A Newsletter on Refugee and Migratory Movements

UDBASTU

the uprooted

Issue 21, July – September 2002

MIGRATION AND MIGRANT WORKERS' HEALTH AND WELL BEING

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Health of migrants and other mobile population has emerged as an area of increasing concern and activity during the last three decades. In general, the new trends, patterns, scope and nature of migratory population have thrown new challenges to management of migration.

Currently, there are about 185 million people living outside their place of birth, which is about 3% of the world's population. It is estimated that this figure will cross 300 million by the year 2050. Globally, about 2 billion people are on the move each year, which includes all kinds of movements.

In Asia, it is estimated that over the 1995-99 period, some 2.6 million workers left their country every year under contract to work abroad. The South Asian countries accounted for 46 percent of this outflow. South East Asia, mainly Filipinos, Indonesians, Thais, Burmese and Vietnamese made up the rest 50%. A large proportion of the workers from South and South East Asia leave for the Gulf countries to perform all types of service, trade and construction jobs. These large flows of population between areas of differing health conditions influence and affect the health and well being of the migrants themselves as well as that of the population of transit and destination countries.

There is the emerging need to have a common understanding of concepts such as "migrant worker" and "well being". Migrant workers are a subset of larger flow of "mobile people" who would be engaged or are engaged or has been engaged in a remunerated activity in States of which they are not nationals. This definition includes men and women, and documented and undocumented workers. On the other hand, "well-being" is a broader concept, which encompasses economic, social and human well-being. There seems to be no clear consensus on what is meant by well being as there are technical difficulties in analyzing various subjective dimensions of well-being. Complexities also arise out of the relationships among economic, social and human dimensions of well-being. However, mental and physical health are essential components of individuals well being. It is equally applicable for migrant workers. We should perhaps take "well being" in its totality while focusing on health aspect of migrants.

Health of migrant workers can be considered in relation to four distinct but inter-related phases of migratory process; namely pre-departure, transit, post-arrival and return. Each of these phases is associated

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with specific set of health issues, which influences the migrants' well-being. It has been recognised that some of the health related consequences may not be realised or appreciated until the individual is much further along the migration process either after settling abroad or even after return to the home country. This adds difficulties in ensuring sound and safe health of migrant workers.

Migrants, in general, are marginalised population in every phases of mobility. They are exposed to unique pressures, constraints and living environments especially those who are undocumented. They are often subjected to discrimination, xenophobia, exploitation and harassment and have little or no legal or social protection. Access to health information and health services are also very limited. Migrant worker's health vulnerabilities are further compounded by cultural and linguistic barriers.

Trafficked and smuggled persons are extremely vulnerable in terms of their health as migrants' legal status primarily determine their access to health services opportunities abroad. As trafficked and smuggled workers try to avoid contacts with authorities out of fear of imprisonment and deportation, they virtually have no rights to social and health care services. They are often forced by their precarious circumstances into unsafe working conditions, accommodations and exploitations. Among the undocumented migrants, women are the most vulnerable group. The exploitative and inhumane environment that they are forced into deprive them of exercising any rights. They can not gain access to basic reproductive health rights even. Moreover, they are often forced or deceived into unwanted and unsafe sex. Unfortunately women can even be vulnerable without having left their home when their partners come back from abroad with diseases such as HIV/AIDS.

IOM is committed to the principle that humane and orderly migration benefits all. Migration Health Services is one of the traditional and long-standing service area of IOM. The provision of medical assistance and the maintenance of health standards for migrants has been part of its functional activities. IOM's health advocacy and services address the entire spectrum of health challenges of migrants, whether regular or irregular. IOM believes that being mobile in and of itself is not a health risk factor. But the situations encountered and the behaviours engaged in during migration may increase vulnerability and health risk for migrants. IOM's health services to migrants includes:

- providing appropriate treatment and preventive health services to migrants.
- supporting the training and education of health care providers and others in the field of migration health.
- assisting agencies and organisations in their attempts to respond to the need of mobile population.

Health of migrants particularly of trafficked person is increasingly gaining importance at policy level as it has broader implications on the health of populations of origin, transit and destination countries. There is a growing recognition that the traditional paradigm based on migration control and health screening could no longer deal with the challenges related to migrants' health. The volume, speed, and nature of movement on one hand, and growth of communicable diseases like STDs, tuberculosis, hepatitis B on the other, are challenging the management of illness and disease of migrant workers. We need a rapid and sound management of illness and disease of migrants in order to make migration safe and to reduce the impact of migration-related diseases on origin and destination countries.

There is a growing recognition that the traditional paradigm based on migration control and health screening could no longer deal with the challenges related to migrants' health.

Health will continue to be a major element in migration debate in the coming years. There is an urgent need for close collaboration of partner agencies such as IOM, WHO, UNAIDS, ILO and NGOs, to develop appropriate policy and operational responses to the health challenges faced by migrants.

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THE RIGHT TO HEALTH OF MIGRANT WORKERS

Syeda Rozana Rashid

Health and migration are increasingly becoming important issues in migration literature. Health issues of migrant populations have long been acknowledged as public health concern[1]. It is due to the fact that over the last few decades, global economy witnessed an increasing flow of people in the international labour market. Along with exploring political and economic implications of migration, migrant workers' right to health has gained momentum. Migration scholars, migrant workers' associations and international agencies have started raising the issue of restricted access of migrant workers to health services in the country of employment despite their growing demand in the labour market. It is also recorded that millions of undocumented migrant workers are staying in different countries of the world in much more vulnerable conditions in terms of their access to health care services. Nevertheless, ensuring a secured and healthy life of migrant workers during their temporary stay abroad with employment have now become a major issue of campaign of human rights activists.

The essay attempts to discuss the health issues of migrant workers from the perspective of human rights. Various issues pertaining to the health of migrant workers have been highlighted. The paper also explored the international instruments under which States are obliged to ensure access to health services to the migrant workers. Some policy suggestions have also been offered in the last section.

Health Issues of Migrant Workers

Labour migration has largely been characterised by deplorable conditions and circumstances. In the host countries migrant workers are generally treated as 'low-status foreigners'. Discriminatory policies against the migrant workers affect their physical and mental well-being. They also suffer from lack of access to health information, medi-care services and social services in the host country.

Following are some of the health issues that will help us to understand the nature of health problem of migrant workers in the country of employment:

- Psychosocial/mental stress
- Physical exhaustion
- Communicable diseases
- Occupational accidents and
- Violence

Psychosocial/Mental Stress

Psychosocial/Mental stress of migrant workers emanates from the cultural shock and adaptation[2] difficulties as they leave behind familiar socio-cultural system. Social adaptation and acculturation is a complicated process involving linguistic, social, cultural, and conceptual transference that can denude migrants of much of what provided the basis for their identity and meaning of life[3]. Acculturative stress is a phenomenon that may underlie poor adaptation, including a reduction in the health status of individuals, identity confusion and problems in daily life[4]. Very often mental pressure is generated from working long hours. Specially women migrant workers engaged in domestic works or factories suffer mentally due to extended job hours, low wage and arbitrary deprivation of liberty.

Physical Exhaustion

Migrant workers very often experience physical exhaustion in the country of employment. Long hours of working coupled with intake of insufficient food causes physical weakness. The fear of repatriation led many of them to continue this life further aggravating the health. Long hours involving physically strenuous work have also led to various ailments like enlargement of heart. Unsafe workplaces have also led to migrants contracting life-long medical conditions

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such as Stevens-Johnson Syndrome[5].

Communicable Diseases
Research on health in employment demonstrates that migrant workers are more vulnerable to higher incidences of illness. Those who have exposure to toxic substances, record increased rates of depression, chronic headaches, skin diseases and neurological disorder.

There has been an increasing trend of tracing relationship between HIV/AIDS and migration. It is argued that due to loneliness and homesickness, migrant workers tend to buy sex to access easy entertainment. Entering into such intimate physical relationships, often without protection, increase the vulnerability of migrant workers to HIV/AIDS. Their vulnerability to HIV/AIDS to a large extent is the result of limited access to information. It is worthwhile to mention that there is hardly any treatment facility available for the migrant workers in the host country. Rather, in most cases, a HIV positive migrant worker is deported from the country of employment.

Occupational Accidents
Migrant workers are also highly vulnerable to workplace injuries due to employers' failure to comply with safety standards resulting to workers' physical disability and even death. Unsafe standards in manufacturing industries, may lead to accidents and may cause loss of limbs, such as fingers and hands. Construction labourers are also at greater risk of falling down from buildings, which may cause death. Occupational accidents are largely caused due to unhealthy working conditions with little or no access to prevention and care.

Violence
Migrant workers very often face violence in the form of verbal and physical abuse and torture. Sexual abuse of female domestic workers and caregivers in many receiving countries give rise to situations where the victim is compelled to take the decision of unsafe termination of pregnancy or going back to the home country. Gender based forms of violence such as rape is prevalent.

Another important aspect as far as the violence is concerned is the torture penetrated by members of law enforcing agencies. The undocumented migrant workers who are detected and put in the police custody are likely to experience the most exacerbated form of such violence.

Legislation constitutes an important instrument to ensure effective equality of opportunity and treatment and to modify attitudes[6]. The next section deals with how accessibility of migrant workers to social and health services can be ensured within the existing laws.

Health under the Framework of Human Rights
Physical and mental well-being is a fundamental right of every man irrespective of their country of origin, race, colour and religion. Safe and secured health of migrant workers has been covered under several international instruments.

1948 Universal Declaration of Human Rights (UDHR) proclaimed the universality and inalienability of such rights. According to the UDHR 'certain principles are true and valid for all peoples, in all societies, under all conditions of economic, political, ethnic and cultural life.' Article 25 (1) of UDHR provides 'Everyone has the right to a standard living adequate for the health and well-being of himself and of his family.' According to UDHL, migrant workers, documented or undocumented, therefore have the right to enjoy health security and services in the host country irrespective of their nationality, socio-economic and cultural differences.

International Covenant on Economic, Social and Cultural Rights (ICESCR) urged state parties to recognise the rights to everyone to enjoyment of the highest attainable standard of physical and mental health. International Covenant on Elimination of All forms of Racial Discrimination laid down in Article 5 that State parties will prohibit and eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin to equality before the law, notably in the enjoyment of economic, social and cultural right to public health, medical care and social services. The Convention on the Elimination of All forms of Discrimination against Women (CEDAW) through its Article 11 and Article 12 guarantees women's right to healthcare in equal footing with men. It also stipulated for special health care and social services particularly in cases of pregnancy, confinement and post-natal period.

Apart from these human rights instruments, health rights of migrant workers' are also stipulated in a number of documents specially enacted for migrant workers. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990 UN Convention) accorded right to health to both documented and undocumented migrant workers and their family members. Article 43 (1) (e) of the Convention envisaged " Migrant workers shall enjoy equality of treatment with nationals of the

State of employment in relation to access to social and health services, provided the requirements for participation in the respective schemes are met.” There are also Conventions on Migrant Workers, enacted by International Labour Organization (ILO) which lay the basis for the medical check-ups for migrant workers to ensure that they are in ‘reasonable health’.

It is unfortunate that legal frameworks are unable to ensure migrant workers basic social and health security and services. This is partly due to non-binding nature of many of these international instruments. Again, migrants’ access to health, though reiterated in basic human rights instruments including the UN Migrants Convention, remains subject to national laws and domestic schemes[7]. Discrimination, exclusion and dehumanisation directed at migrant workers pose enormous political, social and ideological barriers to the extension of adequate or even essential health care services to them[8].

Conclusion and Policy Issues

This essay highlighted the links between migration and health and the vulnerability of migrant workers. It underscores a right-based approach to emphasise migrant workers’ access to health security and services in the country of employment. It established that there are recognised instruments that may serve as the basis to address the needs of migrant workers’ access to health.

However, the fact is undeniable that mere presence of law cannot ensure enjoyment of human rights. The major responsibility lies to prepare the ground for practical policy measures. This implies that there is need of sensitising and raising awareness of employers, service providers, medical practitioners and others involved to provide migrant workers their fundamental rights to health. Migrant workers themselves must be conscious, aware and organised against all forms of discrimination against them.

Accessibility and affordability of migrant workers to health facilities, goods and services will not only benefit the workers themselves, but will also increase their productivity. The task, therefore, is to mount a campaign for safety and physical well-being of migrant workers by forging alliances of civil society groups and by lobbying the governments, particularly those in the receiving countries.

Notes and References:

[1] Taran, Patrick A. 2002, Migration, Health and Human Rights in *Migration and Health*, IOM International Organization for Migration 2/2002.

[2] According to the experts adaptation of individuals in new place constituted by a combination of three strategies-adjustment, reaction and withdrawal.

[3] Taran, Patrick A. 2002, Migration, Health and Human Rights in *Migration and Health*, IOM International Organization for Migration 2/2002.

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[7] Gencianos, Genevieve, Migrant’s Right to Health: Identifying Frameworks and Strategies, a paper presented at the 8th Regional Conference on Migration titled ‘Migration and Migrant Workers Health and Well being: Trend, Issues, Needs and Strategic Response’ BIAM, Dhaka, October 8-11, 2002.

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Introducing new RMMRU Book

DISPLACED WITHIN HOMELANDS:
IDPs IN BANGLADESH AND IN THE REGION

Edited by
Chowdhury R Abrar
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This 224 page volume contains 12 articles on displacement and ethnic minority, disaster-induced displacement, settling the displaced, and regional and international dimensions of displacement. Authors include Mahendra Lama, Roberta Cohen, Muhammad Mamun, H S Hasbullah and Abul Barkat.

LABOUR MIGRATION AND HIV/AIDS: THE BANGLADESH CONTEXT

Shahzada M Akram

International migration is an important factor for economic development in both home and host countries. According to International Organization for Migration (IOM), in the year 2000 more than 150 million people across the globe were migrants. Being a labour surplus country, Bangladesh experience large numbers of people going abroad for overseas jobs every year. So far more than 3 million Bangladeshis have gone to different countries in the Middle East and Southeast Asian countries as migrant workers, and so far have sent more than US$ 22 billion as remittance.

However, the global epidemic of HIV/AIDS is often associated with mobility and migration. After its discovery in 1981 in the United States, HIV/AIDS has now become a serious public health concern worldwide. According to the latest estimates of UNAIDS/World Health Organization (WHO) (December 2002 update), the total number of people living with HIV/AIDS is about 42 million. Among them 38.6 million are adults and 3.2 million are children under fifteen years. Of the total figure, 19.2 million are women. At present 6,000 people are being contaminated daily. The total death toll due to AIDS is more than 20 million around the globe. The epidemic has already caused a sharp reduction in economic growth in many Sub-Saharan countries in Africa. Since Bangladesh's foreign currency reserve depends much on remittances sent by the expatriates, the link between migrant workers and transmission of HIV/AIDS may pose a serious threat to labour export from this country.

Mobility is not in itself a risk factor for HIV, but can create conditions in which people become more vulnerable.

What Is HIV/AIDS?

AIDS is a deadly disease, spreading worldwide alarmingly. By killing or imparting cells in the immune system, i.e., human body's defense mechanism, HIV progressively destroys the body's ability to fight infections and certain cancers. Individuals with HIV in their body become susceptible to life-threatening diseases called opportunistic infections, which are caused by microbes that usually do not cause serious illness in healthy bodies. AIDS usually develops between two and ten years after infection with HIV. A person with AIDS will eventually die from diseases caused by the infections associated with HIV[1].

Routes of HIV/AIDS Transmission

The HIV virus is present in body fluids, e.g., blood, semen, vaginal fluid, breast milk and other body fluids containing blood. When any of these body fluids from an infected person enters into another uninfected person, s/he may get infected with HIV. According to epidemiological research HIV can be transmitted from one individual to another in basically three ways[2].

1. **Sexual Intercourse:** Almost 90 percent HIV transmission happens through unsafe sexual intercourse. The risk of HIV infection intensifies with the presence of any sexually transmitted infections (STIs), during the first few months of infection and during the last stages of the infection.
2. **Through blood, production from blood, and infected materials:** 6 – 10 percent of infection happens through unscreened blood transfusion, using un-sterilised needles and syringes, and using materials produced from blood such as plasma and packed red blood corpuscle (RBC). Sharing needles among the injecting drug users (IDUs) enhances HIV transmission very rapidly.
3. **From mother to child:** HIV can be transmitted from mother to child during pregnancy, birth and through breast-feeding.

Bangladesh Scenario

Bangladesh seems to be still a HIV/AIDS low-prevalence country, since only few such cases have been identified so far. The first patient with HIV in Bangladesh was identified in 1989. Ten AIDS cases and 126 persons with HIV infections were reported by 1999. However, the exact number of HIV infected

persons till date is not known, although there have been a number of estimations by different organisations, ranging from 13,000 to 30,000[3]. A recent newspaper report suggests that the total number of identified HIV/AIDS infected persons in Bangladesh is now 248. So far 20 persons have died due to such infection[4]. In the same report, it has been estimated that this number increases with ten persons each month. However, there has been a debate on the estimated number of HIV/AIDS infected persons in Bangladesh. It has been alleged that officials of international organisations working on health issues exaggerate the number of AIDS infected people in the country, mainly to protect their jobs[5].

Among the identified HIV positive cases, a large number is returnee migrant workers (41%), followed by housewives (12%), infants (5%) commercial sex workers (5%) and truck drivers (5%)[6]. Lack of adequate policy as well as resources for testing HIV/AIDS among common people is the main reason for not identifying the actual prevalence in this country. The existence of a large number of HIV infected people indicates the existence of local reservoirs of HIV[7].

Reasons for AIDS Proliferation in Bangladesh

All the known HIV-risk behaviours and factors – female sex workers, men having sex with men, injecting drug users, and sexually transmitted infections are known to exist in Bangladesh. However, very little information exists on to what extent the common people of Bangladesh is engaged in the afore-mentioned high-risk behaviours. Sex workers and drug addicts are largely blamed for rapid spread of HIV/AIDS in Bangladesh. Some other groups equally share the blame for spreading the disease such as expatriate workers, truck drivers and their helpers[8]. Some 74,000 expatriate Bangladeshis out of 2 million, visit home each year while 50 percent truck drivers and their helpers out of .225 million visit brothels during their trips to various parts of the country[9]. Moreover, the foreign crew of the foreign vessels anchored in either Mongla or Chittagong Ports is likely to be high-risk HIV carriers, who take the opportunity to procure sex from the sex workers based in brothels located near the port areas[10]. This is also a fact that there have been local transmissions among women who are infected by their emigrant worker husbands[11].

HIV Prevalence Among High-risk Groups

However, it is gathered from the sero-surveillance report that the HIV prevalence among the high-risk groups is 0.2 percent[12]. The rate was found to be the same in the last three such surveillances[13]. USAID report reveals HIV prevalence at 0.3% among female sex workers in major urban areas, 0.2% among male patients with sexually transmitted diseases (STDs), and 2.5 percent among IDUs.

Labour Migration from Bangladesh and Transmission of HIV/AIDS

Generally it is said that HIV is transmitted through migration, and migrant workers are indiscriminately harassed in the name of health check up. However, it should be mentioned that mobility is not in itself a risk factor for HIV, but can create conditions in which people become more vulnerable. Separation from spouse and family, engender loneliness and isolation, and a sense of anonymity. This can lead to diverse and unhealthy sexual practices, which make the mobile person more susceptible to high-risk behaviours[14].

Reasons for Migrant Workers' Vulnerability to HIV/AIDS

The following reasons may be identified for increased risks for migrant workers' exposure to HIV/AIDS.

- ***Loneliness and distance from home:*** Isolation from home environment creates loneliness, which enhances different sexual behaviour making the migrant worker vulnerable.

- ***Lack of proper information on safe sex:*** It has been observed that most of the migrant workers fall within the active sex age group. This indicates that all of them are susceptible to sexual urge. However, the level of adequate knowledge on safe sex, STDs and HIV/AIDS is very low which increases the risk.

- ***Undocumented migrant worker:*** Undocumented migrant workers face more uncertainty in their endeavour abroad. As safe workplace, housing, and health services are not ensured for this group of people, and they lack proper counselling, and their vulnerabilities increase manifold.

- ***Peer pressure in host country:*** Many migrant workers are influenced by their fellow workers who practice high-risk behaviour. This enhances chances of HIV/AIDS transmission.

- ***Lack of proper counseling on sexual issues:*** In most of the labour receiving states for Bangladesh, there is significant lack of proper and adequate health counselling. Even in the Bangladesh missions abroad, such services are not available. Therefore, even in need, Bangladeshi migrant workers do not receive necessary counseling there.

- ***Lack of integrated system of return migration:*** There is absence of a systematic data bank on returnee migrant workers in Bangladesh. So there is no scope to identify the HIV positive cases among the returnees.

Impact of HIV/AIDS Transmission on Migrant Workers

There are a number of adverse impacts of HIV/AIDS transmission in migrant workers. At individual level the HIV infected migrant worker may be subject to illness which will eventually lead to death. They also undergo mental pressure, face termination of job, deportation from host country, economic loss due to loss of job, and increased expenses for health service. At the family level the impact may range from decreased family income, malnutrition of children, broken family to transmission of HIV to the spouse.

Level of Awareness on HIV/AIDS

The level of awareness among the common people on HIV/AIDS is low. A government sponsored survey on AIDS and STD which was carried out with the support of UNICEF, reveals that nearly 80 percent of the population is unaware of AIDS and uneducated people are completely ignorant[15]. More horrifying is that 99 percent out of secondary schools also have little knowledge about AIDS. According to another report, 47 percent women become mothers at the age between 15 and 18 of which 67 percent are ignorant of HIV[16]. Regarding the awareness level on STDs and HIV/AIDS among sex workers, a recently conducted research in Gaibandha brothel, done by Progressive Research International (PRI), reveals that 60 percent of the identified sex workers heard of HIV/AIDS but they had no idea whatsoever about the routes of transmission or infection. They expressed their total ignorance of preventive interventions or any cure[17].

Among the migrant workers, awareness on HIV/AIDS may be created through taking some measures. Firstly, initiatives should be taken to keep migrant workers in the host country in a homely atmosphere, so that they do not feel isolated and homesick. Different social programmes may be organised regularly, and they should be encouraged to keep regular contact with their families in home country.

Secondly, migrant workers should be briefed about safe sex, both at pre-departure and after arrival phases. Condom use should be promoted among migrant workers.

Thirdly, adequate medical services should be provided to the migrant workers, so that they can immediately seek physician's support in any form of disease including STIs.

It should be kept in mind that any other disease could be cured, but not HIV/AIDS. HIV transmission at a large scale may destroy the labour force of a country, as it is seen in the Sub-Saharan African countries. At present there is a dearth of adequate briefing for migrant workers on issues relating to STDs and HIV/AIDS at the pre-departure level. Therefore, steps should be taken to address this gap for the safety of our people in host countries.

Notes and References:

[1] National Integrated Population and Health Programme, 2001, *HIV/AIDS Manual*.
[2] *Ibid.*
[3] According to Common Country Assessment Bangladesh, Bangladesh Economic Review, 2000 and Bangladesh Bureau of Statistics it has been estimated that the number of HIV positive adults in Bangladesh is 21,000 (*The Independent*, 3 June 2001). According to WHO and UNAIDS, the number of HIV infected patients in Bangladesh was 13,000 as of December 2001. Data disclosed in a workshop, organised by Bangladesh Human Rights Journalists' Forum in Chittagong on 20 October 2000, showed that there were over 30,000 HIV infected patients in the country as of October 1999 (*Independent*, 31 March 2001).
[4] *Daily Sangbad*, 30 November 2002.
[5] Dr. Jafrullah Chowdhury made the remarks while addressing the opening session of the National AIDS Conference on 27 October 2002. He said, "The number of AIDS patients in Bangladesh is obviously more than 210 as released by the government, but much less than 13,000 provided by WHO/UNAIDS" (*The Independent*, 28 October 2002).
[6] UNDP, 2001, *HIV Vulnerability and Migration: A South Asia Perspective*.
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[9] 'AIDS and People's Awareness', Mahboob Kabir, *The Independent*, 31 March 2001.
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DHAKA DECLARATION ON MIGRANT WORKERS' HEALTH AND WELL-BEING

The 8th Regional Conference of Migrants' Forum Asia expressed its deep concern about the health and well-being of migrant workers and their families in Asia and in other parts of the world. Sixty delegates representing migrant organisations, NGOs, trade unions, networks, international agencies, migration experts and advocates from 13 countries participated in the conference that was held in Dhaka on 9- 11 October 2002. The conference adopted the following declaration.

For many decades, migrant workers have made significant contributions to their own countries as well as the labour receiving countries – without which the economies of many sending countries would have collapsed, and those of the receiving countries would not have attained their impressive economic performances.

These significant roles and contributions have been made at an enormous cost to the life, health and well-being of the migrants and their families.

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

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

We, the participants of the 8th RCM, express grave concern over the continuing denial and erosion of the rights of migrant workers, particularly to life, health and well-being, as evidenced by the recent summary deportations and mass expulsion of migrants (e.g. Malaysia); the increasing incidence of HIV/AIDS; the high rates of occupational accidents and work-related diseases; the steady stream of migrant deaths; the high incidence of mental, emotional and psychological stress and distress; and the disintegration of many migrants' families.

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

Initiatives and efforts to address these health concerns have been inadequate and ad hoc. As a matter of justice, governments of both receiving and sending countries must now respond to the health and well-being of migrant workers and their families, and mobilise and allocate all the resources needed.

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

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

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

RECOMMENDATIONS

The conference also adopted the following recommendations for follow-up and action on six strategic areas.

A. Conduct studies, information gathering, monitoring or research on migrants' health

- Comparative studies on wages, health and other standards, conditions and vulnerabilities of migrants - across Asia; by job category, nationality and gender
- Studies on how families are affected by migration, especially in the case of illness, and upon migrants' return
- In-depth studies on the violations of health, reproductive and sexual rights
- Study/compilation of health and migration policies, laws and practical services
- Study on racism, discrimination in laws, policies and services related to health
- Documentation, monitoring on abuses, rights violations, including health, reproductive rights, violence against women

B. Strengthen/build linkages and networks; conduct joint public actions/campaigns on health

- Link migrants' actions with labour movements/ actions
- Launch regional/global campaign focusing on migrants' health and well-being; including media campaign to raise public awareness and project migrants' health issues
- Explore possibility of regional/global campaign to give migrants due recognition, treatment, services for their contributions to host/home countries
- Improve links with trafficking and other migration networks
- Build or expand core or volunteer groups of health and related professionals assisting the migrants Build national networks of migrant support groups
- Engage with IGOs regarding programmes, services, responses on migrants' health needs
- Strengthen, expand, link up with regional migrant network; strengthen or expand MFA as mechanism for monitoring, implementing coordinating strategies and responses

The present mode of mass labour migration is premised on single-person migration, and the trade and commodification of human labour – treating migrants as mere economic tools, separating them from their families, uprooting them from the support systems of the family and the community, and negating the wholeness of their humanity.

C. Lobby governments in Asia on health-related and migrants' rights concerns

- To give top importance on the creation of local jobs (instead of exporting workers to 3D jobs); emphasising that this is the governments' (esp. sending) basic priority and main duty
- To ensure that there are consulates/embassies in host countries, with appropriate health personnel and services; that these foreign missions should provide health services and counseling, regardless of migrants' visa status
- To organise and conduct direct medical assistance where appropriate, e.g. in labour camps in the Middle East and in detention camps
- To stop / reform discriminatory policies towards migrants, e.g. ban on women from migrating
- To improve government policies/practices on regulating and monitoring recruiters, so that they do not aggravate abuses, or put migrants in greater health risks or more vulnerable situations
- To recognise as first line of protection for health and well-being migrant trade unions, organisations, and support groups

- To forge bilateral agreements protecting migrant workers
- To stop inhumane policies and practices – especially violence against women migrants in the Middle East
- To stop mandatory medical, pregnancy, HIV/AIDS testing; to properly treat, instead of summarily deport, sick migrants
- To ensure mandatory health insurance for migrants
- To adopt national migration polices or laws protecting migrants and their families; consistent with international human rights standards
- To include migrants' health in national policies
- To ratify and implement international instruments, especially the 1990 UN Migrant Workers' Convention

D. Produce and disseminate resource materials on migrants' health and well-being

- Books/references/resource materials on good/bad practices, policies on health (both by governments and NGOs)
- Education kit on migrants' health issues, risks, and vulnerabilities
- Reference on discriminatory policies especially on health
- Information/resource materials on OSH and compensation levels
- Training kits on migrants' health – basic principles, framework, rights
- Resource materials on OSH and compensations

E. Improve/Strengthen health-related direct services for migrants

- Ask governments to provide health policies, services, channels for migrants and families; assist migrants in accessing public medical system, services
- Provide counseling and orientation booths for migrants at border areas (both sides)
- Mobilise more volunteers, doctors, lawyers to help
- Establish/maintain crises and refuge centres

F. Build capacity of MFA member-organisations, migrant organisations, NGOs/support groups in addressing health issues

- Exchange/study programmes among migrant advocates/NGOs
- Education and capacity-building trainings on health and reproductive rights for migrants and support groups (onsite, pre-departure, ex-migrants and their families)
- Help grassroots migrants' groups access financial and logistical resources so that they can sustain/build their organisations
- Provide training/education programmes for migrants to help them know of and access medical services
- Provide orientation and/or migration counseling services (including communication and language training to enable migrants to articulate their health needs/conditions) in host and home countries
- Help NGOs/support groups to access funds, logistics, resources, more human power and volunteers to enable them to do their work better.

HONOLULU COMMITMENT ON MOBILITY, TRAFFICKING AND HIV/AIDS IN SOUTH ASIA

Sixteen organisations representing four South Asian countries adopted the following document at a conference on "The Human Rights Challenge of Globalisation in Asia-Pacific-US: The Trafficking in Persons, Especially Women and Children", held on 14 November 2002 at Honolulu, Hawaii.

For millions of people of South Asia, movement in search of livelihoods is a major strategy for survival. Severe socio-economic inequities, oppression, lack of choices, conflicts and various forms of deprivation compel people to move both within and outside the region. However, the mobility of a large number of people in the region is uninformed and is fraught with serious risks of exploitation and unseen vulnerabilities. Key among them is the trafficking of women and children and vulnerability to HIV/AIDS.

Burdened by huge gender biases, severe forms of exploitation, violence and lack of opportunities and information, a large number of women on the move are vulnerable to being trafficked. This, along with their vulnerability to HIV/AIDS, results, in fact, from the same socio-economic realities that force them to move without informed choices. The incidence of trafficking is acute in South Asia, with over 200,000 women and children being trafficked annually, both across and within national borders. Trafficking amounts to one of the worst forms of human rights violation and exposes women and children to extreme forms of exploitation such as sexual abuse, bonded labour and physical violence. It heightens the vulnerability of the affected to HIV/AIDS and precludes prevention and care.

HIV/AIDS constitutes formidable challenges to human life and security in South Asia, which has one of the fastest infection rates in the world. Safe mobility, prevention of trafficking and containment of HIV/AIDS are therefore central to the development and security of the region. The situation urgently calls for strategies that recognise people's right to move with informed choices and prevent trafficking and HIV/AIDS.

Civil Society Joins Hands

The increasing incidence of unsafe mobility and trafficking of women and children in South Asia threatens to accentuate the impact of the HIV/AIDS epidemic in the region and urgent steps are needed to address this vital link before it vitiates the atmosphere further, said leading South Asian NGO leaders, human rights activists and civil society participants here at the Globalisation and Trafficking Conference, being held in Hawaii.

The mutually aggravating links between widening disparities in socio-economic circumstances, unsafe mobility, trafficking and HIV/AIDS has complex implications on the overall socio-economic development of the region, they said. The region has one of the largest rates of uninformed migration in the world, very high incidence of trafficking and the world's second largest number of people living with HIV/AIDS. In this context, the civil society participants urgently called upon South Asian governments to initiate implementation of the 2002 SAARC (South Asian Association for Regional Cooperation) Convention against Trafficking.

Speaking at the forum for the development of a 'Honolulu Commitment', organised by UNDP REACH Beyond Borders*, they stressed that considerable challenges lay in working within an environment of increasing vulnerabilities and diminishing choices. As representatives of civil society, they pledged to acknowledge this challenge, while committing to promote safe mobility, prevent trafficking and contain HIV/AIDS.

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Symposium Calls for DISSEMINATION OF INFORMATION ON LABOUR MIGRATION THROUGH SOCIAL NETWORKING

Speakers at a symposium highlighted the importance of dissemination of information on labour migration through community leaders and activists. They expressed the view that accessing right information would go a long way in mitigating the problems of the migrant workers in both home and host countries. Major (Rtd.) Quamrul Islam, State Minister for Expatriates' Welfare and Overseas Employment, urged the participants of a three-day workshop to build strong networks in their communities to protect the potential migrants from the unscrupulous activities of recruiting agents. He also highlighted the importance of collaboration of the government, academia and the civil society to protect and promote the interests of the migrant workers. He was addressing at a symposium on *Globalisation, Migration and Development*, organised by the Refugee and Migratory Movements Research Unit in Dhaka on 31 May 2001.

In his keynote address, Brunson McKinley, Director General of International Organization for Migration (IOM), Geneva, stated that migration, if managed properly, could benefit countries of origin and destination as well as individual migrants. He said that remittances of migrant population stands at US$ 100 billion a year, making it second to earnings through oil exports. Mr. McKinley also drew attention to the fact that 47.5 percent of international migrant labour force now comprises of women and that this reality must be taken into account by the states when formulating their migration policies. The Director General offered

IOM's support to Bangladesh in developing national capacities, stating that his organisation's involvement in this country represent a microcosm of its activities globally in response to challenge to better manage international migration.

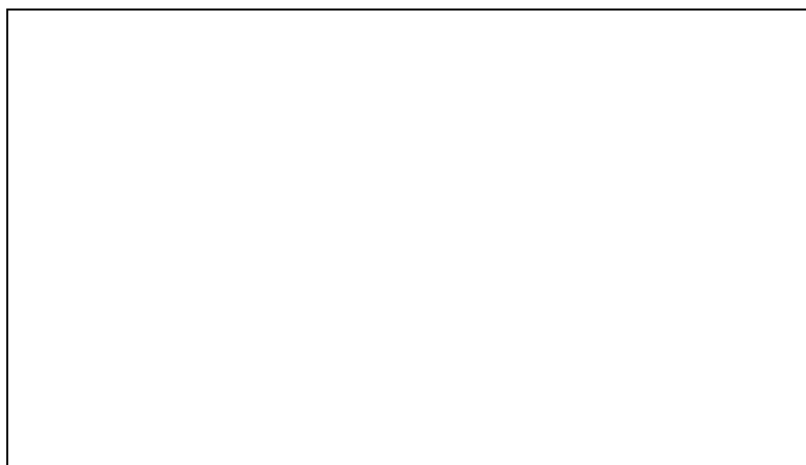
Mr. Reaz Rahman, State Minister for Foreign Affairs, stated that the Bangladesh missions are being geared to be more active in securing the interests of migrant workers. Terming the missions as the frontline in labour export sector, he said that the government is committed to pursue a vigorous economic diplomacy for further secured markets for Bangladeshi labour. Dr. C R Abrar, Coordinator of RMMRU, chaired the session. Earlier Dr. Tasneem Siddiqui highlighted the rationale for preparing the *Training Manual for Community Leaders and Activists on Labour Migration Process* and introduced its key features. Mr. Charles Nuttall, Deputy Director of The British Council, Dhaka, spoke on his organisation's involvement in this project.

The symposium followed a three-day training workshop on *Awareness Campaign for Community Leaders and Activists on Labour Migration Process*, organised from 29 to 31 May 2001. Findings of a number of research projects undertaken by RMMRU suggested that one of the most neglected fields was advocacy to raise awareness about the existing reality of the labour migration process. This encouraged RMMRU to develop training programmes for the protection and promotion of the rights of the migrant workers through disseminating information among local level community leaders and activists. The first workshop was organised in Dhaka on 27–28 April, and the second on 3–4 November 2001. The three-day workshop was arranged for the *Union Parishad* chairmen and members, *imams* (religious leaders), and grassroots NGO workers.

The major outcome of these workshops was a training manual for raising awareness among the people at the grassroots in order to minimise the cost and maximise the benefit of orderly labour migration from Bangladesh. Based of the training manual, a wide range of issues was covered in eight working sessions. These included information on concepts of international labour migration and Bangladesh context, various problems that migrant workers face both in home and host countries, role of government and private agencies in recruitment process, information on different host countries, legal assistance in host countries and role of Bangladesh missions, methods of remittance transfer process and their effective utilisation, and different aspects of trafficking in women and children.

A team of academics, government functionaries, lawyers and bankers under the stewardship of Dr. Tasneem Siddiqui of RMMRU developed the manual. Among others, Dr. Hossain Zillur Rahman, Mr. Shahudul Haque, Director General of Bureau of Manpower Employment and Training (BMET), Dr. Iftekharuzzaman of Bangladesh Freedom Foundation, Mr. Suhrab Hossain, DG of Ministry of Foreign Affairs, Mr. Ghulam Mustafa, Secretary-General of Bangladesh Association of International Recruiting Agencies (BAIRA), Mr. Mohammad Abdul Mannan, Senior Vice President of Islami Bank Bangladesh Ltd., Mr. Saiful Haque, Vice Chairman of Welfare Association of Returnee Bangladeshi Employees (WARBE), Dr. Shahdeen Malik, Dr. Sumaiya Khair, and Dr. C R Abrar acted as resource persons.

Reporter:
Shahzada M Akram



State Minister for Foreign Affairs Mr. Reaz Rahman speaking at the symposium on 'Globalisation, Migration and Development', organised by RMMRU. Also seen in the photo are Major (Rtd.) Quamrul Islam, MP, State Minister for Expatriates' Welfare and Overseas Employment, Mr. Brunson McKinley, Director General, IOM, Mr. Charles Nuttall, Deputy Director, The British Council, Mr. Shahudul Haque, Director General, BMET and

Initiative to
INVOLVE COMMUNITY LEADERS IN COMBATING TRAFFICKING

A Preparatory Needs Assessment Workshop (PNAW) was organised by the Refugee and Migratory Movements Research Unit (RMMRU) at IOM Conference Room, Dhaka on 29 and 30 April 2002 as part of the project of IOM commissioned *Capacity Building for Combating Trafficking in Women and Children in Bangladesh* currently being implemented by RMMRU. Some elected members of the local government, i.e., *Union Parishad* chairmen and members from the target areas of Jessore and Rajshahi were present at the workshop along with representatives of Rights Jessore, ACD–Rajshahi, and IOM and other NGOs working on trafficking issues. Two implementing partners of the project Rights Jessore and ACD shared their findings after conducting several field level needs assessment meeting with *Union Parishad* chairman and members at their respective Unions. The workshop aimed at identifying issues of concerns about trafficking in the project areas and mechanisms of how to combat trafficking.

At the inaugural session Dr. Tasneem Siddiqui, Director, Research and Training, RMMRU explained the purpose of the workshop. Ms. Rina Sen Gupta, National Programme Officer of IOM elaborated its rationale. At the latter half of this session Dr. Siddiqui dealt with conceptual issues. She underscored a clear distinction between the issues of trafficking, regular and irregular labour migration, economic migrants, human smuggling along with issues of forced displacement. This was followed by an open discussion where participants shared their own ideas and experiences of trafficking and its similarity with undocumented economic migration.

The two-day PNAW was divided into five working sessions. The first working session of the workshop discussed causes, method, and target of trafficking and nature of traffickers. Dr. Ishrat Shamim was the resource person. A participatory method was followed in the session. Participants were divided into three groups. The work of identifying the causes, method, target and traffickers was distributed among the groups. A lively discussion took place when each group made presentation on their findings. Group 'A' identified different social, economic, personal and political causes of trafficking, which are operating in both demand and supply sides. As far as the method is concerned, Group 'B' made a distinction between the method of procurement and the method of trafficking. Group 'C' worked on target and nature of traffickers, identified target group according to their socio-economic vulnerabilities. They also divided the people involved in trafficking according to their responsibilities and control over the process.

The second working session dealt with consequences of trafficking. The PNAW tried to ensure maximum participation of the attendants. With that objective group tasks were assigned to find out the consequences at different stages of trafficking. In this way the PNAW was able to identify the social, economic, mental, physical and other types of vulnerabilities operating for a trafficking victim during flight, in the host country and after repatriation. As resource person Dr. Sumaiya Khair provided inputs during presentation and open discussion on the findings of the group work.

General aspects of prevention of trafficking was discussed at the third working session of PNAW. There was an effort to identify the prevention strategy of trafficking on the basis of causes identified at the first working session. The field findings of needs assessment meeting was also presented in this session by the participants from both Rights Jessore and ACD. Making people aware of the consequences of trafficking was identified as the most important component to prevent trafficking. Besides, important issues came up regarding implementation of laws against trafficking, government policies and its implementation.

The fourth session dealt with the role of elected members of the local government in prevention of trafficking. As a resource person, Prof. Dalem C Barman of DU delivered a lecture on the mandate of the local government. He discussed the duties and responsibilities of the local government as entailed in the Local Government Act. It was followed by developing small-scale project through participatory group work. Each group chalked out separate model programme proposals for combating trafficking within the mandate of UP chairman, general members and women members. The objective of developing such project proposal was eliminating structural causes of trafficking and awareness building among the people. The session continued after lunch.

Various techniques to be used in prevention were discussed at the fifth session of the workshop. The

session was moderated by Mr. M. Shahidul Haque, Regional Representative, IOM. At the beginning of the session, Dr. Nazrul Haque, Activity Manager of BCCP, delivered a short lecture on techniques of prevention of trafficking. Later, a lively discussion took place where participants, specially UP chairmen and members, provided valuable inputs from their own experiences about how to reach to the people to disseminate information about trafficking and establish accountability of UP Chairmen and members to perform this role. Ms. Farah Kabir was the resource person of the session.

At the end of five working sessions, a discussion took place on the issues that came up during the two-day workshop. Valuable ideas were floated about trafficking and techniques of dissemination through field level intervention, All these will immensely contribute to the process of developing the TOT module that RMMRU is engaged in. The workshop was formally concluded by Dr. Tasneem Siddiqui of RMMRU.

Reporter:
Syeda Rozana Rashid

PUBLICATIONS

Training Manual on Labour Migration Process for Community Leaders and Activists, Tasneem Siddiqui (ed.), RMMRU, Dhaka, May 2002.

This training manual is the outcome of three awareness campaign workshops organised by RMMRU for raising awareness among the people at the grassroots on different aspects of orderly labour migration from Bangladesh. The training manual covers a wide range of issues in eight chapters. These include concepts of international labour migration and the Bangladesh context, various problems that migrant workers face both in home and host countries, role of government and private agencies in recruitment process, information on different host countries, legal assistance in host countries and role of Bangladesh missions, methods of remittance transfer process and their effective utilisation, and different aspects of trafficking in women and children. A team of academics, government functionaries, lawyers and bankers under the stewardship of Dr. Tasneem Siddiqui of RMMRU developed the manual.

Tasneem Siddiqui is Associate Professor in Political Science at the University of Dhaka. She did her Ph.D from Griffith University, Australia. She has written extensively on different aspects of labour migration. Her books are *Transcending Boundaries: Labour Migration of Women from Bangladesh,* Dhaka, UPL, 2001, pp. 215, *Temporary Labour Migration of Women: Case Studies of Bangladesh and Sri Lanka*. San Domingo: Amigo del Hogar, INSTRAW and IOM, (co-authored) 2001, and *Beyond the Maze: Streamlining Labour Recruitment Process in Bangladesh* (ed.), RMMRU, Dhaka, 2002, pp. 153.

Remittances of migrant population stands at US$ 100 billion a year, making it second to earnings through oil exports.
47.5 percent of international migrant labour force now comprises of women and that this reality must be taken into account by the states when formulating their migration policies.

Workshop: The third *Awareness Campaign Workshop for Community Leaders and Activists on Migration Process* was organised at BIAM on 29 – 31 May 2002. The workshop was participated by 25 representatives from NGOs, *imams* (religious leaders) of local mosques, *Union Parishad Members* (grassroots level public representatives), and workers' associations. This programme was jointly sponsored by The British Council and International Organization for Migration, Dhaka.

A Preparatory Needs Assessment Workshop (PNAW) was organised at IOM Conference Room, Dhaka on 29 and 30 April 2002. This was a part of the project of IOM commissioned *Capacity Building for Combating Trafficking in Women and Children in Bangladesh* currently being implemented by RMMRU. Some elected members of the local government, i.e., *Union Parishad* chairmen and members from the target areas of Jessore and Rajshahi were present at the workshop along with representatives of Rights Jessore, ACD–Rajshahi, and IOM and other NGOs working on trafficking issues.

Seminars and Talks: A symposium on *Globalisation, Migration and Development* was organised at BIAM on 31 May 2002. Mr. Brunson McKinley, Director General of IOM, Geneva, was the keynote speaker. The programme was participated by Major (Rtd.) Quamrul Islam, State Minister for Expatriates' Welfare and Overseas Employment, Mr. Reaz Rahman, State Minister for Foreign Affairs, Mr. Charles Nuttall, Deputy Director, The British Council, Dhaka, Mr. Shahidul Haque, Regional Representative of IOM for South Asia, and Mr. Shahudul Haque, DG, BMET.

A talk on *Bangladesh Election Commission: Problems and Prospects* by Md. Mahbubur Rahman, undergraduate student of the Department of Political Science, University of Dhaka, was organised at the Seminar Room, Faculty of Arts, University of Dhaka, on 28 April 2002. Students, faculty members of Social Sciences, and NGO and human rights activists participated at the programme.

Publications: A *Training Manual for Community Leaders and Activists on Labour Migration Process*, edited by Tasneem Siddiqui, was published in May 2002.

Monthly Meeting: In the Young Researchers' Forum (YRF) monthly meeting of June 2002, a paper was presented on *Sea Level Rise and Population Displacement* by Sadia Samad, undergraduate student, Department of International Relations, and Student Associate, RMMRU.

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