004, pg 72

Following gender disparities have been noted in the area of migration and HIV/AIDS:

- *Women and men experience different forms of abuse and violence, women are more vulnerable to sexual violence.*
- *Gender differences in current laws and policies on migration and labor*
- *Different recognition, acknowledgement and status given to jobs done predominantly by men, and those done predominantly by women*
- *Gender discrepancies in the right to residence of spouses*
- *Different social roles and pressures for the spouses left behind and for men and women*
- *Women and men have different perspectives and concerns on safe sex, sexual health, and relationships*
- *Women and men do not have equal or the same control over sexual negotiations*
- *Men and women have different levels and sources of access to information regarding sex and sexual health*
- *Men and women have different experiences in accessing health care*
- *Culture and social norms allow different levels of freedom and impose different levels of restriction on men and women*
- *Men and women may have different interpretations of the new environment on the basis of old conceptual*

Migrant Female Spouses Left Behind

The rights and concerns of female spouses and women left behind are highly relevant when studying the issue of violence against women and HIV in the context of migration. Spouses and women left behind are often a forgotten group.

Temporary or seasonal migration heightens risks of HIV and STIs transmission to female spouses. Culturally and socially influenced factors dictate the role and obligation of women as providers of sex to their returnee husbands. Disallowing them to negotiate for safe sex and making them prone to reproductive health risks and domestic sexual violations.[10]

Countries like Pakistan, Bangladesh and Phillipines have seen male migrant workers with high incidences of HIV therefore increasing the risk of transmission to their partners and spouses back home.[11] About 35% of documented HIV cases in the Philippines are among overseas workers, and 42% of new HIV cases in 2006 were among this vulnerable group.[12] Pakistan produces a more shocking number 80% of HIV cases were people deported from the Gulf States according to a joint study by UNAIDS and Karachi's Aga Khan University.[13]

The patriarchal family institution results in women being left behind with their in-laws. The male domination of economic and social conditions of women left behind directly and indirectly increases their vulnerability to abuse and therefore HIV. Both spouses and daughters left behind

[10] Paper on the Rights of spouses of migrants in Asia – Issues and concerns of Female Spouses, Malu Marin, CARAM Asia Report on Annual Consultation with the U.N Special Rapporteur on Human Rights of Migrants, 2002, pg 40.
[11] CARAM Asia, State of Health Report – Mandatory Testing, 2007, pg 3.
[12] Medical News Today,2007, UNFPA Launch $2M Program To Address HIV/AIDS Among Migrant Workers, http://www.medicalnewstoday.com/medicalnews.php?newsid=66609
[13] Yusifzai A, 2007, Pakistan Battles HIV/AIDS Taboo (9April 2007), http://news.bbc.co.uk/2/hi/south_asia/6539437

are defenceless from abuse, sexual coercion, incest and other forms of violations which heighten their vulnerability to HIV.

The absence of economic empowerment and lack of control over remittances, unproductive use of remittances and landlessness sometimes force spouses to seek employment. Lacking the education and skills the spouse is therefore compelled to take up unskilled jobs and is vulnerable to sex work and deplorable working conditions.[14]

Social and economic reintegration programmes among migrant communities are a necessity. Migrant workers returning with deteriorating health conditions due to occupational accidents or deportation due to contracting TB, HIV and STIs become dependent on their wives for economic, psychosocial and emotional support. Reintegration programmes are important to help female spouses deal with their medically unfit returnee partners. Economic reintegration will assist in reducing remigration. Whereas social reintegration can include health care interventions, counselling and support to positive migrant workers and their spouses.[15] Reintegration programmes are also important as it is provides a platform to provide spouses with SRHR information and knowledge to raise awareness on HIV and migration.

Women Migrant Workers and HIV

What is the impact of neo-liberal globalisation policies on women migrant workers? Trade agreements have an impact on prices, employment and production structures. These have varying impacts on individuals from different communities and groups based on their different positions in the economic system.[16] While these policies are seen as being "gender-neutral" they in fact affect women and men differently. Mainly due to gender-segregated labour markets, differential skill levels and predefined allocation of appropriate roles for women and men in sending and receiving countries.[17] For instance, even though the WTO - GATS Mode 4 seems to be positive in that it provides opportunities for women's participation in the international labour market. It does not ensure that migrant women will receive fair and equal wages as men, be protected from gender based violations and does not provide necessary minimum standards of social welfare and benefits such as health care and pensions for women migrant workers.

There are two key factors creating a huge vacuum for care work in receiving countries. First, the changing lifestyles of women in receiving countries due to increased career options, higher incomes and affluent lifestyles. Second, men continuing to take on minimal roles in child-raising and household work. The solution offered by states and recruitment agents is the provision of cheap labour for domestic work. The affluent have been provided a choice to transfer and procure care work. Operating like a care chain, migrant women take on the care work of women in developed countries, while simultaneously passing on their care work to other women in their own countries.[18] This phenomenon has invited the label "servants of globalisation".[19]

In Malaysia it is said that every month there are on average 150-200 migrant workers, the majority of them domestic workers seeking refuge at the Indonesian Embassy in Kuala Lumpur.[20] Both the Malaysian and Indonesian governments are failing to protect the rights of migrant workers. Indonesia, along with many other sending countries, include targets for the number of workers it hopes to send abroad in its five-year economic development plans. Indonesia's targets have risen rapidly over time: in the economic development plan for 1979-84, the target was

[14] The Forgotten Spaces, Mobility and HIV Vulnerability in the Asia Pacific, CARAM Asia, 2004, pg 72
[15] Ibid, pg 211
[16] Gender and Trade, Zo Randriamaro, BRIDGE, 2006, http://www.bridge.ids.ac.uk/reports_gend_CEP.html#migration .
[17] Gender and Migration, BRIDGE, 2006, http://www.bridge.ids.ac.uk/reports_gend_CEP.html#migration
[18] Ibid.
[19] Parreñas, Rhacel 2001 *Servants of Globalization: Women, Migration and Domestic Work*. Palo Alto: Stanford University Press.
[20] Seneviratne K, September 2006, Inter-Press Society (IPS) Malaysia/Indonesia: Ethnic Ties Won't Paper Over Class Differences.

100,000 workers; in the plan for 1999-2003, the target was 2.8 million workers. [21] Such export labour policies are worrying as it encourages aggressive recruitment of women into migration. The Sri Lanka Bureau of Foreign Employment (SLBFE) reported 1,807 harassment (Physical and Sexual) cases in 2005.[22] The inter linkages between violence against women and HIV have been argued and proven. These scenarios simply amplify the linkages between violence against women and vulnerability of women migrant workers to HIV.

In a 2002 survey of 110 Filipino domestic workers in Hong Kong (SAR), interviewees reported various sexual and reproductive health problems that revealed limited access to health information and services, as well as the stigma attached to seeking them. These included genito-urinary infections (44%), pelvic inflammatory disorder (17%), unintended pregnancy (13%) and abortion (10%).[23] Any policy which discourages migrant women from accessing health services and information should be abolished.

Other such policies include the 2003 Saudi Arabia Ministry of Health directive which prohibits pregnant domestic workers from accessing health services unless accompanied by the father.[24] These restrictions do not take into consideration the circumstances of the pregnancy such as women whose husbands are abroad or those who have become pregnant as a result of rape.[25] Women are reluctant and fearful of accessing and seeking maternal health services due to gender insensitive policies creating precarious health situations.

Although the situation of migrant domestic workers varies from country to country, as a group women in the informal sector and domestic workers are particularly vulnerable to abuse. Gender selective policies, the power relations in the employer-employee relationship, weakening of labour and social contracts and the underlining gender, class, race and xenophobic discrimination dehumanises and neglects the rights of women migrant workers. These issues are of serious concern. Below are the vulnerabilities and violations of rights related to work, gender, health, access to information and culture which heightens domestic workers exposure to HIV:[26]

Vulnerabilities related to work:

- **Lack of legal protection** – abuses directly correlate to lack of legal protection, inadequate access to legal support, ineffective enforcement of law. In most receiving countries domestic workers are excluded from local labour laws.
- **Lack of labour rights** – unpaid wages, no day off, long working hours, work overload, bad living and working conditions.
- **No Day Off** – countries in the Middle East, Gulf and South East Asia do not provide a day off, in absence of a day off creates isolation and denies access to information, healthcare, legal services, peer and social networks for care and support.
- **Lack of liberty** – no right of movement, physical and linguistic isolation, deprived from contact with the outside world, working in the domestic/private sphere.
- **Withholding of visas and travel documentation** – employer holding to passport/work permits increasing the vulnerabilities of domestic workers becoming undocumented should they need to leave due to abuse and exploitation. Undocumented domestic workers become vulnerable to sexual abuse from enforcement officers.

[21] Graeme Hugo, *Indonesian Overseas Contract Workers' HIV Knowledge: A gap in information* (Bangkok: United Nations Development Programme, 2000), p. 3.
[22] Centre for Women's Research (*CENWOR) , Sri Lanka, 2006,* http://www.cenwor.lk/migworkersviolen.html
[23] Marin, M. 2003. "Sexual Scripts and Shifting Spaces: Women Migrants and HIV/AIDS," pg 19.
[24] UNFPA, State of World Population, A passage to hope, Women and Migration, 2006, http://www.unfpa.org/swp/2006/english/chapter_3/toil_and_tears.html
[25] Ibid
[26] CARAM Asia, Report on Regional Summit on Foreign Migrant Domestic Workers, 2002, pages 19-29.

Vulnerabilities related to Gender:

- **Patriarchy –** Biased and discriminatory gender selective policies – domestic work considered "women's work", protectionist policies, social reproduction work not economically visible.
- **Power relations** – employer-employee relationships, unable to negotiate for better work conditions, live in rule increases the workers' dependencies on the employer – paving way for victimisation, sexual coercion and abuse.
- **Torture and Sexual Violence** – double marginalisation as women and migrant workers. Physical, mental and sexual abuse. Sometimes leading to death. Violence perpetrated by state and non-state actors such as employers and recruiting agents.
- **Families left behind** – tremendous emotional and psychosocial impact on the domestic worker, loneliness and longing for companionship.
- **Single entry policies** – women not allowed to migrate with families.

Vulnerabilities related to Health:

- **Violations to sexual reproductive health and rights** – sexual violation, abuse and rape.
- **Marginalised in terms of information** – Absent SRHR information and programmes. Increasing special vulnerability to HIV.
- **Denial of access to healthcare or social security** – as employed under the informal sector, burden of paying for own health care, payment of first class fees, mandatory testing does not include HIV positive women into the public healthcare system.
- **Mandatory testing and retesting of migrant workers** – increases stigmatisation and discrimination, termination of contract due to test results often without knowledge.
- **Deportation** – due to HIV status, pregnancy, risk of further abuse during deportation process, stigmatisation upon returning home.

Vulnerabilities related to access to information:

- **Lacking adequate pre-departure and post arrival orientation** – inadequate information on health and HIV and, does not integrate rights based approach, emphasises needs and rights of employers instead of domestic workers.
- **Lack of SRHR related information -** Increases women's vulnerability to sexual abuse and contracting HIV and STIs. Dismal access to information regarding gender, sex and sexual reproductive health and rights issues.
- **Inadequate training on survival skills** – trainings focuses on household tasks, pre-departure trainings for women emphasises subservient behaviour towards employer
- **Lack of education and access to information and legal channels**
- **Lack of information on labour and immigration laws**.

Vulnerabilities related to Race and Culture:

- **Discrimination** - differing wages, days off.
- **Xenophobia** – racial intolerance
- **Freedom of religion –** employers disrespecting religious beliefs

Protecting Rights vs. Protectionism

Policies for managing men's migration are seen more in terms of economic criteria while policymaking regarding women's migration is "value-driven". These policies are often influenced by values on women's employment and their socio-economic status.[27] These non evidence based "value-driven" policymaking in the guise to protect women actually fails to address the gamut of sexual and reproductive health and rights, mental and physical health care issues. Furthermore it does not prevent problems such as work place gender exploitation, discrimination in terms of remuneration, and sexual abuse. Gender-sensitive policies and legislature for women migrant workers are much needed. The current state of policies are in conflict with protecting and promoting rights and wellbeing of women migrant workers and are weak in taking on considerations such as trafficking.

"The barriers that some nations create to artificially contain migration create a black market of human trafficking, illegal recruitment, fixer's trade and willful mis-documented migration. If there is too much regulation and red tape, it creates the opposite effect of worker protection. It is useful to draw mechanisms, which are low key, less formal and have more operational focus."

(Ricardo R. Casco, Director of Dept of Labor and Employment, Philippines Overseas Employment Administration. Regional Summit on Pre departure, Post Arrival and Reintegration of Migrant Workers, organized by CARAM Asia, 2000)[28]

Protectionist policies are occurring both at the sending and receiving countries. CARAM Asia through its work in HIV vulnerability of women migrant workers has documented policies and cultural settings which breeds protectionist environments. This environment fails to protect rights of women migrant workers. Examples of protectionism are seen below.

1. Formulation of banning or regulating women migration.

Governments take on extreme protective policies such as banning and restricting women workers from migrating. Rather than creating solutions and policies to protect the rights of migrant workers and dealing with the perpetrators of abuse, these countries end up punishing women seeking livelihood. Behind these restrictions are patriarchal policy makers asserting themselves as parties who are 'protecting' its 'helpless' and 'ignorant' young female citizens.

Cases in the region will show that banning and restricting women from migration does not reduce their vulnerability to violence and exploitation. Contrarily these bans and restrictions induce trafficking as well as recruiters finding loop holes within the restriction enforcement. Some of these restrictions are happening in South Asia. Bangladesh, Nepal and recently India have put in place either banning of women from labour migration or imposed minimum age restrictions. This ban violates women's right to work, development, freedom of mobility and equal status as citizens.

Bangladesh, for example, banned the migration of women in 1998. News reports have indicated that despite the official ban between 10 000 and 15 000 Bangladeshi women left to work abroad illegally despite the 1998 ban. This compared to 14,000 Bangladeshi female workers who were legally employed in foreign countries between 1991 and 1998. [29] In 2002 Bangladesh was forced to lift this band due to pressure from civil society.

In March 2007 the Sri Lankan Government announced a ban on women with children less than 5 years of age from migrating for work. The regulation also required mothers with

[27] Oishi, Nana 2002 "Gender and Migration: An Integrative Approach," Working paper no. 19, Center for Comparative Immigration Studies, University of California, San Diego.
[28] The Forgotten Spaces, Mobility and HIV Vulnerability in the Asia Pacific, CARAM Asia, 2004, pg 60
[29] Tabibul Islam, Ban or No Ban, Women Workers Leave Home, Inter-Press Service (IPS), 2003, http://ipsnews.net/migration/stories/ban2.html.

children aged 5 or older to obtain approval from a government committee, after submitting proof that they can provide appropriate caretakers for their children, before migrating for work. [30]

India in August 2007 has also followed suit by banning women below the age of 30 from migrating for domestic work or care giving. Statistics of women migrating for work have shown a sharp increase, from the major migrant producing state of Kerala. Female migration has gone up from 9.3 per cent in 1999 to 17 per cent in 2004, according to reports issued by the United Nations Secretary General. [31] The new regulation covers 18 countries also require a mandatory $400 monthly salary and a security deposit of $2,500 in the form of bank guarantee with the Indian mission. The new rules also require employers to provide their domestic servants prepaid mobile phones.[32]

Other examples of protective policies include the Philippines which raised the age a woman could migrate to Saudi Arabia to 30. Young women falsified their age opening the way to exploitation by recruiters.[33] Burma banned women traveling through the country (and to borders) alone under the age of 25; they have to be accompanied by a guardian.[34] Thus, allowing traffickers to move women freely under the guise of guardianship. Nepal has signed four out of seven ILO Human Rights Conventions, but these are not effectively implemented. Nepal banned young women from migrating to the Gulf countries, forcing them to migrate through irregular channels.[35]

2. Gender selectivity in recruitment influences feminisation of migration

Forces of globalisation have heightened labour migration and the entry of women into the international labour market. Gender stereotyping of workers are prominent. Migrant women are channeled into work which are low-skilled, low paid, service oriented that require characteristics like patience, tolerance, submissiveness and hard work reflecting culture specific Asian gender construct. [36]

The Philippines holds the record of being the second largest labor-sending country in the world. Women migrant workers comprised 61% of all land-based new hires in 1998 (POEA). The percentage share of deployed women OFW (Overseas Filipino Workers) has steadily increased from a mere 12% in 1975 to 47% in 1987 to 58% in 1995 and 61% 2002.[37] Women overseas workers from the Philippines dominate the service sector the top 2 jobs in 2005 amongst new hires migrating included Domestic worker 29.9%, Entertainer 13.9%.[38] Men, on the other hand, dominate the production and construction related work. Even among sales workers, the men are the supervisors and buyers, while the women are the salespersons and shop assistants.[39]

In Sri Lanka, in 1986 only 33% of workers leaving the country were female workers, in 1996 it rose to 74%. In 2005 women still constitute the majority of those working abroad with 800,837 compared to 420,926 male workers.[40] Based on Sri Lankan Foreign Employment Bureau, 2006 "housemaids" constituted 91% of total distribution of female migrant workers in 2004.

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[30] The Sunday Times, April 22, 2007, http://sundaytimes.lk/070422/FinancialTimes/ft331.html.
[31] India Together, Grounded till thirty, 21 August 2007 http://www.indiatogether.org/2007/aug/wom-migrant.htm
[32] M. Ghazanfar Ali Khan, Arab News, 23 August 2007, India to Impose Restrictions on Hiring of Maids, http://www.arabnews.com/?page=1&section=0&article=100314&d=23&m=8&y=2007
[33] The Forgotten Spaces, Mobility and HIV Vulnerability in the Asia Pacific, CARAM Asia, 2004, pg 60
[34] Ibid, pg 60.
[35] Ibid, pg 60
[36] Ibid, pg 61
[37] Ibid, pg 61
[38] Asia Pacific Research Network (APRN), Migrant workers in Organizing, Mass Campaigns & Mobilization: A Brief Compendium of Our Recent Experiences as a Case Study, MIGRANTE International, *Dec 2006*, http://www.aprnet.org/index.php?a=show&c=APRN%20Conference%20on%20Jobs%20and%20Justice&t=conferences&i=79
[39] Forgotten Spaces, Mobility and HIV Vulnerability in the Asia Pacific, CARAM Asia, 2004, pg 62
[40] Centre for Women's Research (*CENWOR) , Sri Lanka, 2006,* **http://www.cenwor.lk/migworkersviolen.html**

3. Women are subjected to a whole range of mandatory health test.

Women migrants are subjected to a host of mandatory health tests including pregnancy and HIV. By subjecting to these tests, if found to be pregnant (and not married) or HIV+, are devastated personally, subjected to great stigma within their homes and communities, and face the loss of recruitment and a better future in a foreign land. Results are callously given to the potential migrants with indifference. In some cases results are disclosed even to an outsider.

Testing does not aim to include women migrant workers within the public healthcare system. Women who are pregnant often seek risky abortion procedures making them at risk to various reproductive health problems. Mandatory testing It is used as a form of border control by receiving countries and prevents entry of individuals with HIV and STIs. It does not modify behaviours or provide sexual and reproductive knowledge and information to women migrant workers. It only provides a false sense of security that HIV is a foreign problem. [41]

In Sri Lanka, migrant workers undergo testing before leaving for the Gulf. Almost half of all reported HIV cases occurred among domestic workers who had returned from the Middle East.[42] Mandatory testing will over-represent migrant workers in epidemiological data leading to further stigmatisation and discrimination of migrants as carriers of disease.

4. Kafala System, servitude and slave like conditions

The Kafala system in the Gulf Cooperation Council was drawn from a concept of "guardianship" and “sponsorship” by which domestic workers are given a place in their employers abode. [43] In other receiving countries such as Malaysia and Singapore domestic workers are not provided a day off which aims to isolate them from other migrant workers. Like the Gulf States, employers in Malaysia and Singapore are also allowed to hold passports and all official documents until the date of departure, making the domestic worker completely dependent to employers.

These policies create an environment allowing violence and exploitation of domestic workers. Women who were violated and raped suffer dire consequences from the kafala system. The result of these violations forces women to be undocumented in order to escape abusive conditions. Many of them are then arrested as "illegal" workers, detained, and then deported. Should the women turn to the authorities to file a report many times she is returned to her abuser.[44] Should she decide to go ahead with a court case which will carry on for an undetermined length of time, will cost money and may not be successful, her alternative option is to stay in jail.[45] This is mainly because the kafala systems requires for the worker to be stay in that country only if she is living with her sponsor. Even if her sponsor is her abuser. This perpetuates a cycle of abuse and violation which will inevitably impact the migrant worker’s health rights and outcomes.

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[41] CARAM Asia, State of Health of Migrants – Mandatory Testing, 2007,page 6.
[42] UNAIDS. 2004. *2004 Report on the Global AIDS Epidemic*, p. 83. Geneva: UNAIDS.
[42] The Peninsula, Activist wants rights of maids secured, June 2007, http://www.bahrainrights.org/node/1277

[44] Ibid
[45] Ibid

Recommendations for States

Health Rights for Women in Migration

1. Ensure access to health services, including sexual and reproductive services and information to mobile populations in all stages of migration is a critical element to reducing their vulnerability to HIV and providing them control over their health.
2. Scale up sexual and reproductive health programmes to all women, particularly rural women to help prevent STIs and HIV vulnerabilities.
3. Eliminate barriers to health care including high fees for health care services, promoting confidentiality and removing requirements for authorisation by spouse, parent or hospital authorities.
4. Programmes for women migrant workers should not just focus on protectionist policies and 'risk behaviour', but on empowerment; supportive environments, human rights and women's specific vulnerabilities.
5. Invest in public health care services for migrant communities at the receiving countries. Ensure access to health care by meeting prescribed healthcare budgets as outlined by WHO.
6. States should review and reform public health legislation that include migrants, both documented and undocumented, including redress, to ensure that they adequately address the public health issues raised by HIV/AIDS, and that provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS consistent with international human rights obligations. Health services for migrants must include:

    - Information and education for general public and migrants
    - Voluntary testing and pre- and post counselling
    - STD and sexual reproductive health services for all
    - Availability of condoms
    - Access to treatment, support and care
    - Epidemiological surveillance based on target groups like migrants

7. Strengthen representative epidemic and behavioural surveillance of vulnerable mobile populations while protecting confidentiality and individual rights. Ensure data is segregated by nationality, age and gender to ensure appropriate interventions for different contexts.
8. Both sending and receiving countries must invest gender sensitive public health and support services for women migrant workers.

9. Setting up of referral systems between sending and receiving countries to ensure HIV positive migrant workers and their families are provided relevant treatment, care and support.
10. Do away with Mandatory Testing as a basis to determine fitness to work and the deportation process attached to mandatory testing which restricts the right to travel, and denies the right to work.
11. Reintegration programmes should start at the very beginning of migration and addressed in both receiving and sending countries. Reintegration programmes should be gender sensitive, empowering and include social reintegration. All economic reintegration programmes must be addressed within the context of human rights and based on the migrant worker as a human being not an economic commodity.

Labour Rights for Women in Migration

1. Do away with aggressive labour export policies which lead to the commodification of labour and the exploitation of migrant workers.
2. Extend equal protection of the labour laws to domestic workers, including rights to a just wage, overtime pay, weekly rest days, benefits, and workers' compensation.
3. Labour legislation must be complemented by criminal laws allowing for successful prosecution of offences such as physical, psychological, and sexual abuse, forced labour, forced confinement and trafficking in persons.
4. Migrants must be given adequate living conditions to work under. This includes access to decent housing, sanitation and water as laid out by the International Human Rights Declaration.
5. Programmes for women migrant workers should not just focus on protectionist policies and 'risk behaviour', but on empowerment; supportive environments, human rights and women's specific vulnerabilities.

Meeting International Standards

1. To reduce the incidence of undocumented workers, migration must be managed with an approach that is flexible as stipulated under the ILO Forced Labour Convention 9 (no 29).
2. Enforce and harmonise legislature to international standards and laws such as Ratification of the UN's *International Convention on the Protection of the Rights of All Migrant Workers and their Families (1990)*, ILO Code of Practice on HIV/AIDS and the World of Work.

END