ARROWs For Change

Women's and Gender Perspectives in Health Policies and Programmes

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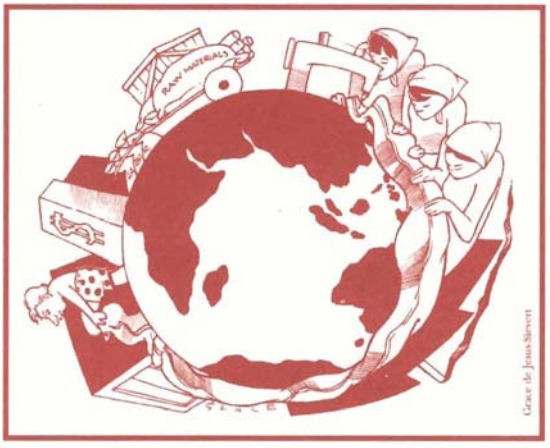
The Health Rights of Migrant Women



Graphic Source: sls Intrna ti l-Manila. 199 "Wo c d migration". Women InAcio c 2& 3/93 aezo . philipp' es: I ' Internationa p. 9.

Current globalisation strategies, restructuring of economies through structural adjustment programmes and removal of protective regulations for cheap, temporary contractual workers favour migrant labour. Poverty, conflicts, environmental catastrophes, forced displacement and changes in production processes have increased migration. The demand for cheap, flexible, contractual and deregulated labour has also encouraged highly organised recruitment. The demand for skilled and unskilled workers in all sectors is growing regionally and globally.

Migrant workers now include more and more females. In Indonesia, the Philippines and Sri Lanka, women account for 60–80 per cent of the yearly deployment flows. This shows the demand for workers in nurturing, child-rearing and care-giving jobs. Cultural factors have also motivated or pushed the migrant women into taking on work that is related to women's reproductive roles. The work, however, is unprotected and informal. In receiving countries such as Malaysia, Saudi Arabia, Singapore and Taiwan, maids are not defined as workers in the labour law. Their contract refers to them as household help. The contract is not even signed by the maids themselves but by the recruiter and the employer.

For the last 20 years, countries in the Asia-Pacific have used migration of its citizens as a major strategy to earn foreign exchange. In Sri Lanka and the Philippines, remittances constitute the second largest foreign exchange earner. Women were found to be more reliable in sending money back and thus families started sending their women abroad to work. Gender selectivity in the recruitment of women migrant workers has placed them in isolated and individuaiised work as maids, entertainers and sex workers. Their health and control over decisions regarding their body are affected by the social construction of male behaviour in both sending and receiving countries. Men dominate the sex workers and entertainers in negotiations on condom usage and the kind of sex they want. Maids are sometimes forced to meet the demands of their male employer. This has led to sexual abuse, violence and discrimination. The lack of legal redress and access to health care services further endanger their health and personal security. Thus, there have been outrageous violations of basic rights and health, tortures and deaths. In Malaysia, in the year 2000 alone, there were several cases of abuse and assault of maids. highlighted in the media. Similar cases have occured in the Gulf.

The single entry policy for migrant workers has brought about loneliness in the absence of family. Consequently, the migrants create their own social and sexual networks. Due to low condom usage, the women could not practise safer sex. They were more concerned about avoiding pregnancy as it would mean loss of job and deportation. In the Gulf region, some of them even faced the death sentence or at least a large number of lashes or whippings if caught pregnant. To avoid this, many went for illegal or self-induced abortions. These adverse effects on women's health develops from the culture of silence that surrounds sex. Good women are expected to be ignorant about sex and passive in sexual interactions. The pressure to have high moral standards restricts them from accessing information on sex while the traditional expectation to remain a virgin until marriage forces them to engage in sexual practices like anal sex which put them at risk of infection. The culture of silence surrounding sex also stops women from seeking health care services. In many countries, infected persons must identify their partners, as required under the Infectious Diseases Act. Women migrants have to be free from infectious diseases in order to renew their work permits. So, in order to maintain their jobs and their moral status in society, they would rather suffer in silence. The mandatory testing for various diseases, especially for HIV, AIDS and STIs, in most receiving countries in Asia is discriminatory. It reinforces stigmatisation,

causes alienation and jeopardises the migrant's job. Policy-makers lack understanding of the control of infectious diseases since mandatory testing does very little to reduce the number of cases. The traditional public health paradigm and strategies developed for diseases, such as compulsory notification for infectious diseases, are now irrelevant. The World Health Organization has asked countries to develop different strategies to reduce infection especially for HIV and AIDS. The women's illegal status in many countries reduces their negotiation strength. They work very long hours for low wages and often in slave-like conditions. One major effect has been acute stress, leading to various psychological problems from which many migrants take a long time to recover. Such consequences go unrecognised and are not considered in the limited economic cost-benefit analysis of migration.

Migrant workers' health rights must be respected in all receiving countries. The health systems in those countries have to modify policies and programmes in both preventive and treatment services to reflect the cultural origin of significant migrant populations. International harmonisation and standardisation of migration health legislation and practices will help protect migrant health rights. As stated in the Beijing Platform for Action, it is only through a rights approach that we can empower migrant women. Co-ordinated research and monitoring of violations and conditions that increase vulnerability should be essential components of interventions. However, only through an effective involvement and participation of women in programmes that empower them throughout the whole migration process of pre-departure, post arrival and reintegration into their own communities will there be an effective change. Governments and international agencies must have the political will to respond to the needs of women migrants.

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For Change, published three times a year, is primarily for Asian-Pacific decision-makers in health, population, family planning, and women's organisations. It provides: ♦ women's and gender perspectives on women's health, particularly reproductive health ♦ a spotlight on innovative policy development and field programmes ♦ monitoring of country activities post-ICPD, Cairo and post-FWCW, Beijing ♦ a gender analysis of health data and concepts ♦ resources for action.

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Sex, Contraception and Reproduction among Young Filipinas in Australia

Little research had been conducted in Australia on issues of sexual health among young immigrant women. The researchers who conducted the research argue that the effectiveness of education about sex, contraception and the prevention of sexually-transmitted diseases is limited because it often fails to provide practical advice about services and how to access information. This omission is particularly important for young migrant women, who often experience greater barriers than other Australians in discussing sexual activity with their parents or other community members.

Despite recognition of the risks associated with disease transmission and fear of early pregnancy, the use of contraceptives and/or prophylaxis among young sexually active Filipinas in Australia is often inconsistent or non-existent. The research examines the interplay between young women's knowledge and attitudes about sex and sexuality, the influence of culture and the social context in which sex occurs. It was done as part of the Australian Longitudinal Study of Women's Health, funded by the Australian Department of Health and Family Services, when all the authors of the research paper were at the Australian Centre for International and Tropical Health and Nutrition (ACITHN), The University of Queensland.

The research involved two categories of women: 1) young Filipinas who were women born in Australia to at least one immigrant Filipino parent and 2) women who were born in the Philippines to one or both Filipino parents and who migrated to Australia before they reached adulthood. In the most recent census, which was conducted in 1996, there were 35,160 second generation Filipinos in Australia. The research is based on qualitative and quantitative data from 40 Filipinas aged 14–25 years who reside in southeast, far west and far north Queensland. 70 per cent of the young women interviewed were born in the Philippines. The majority (52 per cent) had migrated with other family members or joined their mothers who married Australian-born men. 17 per cent had migrated to Australia in search of better job opportunities and 13 per cent had migrated to get married.

The study found that among the 40 respondents interviewed, the level of knowledge of sexually-transmitted diseases was low. Out of these respondents, 65 per cent agreed with their parents' views about sex and virginity; 46 per cent did not want to have sex before marriage; 73 per cent believed that they should have one partner in life, and 65 per cent believed that abortion was a sin. However, only 28 per cent reported that they had never had sex, while 38.5 per cent of the respondents used contraception. Of the 61.5 per cent that did not use it, 48 per cent said that this was because they did not have sex at all; 22 per cent did not have sex regularly; 17 per cent were worried about the effects of contraception on their body; nine per cent were using natural birth control, and four per cent found the contraception available to be difficult to use or inappropriate. Only 15 per cent of the respondents said that they believed that using contraception to avoid pregnancy was a sin, while 85 per cent dismissed this statement. Those who had been pregnant in the last 12 months comprised 12.5 per cent, and five per cent had had an abortion (self-reported).

Many Filipinas in the study saw pregnancy, combined with family problems, alcohol and drugs as the major problems confronting Filipinas in Australia. Two daughters of one family who were interviewed had been single mothers as teenagers and their younger sister had just become pregnant. They expressed their unhappiness and frustration with trying to live a full life and raise a child and were terribly disappointed when their third sister became pregnant.

According to the researchers, the sexuality of Australian Filipina youths is affected by the fact that they have to manoeuvre between two sets of cultural values. They live in a country that holds some views on sexuality that may contradict conventional Filipino values and it is within this divide that they must make their own sexual choices. There is a real need for health education specifically for migrant women who face this conflict. This education needs to include practical advice of services and how to access them, especially in remote cities and towns of Queensland and Australia.

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AJ

Community-Based Mental Health Programme for Migrant Women

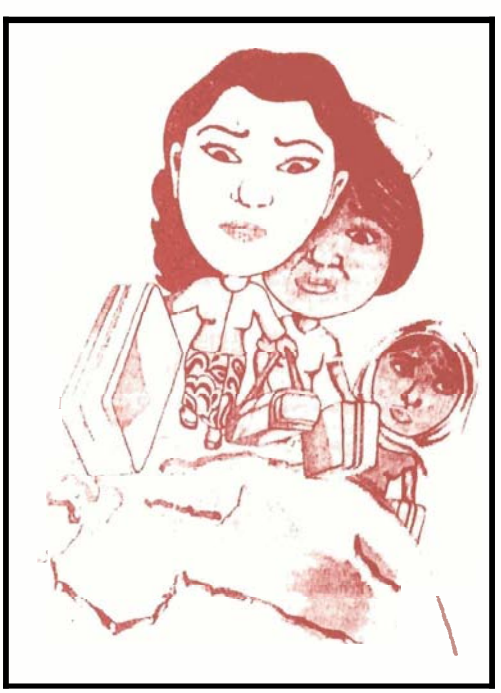
by Mary Lou Alcid, Julius Cainglet and Miriam Tugawin

The Philippines is second only to Mexico in terms of the magnitude of workers deployed to foreign countries. A majority of the workers are women (see Factfile, p.12), most of whom become maids, caregivers and entertainers. Often, the receiving countries do not have laws that cover these jobs and possess patriarchal structures that undervalue housework. In addition, the locals look down on women migrants because they come from a poor country and are desperate enough to take on jobs that local women already shun. These factors cause the overseas Filipino workers (OFWs) to be vulnerable to violence of all forms, particularly gender-based ones such as physical beatings, sexual harassment, molestation and rape. There have also been cases of death resulting from beatings and other forms of physical violence.

For Philippine NGOs addressing migrant issues such as Kanlungan (Centre for Migrant Workers), an NGO working for the rights and interests of OFWs and their families through crisis intervention, education and training, policy advocacy, mass campaigns and community organising, the advocacy for the elimination of violence against women OFWs had mainly been directed at their own government and governments of labour-importing countries. Demands include creation of policies that recognise and protect their rights, and the provision of gender-responsive programmes and services on-site and upon return to the Philippines. Recently, however, the women's health has become a major concern because of the increasing number of women workers returning with battered bodies and spirits. The following focuses on how Kanlungan in partnership with Pugo, a town in Northern Luzon, Philippines, responded to this situation without waiting for government action. The town formed the Pugo Overseas Filipino Workers and Community Association (POCA), which served as a venue for mutual support among the returned OFWs and families of OFWs, through psychological support, peer counselling and livelihood assistance. One of the initial needs POCA responded to was the psychiatric treatment of some women who had returned from abroad with mental illness. POCA linked up with Kanlungan's regional office in the province of La Union for assistance in claiming the women's medical entitlements from the Overseas Workers Welfare Administration, and referral to hospitals locally and in Metro Manila.

In mid-1998, Kanlungan found out about an innovative community-based approach to mental health services being undertaken by the Social Psychiatry Section of the University of the Philippines-Philippine General Hospital under Dr. Rosanna de Guzman. At the time, Dr. de Guzman had just piloted the first community-based mental health programme in the province of Bulacan in Central Luzon. Initial results supported the thesis that the mentally ill recover faster in the care of supportive families and communities than in a mental health facility.

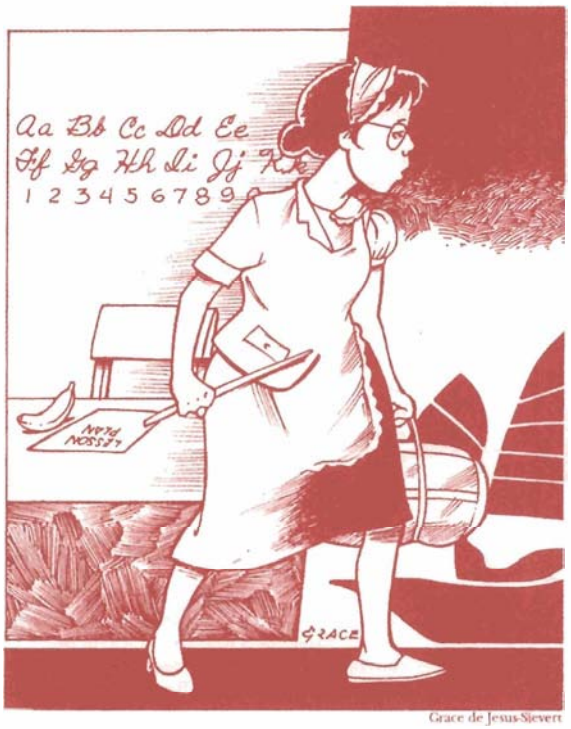
Kanlungan contacted Dr. de Guzman to share the situation in Pugo and explore the possibility of a partnership in the implementation of a community-based mental health programme. Soon after, a POCA-Kanlungan-Philippine General Hospital partnership was formed which designed a similar programme for Pugo. In Dr. de Guzman's original design, the programme should also involve the local government, specifically the doctor and health workers of the Rural Health Unit. Unfortunately, the Rural Health Unit doctor was reluctant to commit to the programme although the health workers did participate in the training and were willing to monitor the progress of those who seek medical services, provided this was prioritised by the Rural Health Unit doctor. The community-based mental health programme employs a combination of therapeutic and empowering strategies to manage mental illnesses within the community. It interweaves treatment management, family counselling, community education, livelihood assistance and networking. Medication is provided if necessary. But the crucial element in recovery is the OFW's immediate environment, i.e. her family and community which



Graphic Source: Isis International-Manila. 1993. "Women and migration". *Women In Action* 2 & 3/93. Quezon City, Philippines: Isis International. p. 52.

have to be transformed into supportive, nurturing and therapeutic ones.

In March 1999, Dr. de Guzman led a team of psychiatrists in the conduct of a free clinic in Pugo to jumpstart the programme. Apart from diagnosis and treatment, the psychiatrists also oriented the families of the mentally ill/distressed on the programme. The families expressed support for and committed themselves to the programme. Several months later, the families formed an organisation called ***Timpuyog Ti Agkakabsat*** (Organisation of Brothers1Sisters). They work closely with POCA in the management of the community-based mental health programme. A substantial part of of the programme was allotted to explaining the community-based approach in treating mental illness. Community meetings were held and printed materials were distributed on how to relate to the mentally distressed ex-OFWs.



Grace de Jesus-Sievert

The community-based mental health programme has yielded some positive results. Some of the women recovered from their illness and were able to socialise again. Others eventually found work or set up their own income-generating activities. Through all these, family support had been a critical part of the patients' recovery. Secondly, community attittudes towards the mentally ill has also changed. Before implementing the community-based mental health programme, the people would mock the mentally ill. With the programme, they began to understand better the plight of the women and became supportive. Slowly, the community learned to treat the mentally distressed with respect.

However, there were problems. The costly medications often drained family and community resources. According to the leader, some patients who were not able to sustain medication began showing signs of poor mental health again. POCA offers livelihood assistance by distributing hogs for families to raise in their own backyard so that they could have extra income to buy medicine. But this is often not enough. The situation has been exacerbated by an indifferent local government. Aside from the fact that the local goverment has no mental health programme, it has not done much to support the community-based mental health programme apart from sponsoring the food for one free clinic. This indifference, if not addressed sooner or later, could affect the future of the community-based mental health programme as government commands much needed resources. Cognizant of this, Kanlungan and POCA have been advocating for the active participation of the local government through the Rural Health Unit in the community-based mental health programme. Thus, POCA endorsed a resolution to the local council asking for support for the community-based mental health programme. It also requested assistance from concerned government agencies such as the Department of Health and the Department of Social Welfare and Development in the same resolution. To sustain the community-based mental health programme, POCA members and the families of the mentally-distressed OFWs are requesting that a psychiatrist be permanently stationed in the community so that access to medical attention would not be a problem. They would also like the rural health workers and community leaders to undergo training in managing mental health cases.

Institutional care for mentally ill patients remains the norm in the country. But it is widely believed that, in most cases, institutionalisation aggravates the patients' condition. It is also expensive. A community-based mental health care programme is a far superior, appropriate and effective (in terms of cost and recovery) alternative. Moreover, it also promotes family and community solidarity.

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G hi : I Intea tio nalM 1 1993. omen mi ption". W n In A (2 & 3/93. Que zon City, Pilippi es: Isis In ational. p. 15.

Hong Kong

Globalisation has brought about economic and social changes that profoundly affect Asian women's health. With this in mind, a conference on "Globalisation and Women's Health: Challenges in a Changing Asia" was held at the Chinese University of Hong Kong on 30th and 31st August 2000. It was co-organised by the Centre for Environment, Gender & Development (ENGENDER), Singapore, together with the university's Gender Research Centre and the School of Public Health. Over fifty people attended the conference. It aimed to develop a more comprehensive understanding of women's health in the changing conditions caused by globalisation and contribute this perspective as a developmental input to policy formulation, implementation and review. In the long term, it aimed to develop an over-arching information dissemination system that will link centres of expertise and databases. The keynote address by Professor Lesley Doyal, Director of the Centre for Health and Social Care at the University of Bristol in United Kingdom, explored the problems and the potential of globalisation in the pursuit of gender equity in health. According to Dr. Vivienne Wee of ENGENDER, the health impact of globalisation is gendered in its effects. This is evident in its related processes such as liberalisation and privatisation. The progressive liberalisation of domestic economies affects the health care, stress and nutritional levels of women as workers, employers and household resource managers. The progressive privatisation of public services generally involves cutbacks in public health care, childcare, care of the elderly and the disabled and other welfare services. This makes them less affordable to the lower-income group, especially the women. Other speakers discussed occupational health, environmental degradation and sexual-reproductive health. Case studies and community health initiatives in response to globalisation in China, Hong Kong SAR, India and the Philippines were provided. The final session involved discussion on possible follow-up to the conference such as the creation of a website on globalisation and women's health.

Source: *Based on materials from the conference on Globalisation and Women's Health. Challenges in a Changing Asia, 30"" & 31st August 2000, Chinese University of Hong Kong.*

India

In May 2000, the Centre for Health Education Training and Nutrition Awareness (CHETNA) of India organised a consultative meet of NGOs working with ***dais*** (traditional midwives) in the state of Gujarat. 23 participants comprising activists, researchers, medical practitioners and consultants from various NGOs across Gujarat participated. Most of the NGOs were pioneers in initiating ***dai*** programmes in remote and rural areas, where ***dais*** play a critical role during pregnancy, childbirth and care of newborns. The meeting was held to share experiences and concerns related to ***dais,*** their needs and problems; to review their role in the state's reproductive and child health programme; and to design strategies to identify their role in the primary health care system. Among the major concerns raised are the lack of adequate government remuneration and community contributions, short supply of delivery kits, lack of appreciation and recognition by medical professionals in the primary health care system, no provision for health care of ***dais*** and decline of the indigenous treatment by ***dais*** due to increasing reliance on modern medicine, In the meeting it was revealed that most government officials felt that despite extensive training and special fund allocation to ***dai*** training, ***dai*** services have been unable to reduce the maternal and child mortality rates. The participants strongly expressed the view that maternal mortality cannot be addressed by ***dais*** alone. The referral system has to be strengthened and emergency obstetric care has to be made available in remote and rural areas. The meeting enabled the sharing of experiences and concerns related to *dai* tradition. The NGOs' willingness to coordinate and work on this issue is expected to effectively strengthen the *dais* role.

Source: CHETNA. 2000. "Working towards recognition of Dai tradition—A report on a consultative meet of NGOs working with Dais (traditional midwives) in Gujarat state". [Unpublished].

Indonesia

■ The tndonesian government has issued two important memoranda introducing policy reforms that can help improve the condition of Indonesian workers abroad. In May, the Indonesian Consulate in Hong Kong issued a circular warning to Indonesian recruitment agencies about underpayment and other contract violations. This is a dramatic breakthrough in recognising the widespread problems, which have been ignored for years. In October, another circular effectively abolished the policy of requiring migrant maids to pass through recruitment agencies each time they renew their contracts. The Asian Migrant Centre, Indonesia Group, Indonesian Migrant Workers Union and Coalition for Migrants' Rights have been at the forefront of these struggles in the past nine years at least.

Source: Varona, Rex. **2000. "Indonesian migrants claim victory on policy reform".** ***Asian Migrants.*** *<http:ll www.asian-migrants.org/news/9733242917806.php>.*

Nepal

The Beyond Beijing Committee, a national coalition of women's rights-related organisations, has been engaged in monitoring and developing advocacy mechanisms as part of the Beijing+5 review. A series of regional and national consultations were held from 1999 to 2000 to review Nepal's progress in implementing recommendations focusing on the BPFA's twelve critical areas of concern. The outcomes were published in a report. The review process looked into the various aspects related to implementing the BPFA. It examined the best practices and their results, new emerging trends and obstacles in the particular areas of concern more qualitatively. For the third critical area of concern, women and health, Nepali women were found to be among the least advantaged women in the world in terms of health and medical facilities. They are faced with unsafe contraceptive methods, unwanted pregnancies, coerced child-bearing and unwanted medical intervention. Women using local family planning clinics suffer from untreated gynaecological afflictions, reflecting the fact that they are treated as mere contraceptive acceptors. Family planning programmes often emphasise medically efficient methods of contraception to the exclusion of barrier methods and fail to offer women protection against STD and HIV infection, exposing them to morbidity, infertility or death. Among the best practices include the highlighting of women's health in the health policy, promotion of different contraceptives at all levels; launching of safe motherhood and family planning programmes; provision of training for female health workers; and, provision of female health workers at all health facilities in Nepal. Among the obstacles still remaining are: 1) Women's health policy is not a major issue for any party or the government; 2) The general trend of investing less in women's health is still significant; 3) Myths and traditional practices related to women's reproductive health are still strong and perpetuate discrimination of women; 4) Illegal and unsafe abortion is killing more and more women; and 5) Family planning is perceived only as a means of population control. However, there are still positive trends emerging, such as the increasing use of condoms due to the publicity given to HIV/AIDS; increasing demand and supply for maternal and child health services; and the gradual recognition of women's fundamental sexual and reproductive rights. The review recommended an abortion act that would define the standards and practices for safer abortion, the provision of information on the side-effects of various contraceptives and the gender training of clinic and health workers to ensure respectful and dignified treatment of women who seek health services.

Source: Beyond Beijing Committee. 2000. *NGO Country Report: Monitoring Platform, Pledge* and *Performance*. Lalitpur, Nepal: Beyond Beijing Committee. 34 p.

Philippines

On 29 May 2000, a forum on "Health for Women, Health for All: How a Lofty Promise Failed" was held in UP Bahay ng Alumni. Jointly funded by KULU, Denmark and Interpares, it assessed "Health for All in Year 2000" in light of globalisation, structural adjustment programmes, World Bank's health care reforms and UN conferences in an intersectoral manner. There was a keynote speech by a community health worker and a panel discussion on the situation in three areas--an ethnic community in the north (Bontoc), a city in Central Philippines (Cebu) and Metro Manila. Another panel discussion focused on the state health education and health care systems, specifically in public tertiary hospital and community-based health programmes. A play depicting perceived determinants of women's health—the government, the Catholic church, multinational corporations—was shown. In the first panel discussion, the problems affecting the three areas were highlighted. For example in Bontoc, despite the decrease in child and maternal mortality, cases of substance abuse, gender violence and reproductive tract infections were increasing. The loss of indigenous healing practices and the medicalisation of child delivery has disempowered women. Hence, participants recommended the promotion of indigenous health practices, recognition of indigenous healers, participatory appraisal of health programmes and strengthening of women's health and safe motherhood programmes. The panel also discussed the inclusion of reproductive rights and health in primary health care, restoration of control of health in women's hands and development and provision of suitable health care for migrant women. According to Sister Mary Grenough, a pioneer of community-based health programmes since 1973 and a member of the Board of Directors of the Council for Health and Development, women's health problems include lack of appreciation of their sexual and reproductive rights, violence against women, lack of health insurance coverage, low health budget allocation and privatisation which has resulted in increased medical fees. It was suggested that education on reproductive and sexual rights be provided and an accessible health system be developed.

Source: Junice D. Melgar (M.D.), Executive Director, Likhaan, 92 Times St., West Triangle Homes, Quezon City 1104 Philippines. Tel: 63-2-9266230; Fax: 63-2-4113151; E-mail: <likhaan@pacific.net.ph>.

From the Information & Documentation Centre

Azu, Masumi. 1997. "Violence against migrant women". Migrant Women's Human Rights in G-7 Countries: Organizing Strategies. San Francisco: Family Violence Prevention Fund; New Brunswick: Center for Women's Global Leadership. pp. 15–22

The organised trafficking of women to Japan is a growing phenomenon. Annually, more than 100,000 Asian women, mostly Thais and Filipinas, go to work in Japan's sex industry. Trafficking includes prostitution, other forms of sexual abuse and coerced labour like sweat shop labour, night club entertainers, "mail-order brides" and maids. In the 1970s, Japanese women started initiatives against such trafficking. They organised protests against the sex tourism of Japanese men to south-eastern countries, particularly the Philippines and Thailand. Although the plight of trafficked women has garnered public attention in the last decade, the dominant Japanese women's movement has not incorporated trafficking in their agendas since Japanese women continue to struggle against male domination at every level in society. However, shelters have been set up in Tokyo and surrounding areas for migrant women. NGOs also help them to escape from pubs and syndicates, obtain the necessary documents to return home, and frequently arrange for psychiatric rehabilitation. In addition, several women's groups collaborated with lawyers to set up a special task force to help mail-order-brides. They provide counselling, legal assistance and job counselling. There are also efforts made to prosecute pub owners and traffickers, and lobby for laws and policies that protect women from abusive relationships.

Source: Family Violence Prevention Fund, 383 Rhode Island St., Suite 304, San Francisco, California 94103-5133, USA. E-mail: <fund@fvpf.org>; Center for Women's Global Leadership, 27 Clifton Avenue, Douglass College, Rutgers University, New Brunswick, New Jersey 08903, USA. E-mail: <cwgl@igc.apc.org>.

Economic and Social Commission for Asia and the Pacific. 1999. "Panel II: rights approach to empowerment of women (Item 5 (b) of the provisional agenda): the Beijing PFA and recent trends in female migration in the Asia-Pacific region". [Paper prepared by the International Organization for Migration]. 53 p.

This paper reviews the Beijing PFA concerning women in migration in Asia-Pacific, looks at recent trends in female migration in the region and explores the impact of the PFA on the issue. International migration flows in Asia in the 1990s cover labour migration, settlement migration and forced migration. Women form a considerable part of all these migration flows. Increasing cases of violence and abuse in irregular migration, particularly trafficking, needs urgent measures to protect migrants' rights. Trafficking has received much attention in Asian countries since the Beijing conference. China and Burma have committed to taking action on the trafficking of women. Nepal, Thailand, Sri Lanka and the Philippines have taken steps to address female migration. Advocacy, research and collaborative initiatives at the regional and international level are important in promoting understanding of the phenomenon. The impact of the various interventions to protect migrant women cannot be assessed with the data available now. The following recommendations could help in the development of indicators for migrant women: 1) defining a framework for monitoring the conditions of migrant women; 2) mapping of data collection systems used by government agencies and NGOs; 3) pilot testing of available indicators and evaluating their performance; and 4) including the view of migrant women as a process of empowerment, as participants of intended programmes.

Source: International Organization for Migration, 17, Route des Morillons, C.P.71, CH-1211, Geneva 19, Switzerland. E-mail: <info@iom.int>.

Asia Pacific Forum on Women, Law and Development (APWLD). 2000. Dignity Denied. Chiangmai: Asia Pacific Forum on Women, Law and Development. 84 p.

This is a report on the November 1999 event, where the Thai Government tried to implement a policy to deport about 600,000 undocumented migrant workers. They were mainly from Burma, with more than half of them women. They were rounded up in raids and accommodated in ill-equipped detention centres. Deportation was done hastily, ignoring safety regulations. Heavily pregnant women were squeezed into lorries for long, strenuous journeys. Political activists at risk of persecution on entry into Burma were included and all migrants were subjected to conditions below the international standards for deportation. Burmese troops closed the official border crossings so the migrants were forced to cross the border in boats or through jungle and uninhabited areas. When the borders were re-opened the Burmese authorities did not try to facilitate the return and re-integration of its nationals. Women were raped and abused, families were separated and pregnant women gave birth in fields.

This report calls for measures to ensure the safety and protection of the rights of all migrant workers during deportations. The Thai government is urged to reconsider the current deportation system. It is asked for special considerations for the vulnerability of migrant workers, especially women and children; protection against abuses; the improvement of the monitoring process; as well as the development and implementation of an effective migrant worker policy.

■ **Source:** APWLD, Santitham YMCA Building, 3rd Floor, Room 305-308, 11 Sermasuk Road, Soi Mengrairasmi, Chiangmai 50300, Thailand. E-mail:<apwld@loxinfo.co.th>

MacIntyre, Martha; Dennerstein, Lorraine. 1995. ***Shifting Latitudes, Changing Attitudes: Immigrant Women's Health Experiences, Attitudes, Knowledge and Beliefs.*** Carlton: Key Centre for Women's Health. 106 p.

This community-based project was stimulated by the awareness of the difficulties newly arrived immigrant women, particularly those of non-English speaking background faced in using Australia's health services. A questionnaire was used to find out the factors affecting their experience of health services, such as health workers' lack of knowledge and understanding of the women's religion, culture and perceptions of health, reproductive organs and functions. The immigrant women felt disadvantaged when seeking and receiving health services. Their employment situation was seen to add to mental ill-health by the women and health workers alike. The majority of women, especially the Muslims, also stated a preference for female doctors. Birthing practices in the country of origin influenced expectations and preparation for delivery in Australia. Infertility was seen as a serious problem for women from all the societies. The knowledge and experience of contraceptives, breast examination and Pap smears in the country of origin affected usage of the services in Australia. Menopause was seen very differently by different ethnic groups, e.g. women from Lebanon, Vietnam and the former USSR saw the cessation of menses and reproduction as a positive experience. The language barrier was viewed as the major cause for distrust and misunderstanding between immigrant women and health workers; therefore, interpreters should be used more often. This research can help improve equity of access of immigrant women to existing women's health services and assist service providers to provide appropriate and culturally sensitive health services.

■ **Source:** Key Centre for Women's Health, The University of Melbourne, 211 Grattan St, Carlton, Victoria 3053, Australia.

Migrant Forum In Asia. 2000. "Asian women and labour migration: the Beijing +5 review" <http://www.isiswomen.org/aworc/bpfa/pub/sec_f/eco00003.htm>. 9 p.

This paper presents an overview of the context and present situation of migrant women. It reviews the strategic actions recommended in the Beijing Platform for Action that concerns women in migration, considers the responses of government and non-government organisations to them, and recommends steps to address the issue more effectively. For most migrant women, migration is an economic necessity. But it exposes them to exploitation in a foreign country, as expendable labour without workers' rights, and as targets for violence and sexual abuse. The Platform identifies critical areas as strategic objectives for government and NGO efforts. The areas of concern are: women and poverty, education and training of women, women and health, violence against women, women and armed conflict, women and economy, and the human rights of women. The paper lists Asian migrant women's issues and the governments' responses to them regarding: 1) welfare and protection; 2) labour rights; 3) health and occupational safety; 4) education and training; 5) undocumented women migrants; and 6) re-integration; as well as the NGO responses for these issues. The challenges for the future require acknowledging governments' responsibility for the migration process and their ultimate accountability for the welfare and protection of migrant women.

■ Source: Migrant Forum in Asia, Unlad Kabayan Migrant Services Foundation, Inc., #1, Maamo Street, Sikatuna Village, 1101 Quezon City, Philippines. E-mail: <mfa@hk.super.net>.

Working Women's Health and Women's Health in the North. 1999. ***Nobody ever asked me if I wanted to know': An alcohol and drug health promotion project with culturally and linguistically diverse working women.*** Victoria: Working Women's Health and Women's Health in the North. 62 p.

This joint project aimed to improve access to information on alcohol and drugs for working women from culturally and linguistically diverse backgrounds (CLDB) living in Victoria. These women find it difficult to access such information in culturally and

linguistically appropriate form. They are under-represented among users of alcohol and drug services, so they are largely uninformed about the range of harm minimisation strategies available. Thus, a training package for conducting health promotion in women's workplaces was developed and community education sessions were conducted. The project used existing structures, networks and resources of women's health, alcohol and drug services to conduct health promotion with CLDB women in their workplaces and in the community setting. This report analyses the project's outcomes and processes. The findings show major gaps in the availability of health promotion programmes for CLDB women. Access to alcohol and drug services could be improved by increasing availability of multilingual brochures about services and provision of culturally and linguistically specific services. The project suggested that there be better cooperation between alcohol and drug agencies, women's health services and CLDB communities and organisations. It also said alcohol and drug health promotion is more effective when presented holistically, rather than in isolation from other women's health issues.

Source: Working Women's Health, 83 Johnston St., Fitzroy, Victoria 3065, Australia; Women's Health in the North, 76, Edwardes Street Reservoir, Melbourne, Victoria 3073, Australia. Tel: 61-3-94623266; Fax: 61-3-94623270; E-mail: <whin@mail.vicnet.net.au>.

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■ *Price: US$10.00 plus US$3.00 postal charges*

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■ *Price: US$10.00 plus US$3.00 postal* charges.'

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■ *Price: US$10.00 plus US$3.00 postal charges.'*

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■ *Differential pricing.* For *more information, please* contact *ARROW.*

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■ *Price: US$5.00 plus US$3.00 postal* charges.'
Note: Payments accepted in bank draft.

Ferninisation of Migration

This refers to the increasing rate of women making up the numbers of migrants. For example, in South East Asia, Filipinas account for 60 per cent of legal migrant workers, excluding seafarers. In Indonesia, of documented migrant workers, for every one male migrant, there are two female migrant workers. In Sri Lanka, an airport survey showed that 84 per cent of the migrant workers were women and of them 94 per cent were domestic helpers.

Source: Adapted from **Fernandez, Irene.** 1998. "Migration and HIV/AIDS vulnerability in South East Asia", [Paper presented at the] 12th World *AIDS* Conference, Geneva, July. <http://www.gn.apc.org/caramasia/c_ifpaper.html>.

Categories of Migrant Women Workers

1) **Documented workers** who are able to obtain employment contracts which can at least guarantee their name and status and the promise of a minimum wage

2) **Documented workers who become undocumented** due to various discrepancies in the system itself or due to manipulations of recruitment and employment agencies and are left to confront the law

3) **Workers who enter the country of destination through illegal routes,** without proper papers and need to evade the law. The situation is created by agents who get workers to enter into contracts in total ignorance of the requirements of cross country movements. This type of migrant workers are found mainly in the entertainment industry and domestic work

4) **Women who get trafficked when they seek to work overseas,** for example, Thai women were found working in sealed garment factories in the U.S.A. They had been brought in with false papers by agents and were deported upon discovery

5) **South-Asian women in transborder migration** within the sub-region where contractual work for citizens of neighbouring countries is not allowed. For example, Indian citizens cannot be contract-workers in Pakistan. Because of this stricture, illegal settlement migration often takes place

6) **Refugee women who become workers,** for example, Burmese refugees in Thailand or Bangladesh

Source: APDC. 1998. Asia-Pacific *Post-Beijing Implementation* Monitor. Kuala Lumpur: APDC. pp. 235–236.

Receiving Countries

These are countries that receive migrant workers in response to a formal migration policy or through illegal migration flows, based on an economic need for labour.

Source: ARROW

Sending Countries

These are labour-exporting countries that made use of the demand for workers in receiving countries by promoting the emigration of the employable population to increase their revenue and foreign exchange reserves. Sending countries usually do not institute sufficient measures to protect the migrant workers abroad. The competition between sending countries causes them to compromise the rights and benefits of the migrant women workers and tolerate the abuses.

Sources: Adapted from: 1) **Hameeda Hosain.** 1998. "The situation of Asian women migrant workers: current trends, and institutional and social problems". *Asia-Pacific Post-Beijing* Implementation Monitor. Kuala Lumpur: Asian and Pacific Development Centre. p. 236; 2) **Southeast Asia Watch (SEAwatch).** *Roadmap* on Migration of Women end Trafficking in Women in Southeast Asia. Quezon City, Philippines: SEAwatch. p. 3.

Trafficking

Trafficking in women is a migration process that compounds the vulnerability of women migrant workers. It is an illicit and deceitful recruitment and deployment of women across national borders for the purpose of or leading to their exploitation in the country of destination. It is a form of human rights violation against women based on the unequal power relations between the traffickers and the exploited women. The traffickers profit by exploiting the economic and social vulnerability of the migrant women and subjecting them to physical and/or psychological abuse at the recruitment and transportation phases of migration as well as at the workplace.

Source: Southeast Asia Watch (SEAwatch). *Roadmap* on Migration of Women and Trafficking in Women in Southeast Asia. Quezon City, Philippines: SEAwatch. p. 4.

Violence against Migrant Women Workers

Any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life.

Source: ESCAP. 1999. "Rights approach to empowerment of women—the Beijing Platform for Action and recent trends in female migration in the Asia-Pacific region". [Paper presented at the] High-level Intergovernmental Meeting to Review Regional Implementation of the *Beijing* Platform *for Action,* 26–29 October 1999, Bangkok. p. 19.

Violence Against Women Migrant Workers

In Asia today, migrant workers are increasingly female. Approximately 1.5 million Asian women are now working abroad either legally or illegally. About 60 per cent of the legal migrant workers (excluding seafarers) from the Philippines are women. In Indonesia, documented external migrant flows show two females for every male migrant. An airport survey in Sri Lanka revealed that 84 per cent of migrant workers were women, of whom 94 per cent were maids.' The Indonesian Migrant Workers Union stated that their number has increased from just 670 in 1989 to 41,400 by the end of 1999--an explosive growth of 6,000 per cent.[2] The increase is largely due to illegal recruitment agencies, overseas employment promoters, manpower suppliers and other legal and illegal subsidiaries.[3]

All too often women migrant workers leave their countries without knowing what lies ahead of them. As women and as migrant workers, they are particularly susceptible to violence. Those who enter countries illegally and without proper travel and work documents are especially vulnerable. Sending countries (see Table 1) try to be competitive by offering their female workers on terms favourable to the receiving countries but neglect to push for proper standards. Asian female migrants, for example, are mainly concentrated in a very limited number of occupations: maids, entertainers (often a euphemism for prostitutes), helpers in restaurants and hotels, and in assembly lines in labour-intensive manufacturing. Ninety-five per cent of Filipino women migrants are working as maids and entertainers, jobs not covered by the host country's labour codes or social security provisions.[4] Being a marginalized group whose mobility is restricted by employers, and in the case of illegal migrants, by the fear of law enforcers as well, they do not have access to necessary healthcare. The receiving country often does not have clear guidelines and regulations for migrant women workers or mechanisms to curb the abuses committed against them. As a result, they are helpless against physical abuses such as kicking, slapping, hair pulling, rape and other sexual assaults. They are also socially isolated, deprived of private space and verbally assaulted. In Hong Kong, some 100,000 Filipino maids suffer exploitation and sexual violence.[5] Tight employment situations cause the women to bear this in silence. Central to the abuse is the poor societal and economic value given to housework as an occupation. Some employers feel it is their right to physically admonish their maids while the latter see this as an ordinary work hazard.[6] The vulnerable nature of migrant employment is an obstacle to the prevention, detection and prosecution of violence against migrant women workers. NGOs and labour organisations lack direct contact with the women due to their isolation at the home. Receiving countries also do not strictly enforce laws to protect the women or prosecute the offenders.[7]

Table 1. Migration: Main Countries Involved

Main sending countries: Indonesia, the Philippines, Sri Lanka and Thailand **Main receiving countries:** The Gulf States (mainly Saudi Arabia and Kuwait), Hong Kong, Japan, Taiwan, Singapore, Malaysia and Brunei.

Data Source: ILO. 1996. "Female Asian migrants: a growing but increasingly vulnerable workforce". Geneva: ILO. Monday, 5 February 1996 (ILO/96/1). <http://www.ilo.org/public/english/bureau/inf/pr/96-1.htm>.

To tackle the problem, sending and receiving countries need to form bilateral agreements that effectively protect the women.[8] Proper orientation to the women on their legislated rights and protection have to be made compulsory. Sending countries need to form regulated agencies in the receiving countries to keep track of the women's welfare. Receiving countries have to review, reform or abolish laws that discriminate against the women. They need to collect data on the incidence of violence against migrant women for analysis and action. Without the necessary statistics, it would be difficult to take action. They have to provide abused workers with shelter, counselling and legal assistance sensitive to their cultural and psychological needs. The work of NGOs in advocating for these changes is essential. All women, irrespective of status, have the right to protection against violence as part of their right to well-being, health and health care services.

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[1] **Lin Lean Lim; Oishl, Nana.** 1996. International Labour Migration of Asian Women: Distinctive *Characteristics* and Policy Concerns. Geneva: International Labour Office.

[2] **international Relations Team, World Council of Churches**. 2000. *Uprooted People*. Geneva: World Council of Churches. Issue 10 February 2000. p. 4.

[3] **ILO.** 1996. "Female Asian migrants: a growing but increasingly vulnerable workforce". Geneva: ILO. 5 Feb. <http://www.ilo.org/public/english/bureau/inf/pr/96-1.htm>

[4] **ISSA**. 2000. "RP next to Mexico in number of women migrant workers". *Repro* Watch. Vol.24 No.1, July 15.

[5] **Matsui, Yayori**. 1999. "The feminization of international migration". Women in the *New Asia*. p. 47.

[6] **Abrera Mangahas, Ma. Alcestis. 1997.** Violence against migrant workers: a Philippine reality check". [Paper presented at the] *First National Convention of the* Philippine Migration Research Network (PMRN), 6 *February* 1997, *Quezon City,* Philippines.

[7] **APDC-GAD**. 2000. *The Beijing +5 Review: Situation of* Women Migrant Workers. Prepared for the 44th Session of the UN Commission on the Status of Women (28 February–17 March 2000, New York). KL: APDC-GAD. p. 7.

[8] Ibid, p. 8.