

Women on the Move

Migration, care work and health



World Health
Organization

Women on the Move

Migration, care work and health



World Health
Organization

Women on the move: migration, care work and health

ISBN 978-92-4-151314-2

© World Health Organization 2017

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. Women on the move: migration, care work and health. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Printed in Switzerland

Contents

Foreword	6
Acknowledgements	7
Acronyms	8
Executive summary	9
Chapter 1. Introduction	13
Why this report?	14
Outline and methodology	17
How demographic trends are shaping transnational care	18
Defining and recognizing care	23
Leaving no one behind: the SDGs and universal health coverage	24
Rights of migrant women care workers	26
Chapter 2. In the receiving countries	31
Effects on the care economy and health systems	32
Drawbacks for countries along transnational care chains	35
Benefits for individual migrant care workers	35
Drawbacks for migrant women working as carers	36
Implications for health systems and for achieving UHC	41
Chapter 3. In the sending countries	45
Benefits for economies and households	46
Challenges for families left behind	49
Chapter 4. Policies to support the health of migrant women involved in personal care work	57
Policy coherence and a whole-of-government approach	58
Towards transnational social protection	61
Towards transnational access to health system coverage	62
Non-discrimination and social participation to achieve universal health coverage	63
Care work, gender and intersecting drivers of inequalities	67
Framing transnational care work as a global public good	69
Chapter 5. Three next steps	73
Step 1. Generate evidence	76
Step 2. Improve access through non-discrimination and participation	78
Step 3. Value care as a public good and harmonize policies	80
References	82

Annexes

1. Data figures related to migrant stocks Page 97
2. The Carers' Compass Page 100

List of tables

1. Relation between income level and percentage of the population over 60 years of age Page 19
2. The SDGs and targets most relevant to migrant women care workers Page 25
3. The 12 priorities of the Framework of priorities and guiding principles to promote the health of refugees and migrants Page 71
4. Summary of the three “next steps” Page 75

List of figures

1. Global population by broad age group between 1950 and 2050 (projected) Page 19
2. Seven drivers of women's economic empowerment Page 20
3. Countries housing 75% of total migrant stock in 2015, classified according to World Bank categories in 2014 Page 21
4. Conceptual framework for the social determinants of health Page 22
5. Change in women's labour force participation (2000–2015) and percentage of foreign-born among home-based caregivers (2015) Page 33
6. Percentage of foreign-born among home-based caregivers of long-term care Page 34
7. Social determinants of health diagram adapted for migrant women care workers Page 68

List of boxes

1. International human rights architecture relevant to migrant women care workers Page 27
2. Soft-law instruments relevant to migrant care work Page 28
3. Regional/subregional human rights architecture relevant to migrant women care workers Page 29
4. Bilateral agreements: the case of Bangladesh and Jordan Page 37
5. The demanding nature of care work Page 39
6. Migration and remittances – economic and gender considerations Page 48
7. Example of the care chain from child and grandparent perspectives Page 51
8. Example of Australian care workers and family reunification Page 59
9. Example: the importance of community health workers in the United States of America Page 64
10. Example: the Philippine Migrant Health Network Page 64

List of pictures

Page 12 Matthias Zomer

Page 16 IOM / Jemini Pandya

A Sri Lankan labour migrant takes care of a 90-year-old Italian woman. Such essential family care assistants in Tuscany, Italy, have been recruited under a pilot IOM programme funded by the Italian Ministry of Labour and Social Affairs.

Page 26 WHO / Fredrik Naumann

Isabella Nordby (left) and Aagot Dahlen give a course diploma to Saida Dostzada. The women provide diabetes information to migrant women as part of a course designed to teach them about healthier living. Preventing diabetes is part of the curriculum, and the women cook food from their home countries but with adapted, healthier recipes.

Page 30 Monica Campbell / PRI's The World

Live-in caregiver Joesy Gerrish, from Fiji, with her employer Florence Tratar, who had an accident that left her in a wheelchair.

Page 40 Kenneth Pornillos / World Bank

Older brother carries younger brother. Legazpi City, Albay, Philippines.

Page 42 Gerd Altmann

Page 44 Eric Miller / World Bank

Local hospital. In the waiting room, parent with sick children. Marracuene, Mozambique.

Page 47 IOM / Bashir Ahmed Sujan

Control over earning is an important dynamism in women's empowerment. A woman returnee migrant worker from Saudi Arabia exchange money at the money changer booth at the ZIA International Airport, Dhaka, Bangladesh.

Page 50 IOM 2009

How can migrant mothers stay in touch with their children left behind? In Ukraine, IOM targeted some high-migration regions where up to 25% of children are growing up with one of their parents – often the mother – working abroad. IOM invested in field-based research and took a number of steps to reach out to these families as well as improve key local actors' – such as teachers, psychosocial workers and local NGOs – knowledge about the needs of these children. IOM also organized "Creative laboratories," using theatre, role-playing and arts as well as sport events and theatre shows, to help several hundred children in Ukraine explore and express their feelings about their parents' absence.

Working with local authorities both in Ukraine and Italy – a major destination country for Ukrainian women migrant workers – IOM provided equipment and training on using Skype to children, teachers and migrant mothers. These mothers, many of whom are domestic workers and caregivers, also benefited from focus groups and psychosocial support where they could openly talk about the impact of the separation from their families on their well-being.

Page 53 (left) IOM / Tatiana Jordan 2009

Many Moldovan villages are populated with elderly people taking care of their grandchildren – Nicolae with one of the three that he looks after. According to a recent IOM study in the Eastern European country, two out of every 10 rural households which had been previously receiving remittances from abroad, were no longer doing so.

Page 53 (right) Tom Cheatham / World Bank 2013

Grandmother and grandson, Phalankone village, Myanmar.

Page 55 WHO / SEARO / Pierre Viroit

Illustration about tuberculosis in India.

Page 56 Li Wenying / World Bank

For most of the rural migrants in Chinese cities, lack of skills is a big barrier for them to make a decent living. The government now offers a range of free training courses to get them better prepared for the job market. Chongqing, China.

Page 72 IDWF

In Bangkok, the Network of Domestic Workers in Thailand started the day by sharing information about their legal rights and the Network's goals with other domestic workers and passers-by in Rot Fai Park in downtown Bangkok.

Page 79 UN Women Cambodia / Charles Fox

In Cambodia, 70 per cent of women are engaged in vulnerable employment; more than 500,000 work in garment and footwear factories. Empowering women to exercise their rights to decent work, the UN Trust Fund to End Violence against Women (managed by UN Women on behalf of the UN system) is working closely with partners to ensure discrimination-free work environments in Cambodian factories. Chhun Srey Sros, 24, lives in Sangkat Chaom Chao and works in a Cambodian factory where the UN Trust Fund and its partner, CARE, have developed and distributed educational materials and a sexual harassment policy for the workplace. Sixth among 10 siblings, Srey Sros dropped out of school when she was in 10th grade to support herself and her family. She has worked in the garment factory for three years and makes up to US \$200 per month with overtime.

Foreword

In so many homes and places around the world, women of all ages, ethnicities, cultures and backgrounds are providing essential care to others, within and outside their own families, to sustain health, well-being and comfort. While men also contribute, available data show that the overwhelming proportion of care workers worldwide is women, and increasingly they are migrant women.

As women's economic empowerment builds, lives are being transformed, including decisions made to travel from their own homes, families and communities to earn a living. In the destination countries and territories, these migrant women are making a positive contribution to the health and well-being of others as they work in the care sector, often informally. They fill unmet needs for long-term care in our ageing societies and buttress health and social care systems in many countries as a kind of invisible subsidy. However, their own health is at stake. Are they able to access the services they need? If not, why not, and what can be done about it? What happens to the health and care situation for the families they leave behind? Although there are still more questions than answers and data gaps remains substantial, it is right and timely to ask such questions, and develop and implement workable solutions as a global community.

This report is unique and important for WHO. It breaks new ground in casting a wide net across disciplines –health, labour, employment, social protection, social services, law, immigration, cross-border movement and citizenship– to shed light on a particular population group that both provides care as well as needs it to maintain their own health and well-being. It looks at the lives of these migrant women care workers as well as the situation for their households left behind. It takes a transnational perspective appropriate to our interconnected world.

We expect this report to inform international, regional and local debates about migration, care work, and health and well-being for women. It is a call for more policy coherence, and for political decisions and leadership, to counter negative narratives on migration with the positive examples of the important contributions that migrants make.

The top priority of Dr. Tedros Adhanom Ghebreyesus, Director-General of WHO, is to progress universal health coverage (UHC). This is the aspiration that all people can obtain the prevention and treatment health services they need without suffering financial hardship. UHC can improve population health and promote economic development by lifting the barriers created by unequal access to quality health care services. UHC must effectively and equitably include all people, including the millions of migrant women working in the care sector around the world, who may suffer from discrimination and exclusion in their host societies despite their contribution to health and well-being.

As the only international organization in health accountable to all the world's governments, WHO will rise to meet this challenge. Underpinned by our commitment to equity, gender and human rights, it will be the role of WHO to ensure that this population group can benefit from our efforts for achieving universal health coverage. We will play our part in ensuring that all those working in the health and social care sectors, including migrant women, are counted and recognised for the contribution they make to protecting and promoting health and well-being for so many individuals, households and societies around the world. We will hear them. We will involve them. We will not leave them behind.



Dr Flavia Bustreo
Assistant Director-General
Family, Women's and Children's Health Cluster
World Health Organization

Acknowledgements

This report was developed under the overarching **leadership** of Veronica Magar (Team Leader for Gender, Equity and Human Rights, GER, at WHO HQ in Geneva), with **guidance and strategic direction** from Flavia Bustreo, Assistant Director General (ADG) of the Family, Women's and Children's Health Cluster and strategic shaping by Anne Marie Worning (as Acting ADG). They collaborated with both Ilona Kickbusch (Graduate Institute of International and Development Studies, Geneva), who helped develop the original concept and framing, and Sarah Gammage (International Centre for Research on Women) who supported the team advance the report to its final shape.

Extensive expert technical content was provided by: Sarah Gammage (International Centre for Research on Women), Olena Hankivsky (Simon Fraser University), David Ingleby (University of Amsterdam), Ilona Kickbusch (Graduate Institute of International and Development Studies, Geneva), Sonya Michel (University of Maryland), and Mary Manandhar of GER HQ. The technical contribution on legal frameworks was provided by Elena Abrusci and Andrea Nicholson (University of Nottingham).

The project was coordinated by Mary Manandhar, in collaboration with Adama Diop and Gerardo Zamora, building on early stage coordination by Gemma Hunting who also contributed technical content. The **GER HQ team** – Adama Diop, Ahmadreza Hosseinpoor, Theodora Koller, Eva Lustigova, Rebekah Thomas and Gerardo Zamora – contributed throughout, during consultations and providing feedback on drafts. We thank Evelyn Finger for administrative and logistical support, and Kate Bagshaw and Kristie Khatibi for their contributions.

Over the course of the project, several **interdisciplinary, multistakeholder and international consultations** took place which greatly helped to shape the report, sharpen the focus on the central theme of women migrant care workers and source relevant literature.

Contributors at the **Berlin (Germany) meeting** were: Pascale Allotey, John K Anarfi, Bipasha Baruah, Theda Borde, Asha George, Hiranthi Jayaweera, Ilona Kickbusch, Monami Maulik, Raya Muttarak, Bandana Purkayastha, Oliver Razum, Ann Singleton, Lindsay Stark, Sharuna Verghis and Judith Wenner. Special thanks are due to the Federal Ministry of Health of Germany, and to Mr. Björn Kümmel, Deputy Head of the Division Global Health. The Ministry hosted and supported this consultation.

Contributors at the **Dakar (Senegal) meeting** were: Taleb Abdellah, Jean-Francois Aguilera, Letty Chiwara, Nima Ganga,

Ahounou Gaston, Abraham Rojas Joyner, Nata Menabde, Saseendran Pallikadavath and Irudaya Rajan. Other UN agency colleagues also contributed – see the list below. Special thanks are due to Joe Thomas (Population Partners in Development) for supporting this meeting.

A global panel of expert reviewers provided key literature and valuable feedback on early drafts, with some also attending the international expert consultations cited above: Pascale Allotey, Veronica Birga, Krishanti Dharmaraj, Anjali Fleury, Asha George, Wendy Harcourt, Jenna Hennebry, Eleonore Kofman, André Laliberté, Helma Lutz, Rianne Mahon, Elizabeth Mason, Bandana Purkayastha, Ann Singleton and Cathy Zimmerman.

WHO Regional Office focal points for gender, equity and human rights contributed their expertise and identified regional literature. Isabel Yordi Aguirre merits particular mention for her extensive contribution throughout the process. We also acknowledge other regional colleagues: Hala Abou Taleb, Britta Baer, Benedicte Briot, Anjana Bhushan, Anna Coates, Lilia Jara, Aasa Nihlen and Triphonie Nkurunziza.

Colleagues across WHO HQ contributed in various ways. We acknowledge the partnership of Edward Kelley and Kanokporn Kaojaroen in the team coordinating work on migration. For their ideas, data and feedback, we also particularly thank Ibadat Dhillon, Chris Dye, Rachel Baggaley, Megan Gerecke, and Tana Wulji.

Experts from other UN agencies and international organizations generously provided insights and generous collaboration throughout the process. From IOM, Jacqueline Weekers and Eliana Barragan provided substantive input and shared key resources. We also thank: Veronica Birga (OHCHR), Letty Chiwara (UN Women), Claire Hobden (ILO), Petra ten Hoop-Bender (UNFPA), Marta Foresti (ODI), Maria Gallotti (ILO), Maina Allen Gidraf Kahindo (UNHCR), Susan Maybud (ILO), Shahrashoub Razavi (UN Women), Xenia Scheil-Adlung (ILO), Evelyn Smail (ODI) and Rachel Snow (UNFPA).

We thank David Bramley for editing, Elena Cherchi for layout and graphic design, and Naziha Sultana (International Centre for Research on Women) for assistance with data analysis and related graphics. An earlier draft of the report was edited by Richard Cheeseman.

This report and its dissemination would not have been possible without **substantial financial support received from the Bill and Melinda Gates Foundation**.

Acronyms

AAAQ	Availability, Accessibility, Acceptability and Quality
ASEAN	Association of Southeast Asian Nations
BLA	Bilateral Labour Agreement
CEDAW	Convention on the Elimination of Discrimination Against Women
CHW	Community Health Worker
CSDH	Conceptual Framework for the Social Determinants of Health
DRUM	Desis Rising Up and Moving
EU	European Union
GCC	Gulf Cooperation Council
GER	Gender, Equity and Human Rights team at WHO
GDP	Gross Domestic Product
GFMD	Global Forum for Migration and Development
GMG	Global Migration Group
GPGs	Global Public Goods
GPI	Genuine Progress Indicator
HEAT	Health Equity Assessment Toolkit Plus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDWF	International Domestic Workers Federation
IEN	Internationally Recruited Nurses
ILO	International Labour Organization
IOM	International Organization for Migration
ISCO	International Standard Classification of Occupations
ITUC	International Trade Union Confederation
MERCOSUR	Mercado Común del Sur
MIPEX	Migrant Integration Policy Index
MOU	Memorandum of Understanding
MWCW	Migrant Women Care Workers
NHPSPs	National Health Policies, Strategies and Plans
OAS	Organization of American States
OECD	Organisation for Economic Co-operation and Development
PICUM	Platform for International Cooperation on Undocumented Migrants
SDG	Sustainable Development Goals
SDH	Social Determinants of Health
UHC	Universal Health Coverage
UN DESA	United Nations Department of Economic and Social Affairs
UNGA	United Nations General Assembly
UNHCR	United Nations High Commission for Refugees
UPR	Universal Periodic Review
WHA	World Health Assembly
WHO	World Health Organization

Executive summary

Ageing in late industrial and middle-income economies, combined with rising demographic dependency ratios and female labour force participation, has led to emerging care deficits in many developed and developing countries. Around the world, more women are entering the labour force, thus taking them away from traditional unpaid caring roles.

This report focuses largely on one population group: **women migrant care workers** who provide home-based personal care. However, many of the issues, and the next steps suggested here, also apply to other migrants and refugees – particularly women and girls – as well as to other socially excluded and marginalized groups engaged in paid and unpaid care work across the world. Without a doubt, women migrant care workers play an increasingly prominent role in securing and protecting the health status of others and are contributing both to health in the broadest sense and to health systems. Yet relatively little is known about their own health status, the health implications to their families of their out-migration, and the extent of their important contributions to health systems. Around the world, care workers are overwhelmingly female, and many are migrants. This report documents how, despite making a large contribution to global public health, they are exposed to many health risks themselves, while enjoying few labour market and health protections. The report also underscores that paid and unpaid care work is central to the broad health and well-being of individuals, their families and communities, as well as society at large.

The care paradox: global public health and the role of migrant women care workers

Increasingly, immigrant women are being imported into receiving country economies to care, often in informal settings, and are frequently engaged by private households, without full access to social protection and labour rights. Yet this group of migrants provides essential care services and, increasingly, health-care services, thus contributing to health systems and to health and well-being worldwide.

As the leading normative agency on health, the World Health Organization (WHO) calls attention to the paradox that migrant women care workers buttress health systems in countries with shortfalls in health-care provision, while their own rights to health may be eroded and their health-care needs are unfulfilled. Migrant women care workers act as a cushion for states that lack adequate public provision for long-term care, child care and care for the sick.

Unmet needs and growing demand for care

Home-based personal care – whether for older persons, children, or those with chronic diseases or disabilities – constitutes an important component of modern health systems. This applies to both high-income countries, where formal health-care institutions and services are struggling to meet the growing demand for such care, as well as to middle- and lower-income countries and regions where home-based care relieves the demand for, and expense of, institutional care. In all societies there is a cultural preference for care “in the family” or for “ageing in place”.

One area in which the care deficit in receiving countries is particularly pronounced is long-term care for older persons. Critical shortages of long-term care workers make quality services unavailable for large parts of the global population aged 65 years and over. The extent of the unmet need varies worldwide, but in Europe alone the shortage is estimated at around 2.3 million formal long-term care workers.

The policy architecture related to care work, migration and women

The unique status of migrant women care workers as both providers and consumers of health and social care requires that both sending and receiving countries reflect on this paradox and work urgently, and much more collaboratively, to overcome challenges, contradictions, gaps and inconsistencies in international, regional, national and subnational policies, laws and programmes across all relevant sectors. This report proposes the integration of policy actions – and of gender, equity and human rights approaches – to mediate concerns about care deficits and decent and safe work in the care sector as a crucial component of maintaining global and national public health.

Why this report?

WHO initiated this report in response to growing global political interest in population health and development, particularly noting discussions at the 42nd G7 meeting in Japan in May 2016 which called for more attention to migrants and their role in paid and unpaid care work. It is hoped that this report, and its reflection on potential next steps, will foster further debate about approaches to ensure that the global community meets its obligations to leave no one behind in securing long-term equitable and sustainable development. The analysis is also shaped by commitments to the principles of human rights, the Tanahashi Framework on health

service coverage and evaluation, the United Nations Migration Governance Framework,ⁱ the Framework of priorities and guiding principles for a World Health Assembly Resolution on the health of migrants and refugees, the concept of progressive universalism towards achieving universal health coverage (UHC), and the 2030 Agenda for Sustainable Developmentⁱⁱ with its overarching goal of leaving no one behind.

Migration, health and gender

Chapter 1 introduces the intersecting themes of gender, migration and health care, focusing on why a report is needed that pays special attention to the contributions and health-care needs of migrant women care workers engaged in personal care in private homes. It provides an overview of the report and outlines the methodology, literature review and data sources used for the analysis. This chapter emphasizes that much of home-based care work that should be considered part of a health system takes place in the shadows, beyond the reach and remit of the statutory agencies. The literature and examples referred to in this report indicate that a substantial and growing proportion of this work is being undertaken by migrant care workers, most of them women. We focus primarily on migrant women care workers, although the data and literature indicate that migrant men are also finding work in the care sector and as home-based personal care workers.

The chapter introduces the concept of the social determinants of health and explains why this framework is particularly important as one examines the health outcomes of migrant women care workers. There is an appeal to the SDG framework and human rights architecture to include the commitments to universal health care, the recognition of care work and decent work for migrants, and to argue for complementary and intersectional approaches that recognize the health-care contributions and needs of migrant health-care workers and their families in both home and host countries.

The role and health status of migrant women care workers in receiving countries

Chapter 2 highlights how the unmet need and rising demand for caring labour has contributed to growing involvement of migrant women care workers in home health-care provision. Data are sometimes patchy but it is clear that, as populations age and more native-born women enter and remain in the labour market, there is a growing need for care for young children, older people and those who are sick in public and private institutions and in the home.

The chapter explores the health implications of care work for migrants and emphasizes how migrant women care workers can face health challenges as a result of their work and migration status. It shows that they may also be excluded from, and underserved by, the very health systems to which they contribute. Exclusion can stem from a variety of causes, including race or ethnicity, language, higher levels of informal and irregular work and the fact that, where migrants are undocumented, their health-seeking may be limited. Migrant women's exclusion may also reflect a lack of knowledge about their rights and about access to health services and social protection. The chapter describes how, when migrant women leave to care for others in host countries, their departure can exacerbate existing care deficits in their home countries. Moreover, their migration often gives rise to the formation of global care chains that have implications for the health and well-being of those who are left behind and those who must substitute for care in the home country.

Health and care implications for the families left behind in the sending countries

Chapter 3 takes a closer look at the situation faced by the families left behind by the migrant women care workers. It considers the challenges faced by children, older persons and men in the families in the sending countries. It explores global care chains, where care deficits are resolved in one country at the expense of rising care deficits in another. This chapter argues that, when persons are unable to return regularly or freely to their home countries, they are forced to construct transnational families and engage in transnational parenting using whatever means are available to them. The impact of absent parents and breadwinners on restructured households is also explored, looking at the health and psychosocial outcomes for children, men and older people.

Policy coherence and multisectoral collaboration

Chapter 4 explores access to health care and examines how labour and human rights are addressed in the policies of the countries most affected – both sending and receiving. It notes how the social determinants of health for migrant women care workers are, or are not, being addressed. The nature of existing policies as they affect migrant care workers is explored, noting siloed and frequently contradictory migration, labour and social protection policies. This leads to consideration of how international, regional and national policies will need to change to ensure that the needs and rights of migrant women, in all their diversity, are broadly promoted. The chapter also explores the mobilization of migrant workers, including women working as personal carers, and their ability to make claims on service providers and existing commitments to protect the terms and conditions of care work. Finally, the chapter highlights the importance of existing rights and commitments to the Sustainable Development Goals (SDGs) as frameworks for addressing care needs and care work and improving outcomes for migrant women care workers and their families worldwide.

i Migration governance framework. Geneva: International Organization for Migration (https://www.iom.int/sites/default/files/about-iom/migof_brochure_a4_en.pdf, accessed 20 August 2017).

ii Sustainable Development Goals. New York (NY): United Nations Development Programme; 2016 (<http://www.undp.org/content/undp/en/home/sustainable-development-goals.html>, accessed 20 August 2017).

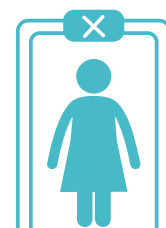
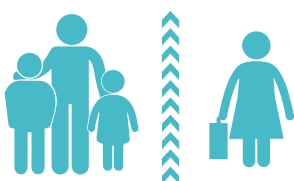
Three next steps for migrant women care workers and global public health

Chapter 5 outlines three key steps for all countries and regions to consider in order to address the needs, risks and vulnerabilities that migrant women care workers face in light of the preceding analysis. These next steps for improving the health and well-being of migrant care workers and their families are:

- 1 Generate evidence on the nature of migrant care work, the contributions to global health and the terms and conditions of employment.
- 2 Improve access to UHC through specific measures to address non-discrimination, and promote the inclusion and social participation of migrant women and other care workers.
- 3 Recognize, value and promote care as a public good that contributes to global health and well-being.

More collaboration is needed to measure, understand and overcome the intersecting complexities, challenges, contradictions, gaps and inconsistencies in international, regional, national and subnational policies, laws and programmes across all relevant sectors.

Governments are urged to recognize and support paid and unpaid care work, protect migrant women care workers against violations of their human rights and labour rights, and promote international, regional and country action to ensure access to health for all in an ethical and transparent governance model. Without such political leadership and vision, accompanied by robust evidence, strategies and tools for promoting intersectoral action, and the economic and social empowerment of migrant women themselves, change cannot be sustained.





Introduction

“Care workers provide care for people in private homes or in public and private institutions, such as hospitals and nursing homes. Care workers also provide less direct personal care services such as cooking, cleaning the house, washing the laundry and other housekeeping activities, which are necessary for the welfare and comfort of members of a household.”

Michelle Bachelet¹

Chapter 1: Key messages

- As old as human history, migration is not a new or overwhelmingly recent phenomenon.
- One in every seven persons in the world is a migrant – roughly 1 billion people.
- Women migrate as much as men; women account for 48.2% of all international migrants.
- New data are beginning to allow us to document and quantify who is moving. However, data on what they do is less available. OECD data show that migrants make up a rising proportion of home-based care workers in receiving countries. The overwhelming majority of these care workers are women.
- Demand for home-based care is increasing as households seek to complement, or compensate for, under-provision in formal care settings.
- WHO’s normative role and leadership in global public health require it to highlight the contributions of migrant women care workers as they buttress health systems.
- Care is a crucial component of the health and well-being of all people everywhere, and as such it is a public good. Those who are providing this care in any setting must not be left behind by the Sustainable Development Goals, including steps to achieve universal health coverage.
- Migrant women care workers and the families they leave behind are all rights-holders. Their right to health and other related rights, together with their health and well-being needs, must be met through equity-focused, gender-transformative and human rights-based policies, laws, regulatory frameworks and programmes.





Why this report?

Care is a crucial dimension of individual and social well-being, and provides an essential contribution to economic growth. The provision of care – formal and informal, paid and unpaid – is both integral to and crucial for the functioning of national health and social protection systems.

At present, “one in every seven persons in the world is a migrantⁱ – roughly 1 billion people”ⁱⁱ. Women account for almost half (48.2%) of all international migrants^{3,4}.ⁱⁱⁱ These include mothers, grandmothers and/or adults with caregiving responsibilities of their own (for older people, the sick and those with disabilities, and children). Migration has begun to find a place in global health discussions and health issues are increasingly being raised in high-level dialogues on development and migration. Governments are being challenged to integrate the health needs of migrants into national plans, policies and strategies, yet the field of migrant health is still a relatively under-researched area of global health⁵.

The report’s principal emphasis is that there is a pressing need to understand the unique situations and health outcomes of this population group. The low status of domestic and care work contributes to its invisibility, informality and under-regulation. Taking the connected themes of migration, gender and health, this chapter focuses on why a report is needed that pays particular attention to migrant women care workers, their own health and well-being, their contribution to the health of others through the provision of care, and what happens to the family members they leave behind.

i The United Nations definition of “migrant” refers to individuals currently residing in a country other than where they were born. The quotation is from “Gender and migration: care workers at the interface of migration and development”, a speech delivered by UN Women Executive Director Michelle Bachelet at the event titled “Gender and Migration: Care Workers at the Interface of Migration and Development”, during the Fourth United Nations Conference on the Least Developed Countries (LDC-IV), Istanbul, 11 May 2011 (See Ref. 40).

ii In this estimate, the International Organization for Migration includes those who are internally displaced people and refugees.

iii See: <https://esa.un.org/unmigration/>, accessed 20 August 2017.

At risk of being left behind: the case of migrant women care workers

Women across the world shoulder most of the effort in providing care to those who need it.⁶ Among these women, immigrant women are providing personal, often home-based care to children, disabled persons, those with chronic illnesses or those needing long-term or palliative care, as well as to growing ageing populations.

Ageing in late industrial and middle-income economies, combined with rising demographic dependency ratios and female labour force participation, has led to emerging care deficits in many contexts in both developed and developing countries^{7,8}. As more women enter the labour force, they are less able and have less time to fulfil traditional unpaid caring roles, in their own households. Increasingly, immigrant women are being imported into host economies to care, often in informal settings, and are frequently engaged by private households without full access to social protection and labour rights^{9,10}. Yet, as paid workers, this group of migrant women provides essential care services, thus contributing to health systems worldwide.

Women migrant care workers provide much-needed services but are often neglected, or their needs are left unfulfilled, by state agencies. Despite these women’s significant contribution to community public health and well-being, they often lack full legal authorization to live and work where this growing health-system deficit takes them – mainly North America, Europe and the countries of the Gulf region.

What determines their health?

A recent International Organization for Migration (IOM) report¹¹ emphasized that investing in the health needs of migrants and mobile populations (including those women who migrate and work as carers) throughout the migration cycleⁱ protects global public health, facilitates social integration and contributes to economic prosperity. Yet despite this, very little attention has been given to the health needs and related rights of this population group. Migrant women care workers face multiple barriers to accessing health care for themselves. Their living and working conditions, and the sociocultural norms and values of their communities are social determinants of their mental and physical health.

Migrant women care workers present a set of unique health-related scenarios: often isolated in private homes, with restricted movement, they live largely without access to legal, labour or social protections. Their low status exacerbates this invisibility, informality and under-regulation. Their foreign-ness leaves them vulnerable to discrimination, with detrimental effects on their health. We are witnessing unprecedented levels of xenophobia, racism and sexism against migrants. Instead of being recognized as an economic and cultural asset, migrant women, including those working in the care sector, can face discrimination, exclusion and abuse, which contribute to widespread suffering and poor health.

How much do we know?

There are no large nationally representative data sets that shed light on migrant women care workers. Such women are effectively invisible to policy-makers and uncounted as a discrete category. Their invisibility is compounded by the fact that migrants are increasingly at the centre of a charged and negative discourse. Some governments and media outlets are questioning globalization and blaming migrants for disease and unemployment. In this context, migrants are even less likely to seek and claim their rights, including their access to basic health and social services.

Care work: a gendered realm

A central paradox in global health is that “women are conspicuous in the delivery of care and thus the delivery of health, but are invisible to the institutions and policies that design and implement global health strategies”¹². Women workers are too often undervalued, underpaid, and concentrated in precarious informal work sectors, and their own health-care needs are being neglected.

It is clear that care work is feminized and is increasingly done by

migrant women^{13,14}. Recently, in the first comprehensive survey of care workers in home-based and residential care provision in Germany, care work emerged as a female-dominated activity (more than 90% of care workers), independent of sector and migration background¹⁵. Gender analyses of migrant care work have tended to focus on women to the exclusion of men^{16,17,18,19}. However, men are increasingly being employed in this sector²⁰, although they cannot avoid being affected by its overall feminization. In an analysis of personal care work in Norway and the United Kingdom of Great Britain and Northern Ireland²¹, it was reported that, although the majority of workers taking part in the transnational care market (including countries outside their home country) are women, “increasingly care work also attracts migrant men”. But for these men, care work “is still a less traditional role” and the choice to enter this sector “may be one that is not consciously planned”. Stepping outside the boundaries of acceptable male employment can impose significant emotional and psychological costs on male care workers. A study of male Filipino domestic workers in the Netherlands, for instance, found that their sense of self-worth was threatened due to their performing “feminine” roles. They in turn behaved in ways thought to reaffirm their “masculinity”, which hindered their ability to access employment and actually reinforced discriminatory gender norms²².

Are migrant women care workers at risk of being left behind?

As the global community embarks on a collective journey to transform our world through the 17 Sustainable Development Goals (SDGs) articulated in the 2030 Sustainable Development Agenda, we must honour our collective pledge that no one will be left behind.

The 2016 G7 Summit, hosted by the Government of Japan, specifically highlighted the health-care needs of migrants and refugees,ⁱⁱ prompting this report. Discussion on this continues in high-level political circles, within WHO and other agencies of the United Nations system, and beyond.

Applying an intersectional approach to this diverse population group

Women’s needs and aspirations vary according to their economic and social status, migration status, location, community and many other factors²³. Many of their health outcomes will, in turn, depend on these factors.

i Consists of: pre-migration phase, movement phase, arrival and integration phase, return phase. See Reference 5 (Barragan et al.).

ii See: <http://www.mofa.go.jp/files/000158338.pdf>, accessed 20 August 2017.

Introduction

An intersectional approach builds on, and extends, gender analysis to expose differences within groups and health inequities^{24,25,26}. Intersectionality promotes an understanding of human beings as shaped by the interaction of different factors (e.g. gender, race/ethnicity, indigeneity, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within connected systems and structures of power (e.g. laws, policies, state governments and other political and economic unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression shaped by globalization, racism, homophobia, ableism and patriarchy are created. Women – in all their diversity – face layers of discrimination that overlap and compound each other, based on these intersecting drivers of inequalities.

Applying an intersectional approach to migrant women as care workers offers a nuanced understanding of how migration to care affects individual women and their households and how the identity of migrant women care workers can affect their own experience of the costs and benefits of migration. The outcomes for migrants will differ by many intersecting categories (including race/ethnicity, age, class and caste, urban/rural location), as well as by sex. These will interplay with the context into which they migrate and the extent to which they have social and economic rights as migrants. The impact on those left behind will also differ by these characteristics and by the context in which they live. Thus the scenarios in which migrant women work as carers will be numerous and complex.



Outline and methodology

This report seeks to make visible the complex relationship between migration and diverse forms of care work, migrant women's health and global public health, and to link these to concrete policy actions. It focuses on migrant women care workers. Where possible, the definition of home-based personal care workers (ISCO-o8 code: 5322) is applied. These are workers who provide routine personal care and assistance with activities of daily living to persons who need such care as a result of the effects of ageing, illness, injury or other physical or mental condition in private homes and other independent residential settings. Our specific interest is in migrant home-based personal care workers because their migration status frequently places them in greater need of recognition and support.

Chapter 1 provides an introduction to the intersecting themes of gender, migration and health care. This chapter emphasizes that much home-based care work should be considered part of the health-care system and examines the unique contribution of migrant women care workers to resolving health-care needs in host countries. It argues that, given the growing demographic and economic importance of migrants – half of whom are women – along with their influences on the social and economic sectors in sending and receiving societies, increased attention to migration and its relationship with health is crucial.

Chapter 2 highlights how the unmet need and rising demand for caring labour has contributed to the demand for migrant women care workers, and describes the terms and conditions of their employment as care providers in private households.

Chapter 3 considers the families left behind and looks at the need for global health care and social protection systems to respond to the needs of those left behind.

Chapter 4 explores access to health care and social protection for migrant women care workers. It uses insights gained from the literature reviewed and analysed to suggest directions for future global, regional and national public health policies, health systems and research.

On the basis of the issues explored and evidence presented, **Chapter 5** concludes with some directions for policies to address care needs, care work and health as three next steps for support by the international community, including WHO and its partners. It calls for commitments to universal health coverage (UHC) to include migrants as they move transnationally. It urges leaders to recognize explicitly the contribution that care workers make. It calls for changing policies to ensure complementary and intersectional

approaches that recognize the health-care contributions, needs and rights of migrant health-care workers and their families in their home and host countries.

The **methodology** began with a series of iterative consultative processes and a literature analysis looking broadly at gender, migration and health. As the enquiry evolved, a decision was taken to narrow the focus to produce a targeted report on migrant women care workers, their lived realities (positive and negative), the implications for those family members they have left behind, and the policy architecture across the different sectors that shapes many aspects of their migratory lives and the lives of the families that are left behind.

The initial extensive literature review fed into a series of expert meetings and consultations which drew on evidence from published qualitative and quantitative research, including systematic reviews of academic as well as grey literature. The process considered South-to-North and South-to-South migration flows and, in the case of China, internal migration flows between provinces and autonomous regions.

At the international level, the review looked at studies that analysed the policies of international organizations, such as the United Nations, International Labour Organization and others^{27,28}. At the community and institutional level, it considered the work of the many scholars who have analysed the implications of immigration laws and regulations (so-called immigration regimes) for migrants, children and their families, as well as the ways in which labour laws and regulations do (or, more commonly, do not) help protect migrant care workers yet shape their working conditions. At the local level, the review turned to researchers, often ethnographers, who have examined the everyday experiences of care workers and those they care for in homes and sickrooms.

Throughout the process, there was continual consultation, feedback and reviewⁱ involving experts working in subject areas such as gender, migration, labour markets, health systems and the care economy, including within WHO and other United Nations agencies, as well as academic researchers and policy actors.

The main methodological limitation of this report relates to the iterative nature of the literature search as the report's focus developed over time, starting from a broader theme on women migrants and their health, and becoming more focused on international migrant women involved in care work. The involvement

i See: Acknowledgements.

of multiple stakeholders (including WHO staff across the six WHO regions, and consultants, consultation participants and expert reviewers) led to different approaches being used to source literature instead of a systematic review approach.

Most of the literature used was in the English language, with a few Spanish sources. The scarcity of data specific to women migrant care workers presented a substantial challenge. This underscores the urgent need for better information systems that can disaggregate

data on different subpopulations such as migrants in different occupational groups, as well as the known drivers of inequity, including gender, age, location, income/poverty and ethnicity.

Women who move within national borders to take up care and other work are not included in this review. However, many issues will also relate to them, particularly if subnational laws, regulations and administrative procedures differ across the country.

How demographic trends are shaping transnational care

Home-based personal care – whether for older people, children, or those with chronic diseases or disabilities – is an important component of modern health systems. This applies to high-income countries, where formal health-care institutions and services are struggling to meet the growing demand for such care, as well as to middle- and lower-income countries and regions, where home-based care relieves the demand for, and expense of, institutional care (which may also be in short supply, inaccessible and/or inappropriate in certain cases). In all societies there appears to be a cultural preference for care “in the family” or for “ageing in place” which contributes to the demand for home-based care provision²⁹.

Population ageing is increasing the demand for care work and caregivers

For the first time in history, most people can now expect to live into their sixties and beyond³⁰. When combined with marked falls in fertility rates, these increases in life expectancy are leading to the rapid ageing of populations around the world. A child born in Brazil or Myanmar in 2015 can expect to live 20 years longer than one born just 50 years ago. In the Islamic Republic of Iran in 2015, only around 1 in 10 of the population is older than 60 years. In just 35 years’ time, this will have increased to around 1 in 3.

To ensure that adults live not only longer but healthier lives, the Global strategy and action plan on ageing and health was adopted in May 2016 by the World Health Assembly. The strategy has five strategic objectives and is a significant step forward in establishing a framework to achieve healthy ageing for all. It includes a call for countries to commit to action, and develop age-friendly environments. It also outlines the need to align health systems to the needs of older persons, and to develop sustainable and equitable systems of long-term care. It emphasizes the importance of improved data, measurement and research, and of involving older persons in all decisions that concern them.ⁱ

i For more information on WHO’s work on ageing and health, see: <http://www.who.int/ageing/en/>, accessed 20 August 2017.

These demographic changes, accompanied by social changes, are leading to increased demand for paid care work across the world to the extent that health experts have declared a global crisis in long-term and home-based care³¹.

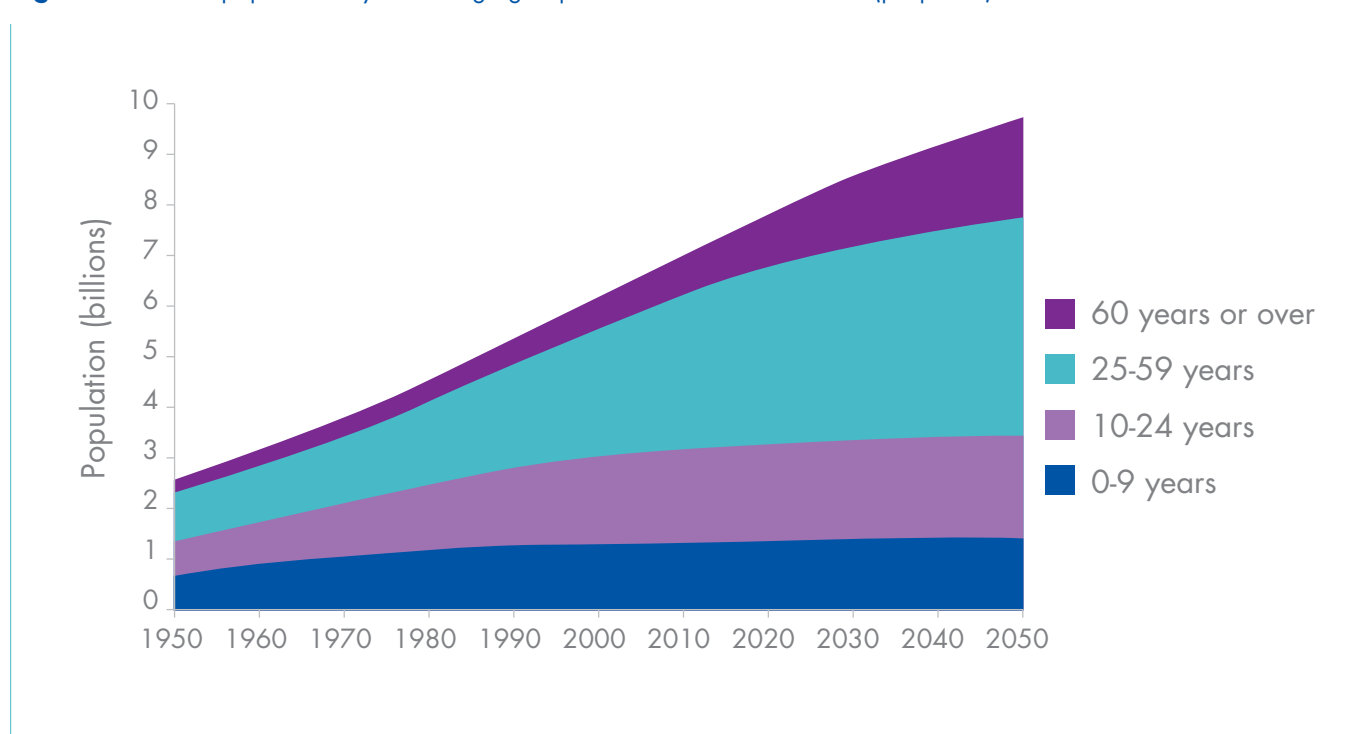
Figure 1 shows the scale of actual and projected change in different age groups of the global population over a period of 100 years from 1950.ⁱⁱ However, these global averages mask very large differences between countries. Old-age dependency ratios are closely related to a country’s prosperity (measured by the World Bank as per capita gross national income, or GNI), summarized in Table 1.

Models based on the relation between economic development and population structure offer useful insights into the drivers of care shortages, although they should not be applied too deterministically³². Broadly speaking, ageing societies need migrants both to boost economic activity in general (by spending from their wages and contributing to the tax base) and to carry out care work in particular. Migrants who work reduce the economic dependency ratio (i.e. the number of non-working “economic dependents” to workers). This enables tax models that apply taxes to earnings to finance health care and pensions more effectively.

The rising demand for migrant labour is seen as the result of demographic ageing together with a dearth of, or cutbacks in, public provisions for care in many host countries. In addition, more and more women – who in most societies are the traditional providers of unpaid care – are leaving their homes to enter the paid labour force. This creates a demand for substitute carers, and frequently for care in the household.ⁱⁱⁱ

ii For a graphic representation of the world’s ageing population, see: <http://www.who.int/ageing/events/world-report-2015-launch/populations-are-getting-older-full.gif?ua=1>, accessed 20 August 2017.

iii Substitute carers may be either other family members, both paid or unpaid, or paid care workers. Family carers may either receive specified wages or share generally in the remittances sent back to a household by migrant care workers abroad.

Figure 1. Global population by broad age group between 1950 and 2050 (projected)

Source: United Nations. World Population Prospects, 2015.

TABLE 1. Relation between income level and percentage of the population over 60 years of age

National income level	%
High-income countries	22
Upper-middle-income countries	13
Lower-middle-income countries	8
Low-income countries	5

Source: UN DESA 2015:26³³.

Long-term careⁱ provision to meet the needs of older people

Long-term care provision for older persons is of key relevance to this review of migrant women care workers³⁴. A survey of long-term care for the International Labour Organization covered 46 countries – 80% of the world’s population – and examined care for people over 65 years of age. “Globally in most countries, no form of public support for long-term care exists at all, and only very few countries have decided to provide social protection for older people in need of it”³⁵. Where long-term care exists, it is underfunded, frequently inaccessible because of workforce shortages and has an over-reliance on out-of-pocket payments (favouring the rich) as

well as informal care. Only 5.6% of the global population lives in countries that provide long-term care to the whole eligible population on the basis of national legislation. The survey also observed two predominant patterns in the employment of migrant long-term care workers: in Northern and Western Europe, migrant workers are typically employed by long-term care organizations funded from public sources and generally have a higher level of training, but this differs from the Mediterranean, Eastern and Continental Europe contexts where most migrant workers are employed and remunerated by the persons in need of care or by their families and often live in the household of the care recipient³⁶.

ⁱ Strictly speaking, “long-term care” also includes care for people with disabilities, but it is often used as a synonym for the care of older people.

Labour shortages and women’s empowerment draw more women into the workforce

The report of the United Nations Secretary-General’s High Level Panel on Women’s Economic Empowerment, 2017³⁷ sets out clearly why women’s economic empowerment will be so important for sustainable development. It lists seven drivers for this, as depicted in Figure 2. Legal protections, reforming of discriminatory laws and regulations, and recognition of informal and unpaid work, including care work, are included and very relevant to the topic of this report.

As development proceeds, a combination of slowing population growth and accelerating economic activity also creates labour shortages. This may further encourage women to exchange their unpaid household tasks for paid jobs, leaving a gap which must

often be filled by paid workers. Labour shortages act as a “pull” factor for migrants for whom some of the jobs available will be care work – to replace other women entering the workforce.ⁱⁱ

An increasing proportion of this home-based personal care work is being provided by migrants – most of them women and girls who are transnational migrants, internal (especially rural-urban) migrants, and intraregional migrants – in the high-income countries, including parts of Asia and the European Union (EU). Typically, these women leave behind care responsibilities which must now be reassigned to their households, families, communities and state (and/or private) health and social welfare systems. Overall, the global burden of looking after children is decreasing as the trend towards lower birthrates becomes more widespread, with notable exceptions (parts of Africa, and some countries where the old age population has not yet increased).

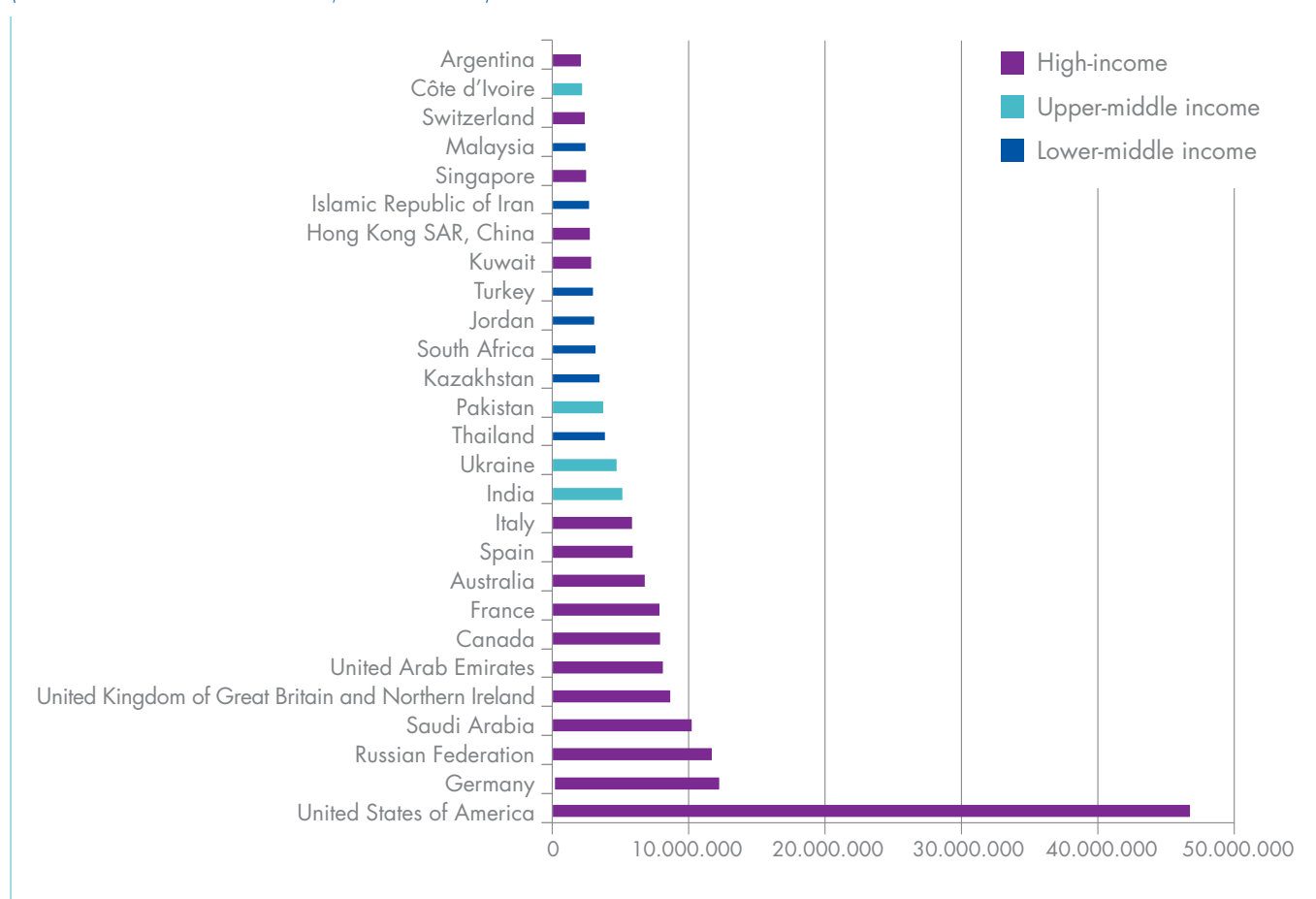
Figure 2. Seven drivers of women’s economic empowerment



Source: UN High Level Panel, 2017 <http://hlp-wee.unwomen.org/en> – Reference 23

ii As an illustration, the numbers of domestic workers employed in Latin America and the Caribbean almost doubled between 1995 and 2010. The International Labour Organization report links this to the rapidly rising labour-force participation of women.

Figure 3. Countries housing 75% of total migrant stock in 2015, classified according to World Bank categories in 2014 (based on data from UN DESA, Reference 33)



Transnational migration into care work: missing people

In 2000, 75% of the world's migrants lived in only 27 countries. In 2015, that number was still 27 despite the fact that more countries had moved into the high-income category. While immigrant populations come from an increasingly diverse array of origin countries, they have tended to concentrate in an increasingly small number of destination countries." Figure 3 shows how high-income countries dominate as destination countries³⁸.

The 11 countries housing the most migrants (from Italy to the United States of America) are home to 54% of the world total. The only upper-middle- or lower-middle-income countries in Figure 3 are major refugee destinations such as the Islamic Republic of Iran, Jordan, Pakistan and Turkey. Other countries have a strong tradition of labour migration from their neighbours (e.g. India and Ukraine where migrant stocks are declining, and Kazakhstan, Côte d'Ivoire and South Africa where they are increasing). Exceptionally rapid economic growth over the past 15 years has also attracted new migrants to Malaysia and Thailand.

Migration corridors define established and historical flows between countries and seem to be very slow to change. Migration is likely to continue to be funnelled into a small number of destination countries, resulting in even greater imbalances and tensions. There is an urgent need to create new migration corridors and policies that enable migrants to move freely and contribute their labour with full economic and social rights.

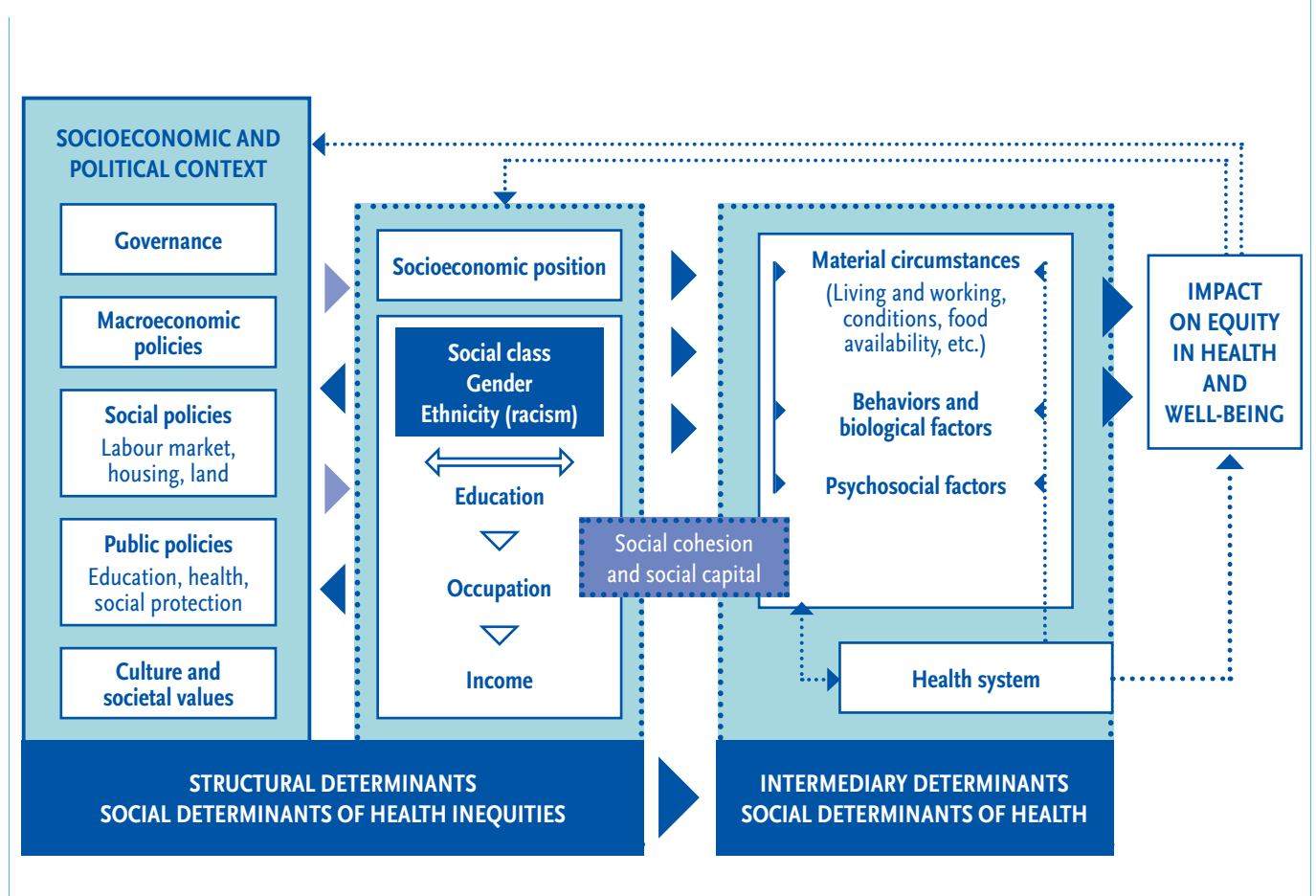
Although there are data on these migration trends and corridors – i.e. which countries are sending and receiving migrants, in what numbers, and the proportions of males and females – there are very few systematic data on what these migrants do in the countries that receive them. In that sense, the migrants are missing people. The authors of this report faced considerable challenges in sourcing precise and disaggregated data on the numbers and types of migrant women care workers worldwide and mapping their migration trajectories.

Migration status as a social determinant of health

The social determinants of health are the circumstances in which a person is born, grows, lives, works and ages, all profoundly influencing health and well-being³⁹. These circumstances are shaped by the distribution of power, money and resources at global, national and local levels, together with an individual’s socioeconomic position, social class, gender, ethnicity, education, occupation and income. Figure 4 shows WHO’s conceptual framework for the social determinants of health.

WHO has globally raised the importance of understanding the social determinants of health with the aim of identifying subpopulations that are being left behind and working towards better addressing their needs. In the case of migrant women care workers, migration status acts as a social determinant of health, interplaying with many other social determinants depicted in Figure 4, especially socioeconomic status, living and working conditions, and public policies that affect their lives and legal status.

Figure 4. Conceptual framework for the social determinants of health



Defining and recognizing care

One factor hampering the collection and presentation of precise data on migrant women care workers as a population group is the lack of consensus on a definition of care work. The following definition is from Michelle Bachelet who was Executive Director of UN Women from 2010 to 2013⁴⁰:

“Care workers provide care for people in private homes or in public and private institutions, such as hospitals and nursing homes. Care workers also provide less direct personal care services such as cooking, cleaning the house, washing the laundry and other housekeeping activities, which are necessary for the welfare and comfort of members of a household.”

Care workers can be employed either by a household or by an external organization. The former can be based on a formal or informal contract but is only weakly regulated, if at all. The latter may refer to work carried out in a domestic setting or in an institution and is more frequently covered by a formal contract and subject to at least a moderate degree of regulation. The boundaries between these two categories are not completely rigid. This category will be much easier to map and document, as it is more likely to fall into a standard occupational classification such as the International Standard Classification of Occupations (ISCO), 2008.ⁱ

ISCO code 5322

Code 5322 of the ISCO refers to workers who provide routine personal care and assistance with activities of daily living to persons who are in need of such care due to the effects of ageing, illness, injury, or other physical or mental condition in private homes and other independent residential settings. However, few national statistical agencies consistently apply these definitions or publish data on this category of worker. The data are frequently incorrect and underestimate the numbers of paid home-based care workers meeting health and social care needs because much of the care is informal and unregulated. Additionally, many of those who work in private homes provide much more than assistance with health care needs since caring tasks span a range from domestic work to more recognizable health care. Home-based care workers who administer medicines, provide a range of medical treatments, and may even engage in physical and emotional therapy, frequently also cook, clean and do laundry and other housekeeping chores.

Identifying who is a home-based care worker among other types of care providers and domestic workers is extremely difficult. The data do not capture these roles well. Moreover, those defined as domestic workers also frequently undertake types of work that contribute to care and health maintenance. Although roles and definitions of domestic work vary and not all domestic work involves care, “the majority of domestic workers are care workers and/or spend the bulk of their time doing care work”⁴¹. Therefore, although the full range of domestic work is often not regarded as “health work”, much of it should be included in the range of activities deemed necessary for caregiving^{42,43}.

The inclusion of all these tasks in definitions of care work highlights how many domestic workers provide care and support the well-being of individuals and families⁴⁴. Expanding the understanding of care work in this way can ensure that no one is left behind. It helps bring research and action related to the health sector closer to the broader concept of care work, and responds to the integrated vision of well-being and development expressed in the SDGs.

This report focuses on paid home-based care workers who attend to the varied needs of children, older persons, those with disabilities and the sick. In terms of health improvement through personal care work, and in the context of leaving no one behind, one approach would be to treat transnational care work and associated care workers as a global social or public good on the basis that the benefits of care cross borders and are global in scope^{45,46}.

In the context of this report’s focus, and taking transnational care chains and the care migrant women contribute to public health systems as a health-related public good, the two areas of policy and regulatory regimes, as well as the nature of health systems, become relevant. It requires the collective and coordinated action by governments at international, regional, national and local levels to more closely relate care work to the promotion, maintenance and protection of health and well-being. Moreover, framing care work as a social or global public good could help counter negative narratives about migrants and migration that are increasingly taking hold in media and in public and political discourse.

It must be recognized that the provision of home-based care is now part of a global health system that is characterized by asymmetrical provisions and arrangements in different regions of the world, and even within individual countries^{47,48,49,50}.

ⁱ See: <http://www.ilo.org/public/english/bureau/stat/isco/isco08/index.htm>, accessed 20 August 2017.

Leaving no one behind: the SDGs and universal health coverage

This report draws on the Sustainable Development Agenda 2030 framework with its goals (SDGs) and targets to call for equity-focused, gender-transformativeⁱ and human-rights-based approaches for enhancing the health and well-being of this population group. As depicted in Table 2, the SDGs that are most relevant to this analysis are Goals 3, 5 and 8, with some relevant targets. SDG 10 – reducing inequalities – is also relevant.

A commitment to the SDGs underpins the New York Declaration for Refugees and Migrants, adopted by the United Nations General Assembly (2016: A/RES/71/1ⁱⁱ). This sets out a process for developing policy negotiations for a Global Compact for Safe, Orderly and Regular Migration, to be achieved by 2018, that will strengthen migration governance and respond to the human and economic rights of migrants. The New York Declaration also calls for Member States to recognize the positive contributions of migrants to economic and social development in their host countries.

The Sustainable Development Agenda 2030 explicitly recognizes migration as a central issue in development and provides new openings for approaching and responding to the relationship between migration and health. In particular, SDG target 3.5 focuses on strengthening health systems as an important step towards achieving UHC. SDG target 8.5 applies with particular urgency to women migrants and those working in the care economy. It also applies to the collapse of access to decent work in the labour market in labour-sending countries which contributes to out-migration.

“Leaving no one behind” is a key aspiration of the Agenda. It urges the strengthening of health systems towards the goal of UHC so that all people can access the quality health services they need without experiencing financial hardship. UHC is at the centre of current efforts to strengthen health systems and improve the level and distribution of health services^{51,52}. An accompanying paper to this report provides more information⁵³.





Key issues related to migrant women care workers are that they should be able to access high-priority services without discrimination and without incurring prohibitive out-of-pocket payments. Their participation in planning and monitoring services, and promoting accountability, are also important. The recent IOM report highlights this, stating: “achieving UHC will require bringing these groups [groups exposed to very specific health risks, including irregular migrants and low-skilled workers, particularly women and youth in precarious employment settings, who are often invisible in health and social protection systems] out of the shadows to protect their right to health and ensure their access and inclusion to equitable health services”⁵⁴.

Applying a progressive universalism approach, so that disadvantaged subpopulations benefit at least as much as more advantaged subpopulations in reforms towards UHC, is central to this. Making health sector plans more equity-oriented, rights-based and gender-responsive contributes to progressive universalism and the progressive realization of the right to health.

i Gender-transformative means to address the causes of gender-based health inequalities by including ways to transform harmful gender norms, roles and relations. The objective of such programmes is often to promote gender equality and foster progressive changes in power relationships between men and women.” Source: WHO Gender Responsive Assessment Scale. In: Gender mainstreaming for health managers: a practical approach. Facilitator’s Guide, World Health Organization. Department of Gender, Women and Health; 2011 (http://apps.who.int/iris/bitstream/10665/44516/1/9789241501071_eng.pdf)

ii UN 2016. New York Declaration for Refugees and Migrants. Resolution adopted by the General Assembly on 19th September, 2016. United Nations General Assembly 71st session. Document A/RES/71/1 See: http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/71/1

TABLE 2. The SDGs and targets most relevant to migrant women care workers

Sustainable Development Goals		Target relevant to women migrant care workers
 <p>3 GOOD HEALTH AND WELL-BEING</p>	Ensure healthy lives and promote well-being for all at all ages	<p>3.8</p> <p>Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.</p>
 <p>5 GENDER EQUALITY</p>	Achieve gender equality and empower all women and girls	<p>5.4</p> <p>Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.</p>
 <p>8 DECENT WORK AND ECONOMIC GROWTH</p>	Promote sustained, inclusive and sustainable economic growth, employment and decent work for all	<p>8.5</p> <p>Achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value.</p> <p>8.8</p> <p>Protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment.</p>
 <p>10 REDUCED INEQUALITIES</p>	Reduce inequality within and among countries	<p>10.3</p> <p>Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard</p> <p>10.4</p> <p>Adopt fiscal, wage and social protection policies, and progressively achieve greater equality.</p> <p>10.7</p> <p>Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies.</p>

Rights of migrant women care workers

Underpinning the SDGs, an array of human rights instruments provides a framework for addressing migrant workers' rights, including their right to health. The international and regional human rights framework (see Box 1 and Box 3) provides extensive legal protection to the right to health for migrant women care workers through treaties and conventions. Soft-law (non-binding) instruments also exist which aim at widening the interpretation

of the former legal instruments, as summarized in Box 2. Both the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,ⁱ and the Convention on the Elimination of Discrimination Against Women (CEDAW) General Recommendation 26 on Women Migrant Workers,ⁱⁱ explicitly refer to the right to health care for migrant workers.



© WHO / Fredrik Naumann

i See: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CMW.aspx>, accessed 20 August 2017.

ii See: http://www2.ohchr.org/english/bodies/cedaw/docs/GR_26_on_women_migrant_workers_en.pdf, accessed 20 August 2017.

BOX 1. International human rights architecture relevant to migrant women care workers

International and regional human rights frameworks provide extensive legal protection to the right to health of migrant women care workers (and other migrants), through general and specific treaties and conventions, taken together with soft-law (non-binding) instruments aimed at widening the interpretation of the former legal instruments. However, we must consider:

1. States have the legal obligation to respect, protect and fulfil the human rights recognized in the treaties and conventions to which they have become Parties. Without ratification, there are no legally binding obligations upon States.
2. International and regional human rights treaties and conventions set forth principles and standards as well as a set of specific human rights that States Parties undertake to respect, protect and fulfil. For this purpose, States are under an obligation to adopt legislative and other measures that are necessary to give effect to the provisions contained in the human rights instruments that they have ratified. These provisions are, by nature of international law, often general and vague. Although States have ratified those legal instruments, the effective protection of the right to health for migrant women care workers depends on the domestic implementation through detailed national legislation and policies.

The International Convention on the Protection of Migrant Workers and Members of their Families (ICRMW)ⁱ provides a more detailed protection for the right to health of female migrant workers, establishing the obligation of States to ensure to all migrant workers and members of their families within their territory or subject to their jurisdiction the rights set out in the Convention for reasons of, inter alia, sex and nationality. **General Comment No. 1**,ⁱⁱ adopted in 2011 by the Committee on the Protection of the Rights of all Migrant Workers and Members of their Families, particularly takes into consideration the vulnerable situation of female care workers and calls upon States to incorporate a gender perspective in efforts to understand their specific problems and develop remedies to the gender-based discrimination that they face throughout the migration process.

i <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CMW.aspx>

ii http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CMW%2fC%2fGC%2fi&Lang=en

The Committee on the Protection of the Rights of all Migrant Workers and Members of their Families monitors the implementation of the ICRMW through the review of States' reports. Unfortunately, as of August 2017, the Convention has been ratified by only 51 countries, among which almost none are current receiving countries of migrant domestic workers. The other fundamental international human rights instruments – such as the **International Covenant on Civil and Political Rights**,ⁱⁱⁱ the **International Convention on All Forms of Racial Discrimination**^{iv} and the **Convention on the Rights of the Child**^v – set key obligations upon States that, read together, provide an adequate framework of protection for migrant women workers.

All of these establish the principle of non-discrimination between men and women and require States to enforce the rights regardless of the sex, and most of them provide minimum working conditions and the right to health. In particular:

- The International Convention on Economic, Social and Cultural Rights provides that Member States should ensure the “right of everyone to the enjoyment of the highest standard of physical and mental health” and the **General Comment No. 14**^{vi} on the right to health extends this protection to women who are legal or illegal immigrants.
- The **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**^{vii} establishes a duty upon States Parties to ensure the right to health and safety for women in the work context, with specific attention to the function of reproduction. The Committee on the Elimination of Discrimination against Women, in its **General Recommendation No. 24**^{viii} on women and health, highlights the vulnerability of migrant women to this extent. In its **General Recommendation No. 26**^{ix} on women migrant workers, the Committee specifically expands the protection of the CEDAW to this category.

iii <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx>

iv <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx>

v CRC: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>

vi http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en

vii <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>

viii http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCEDAW%2fGEC%2f4738&Lang=en

ix http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2f2009%2fWP.1%2fR&Lang=en

BOX 2. Soft-law instruments relevant to migrant care work

Soft-law instruments issued by some United Nations Special Procedures set a very advanced level of protection of the right to health for migrant women care workers. They call upon States to recognize the specific challenges that migrant women (both legal and illegal) care workers face in relation to the enjoyment of their right to health. Unfortunately, these documents are not legally binding. However, they do constitute authoritative guidelines and may encourage further discussion and inform international and domestic bodies.

The **International Labour Organization (ILO) framework on labour rights** provides additional protection. Each of the conventions and recommendations establishes, respectively, specific obligations and non-binding guidelines upon States Parties. When taken together, they can provide a satisfactory framework of protection for migrant women care workers, subject to careful monitoring by the Committee of Experts on the Application of Conventions and Regulations.

The two specific **ILO Conventions (No. 143ⁱ on Migrant Workers and No. 189ⁱⁱ on Domestic Workers)** provide further protection. Regrettably, in the Convention on Domestic Workers, there is no specific reference to the need to protect and ensure the right to health for female migrant care

workers. In the Convention on Migrant Workers, there is no mention of domestic workers and care workers. Moreover, as of August 2017, the two conventions are ratified by only 23 and 24 countries, respectively, thus significantly limiting their impact, and very few of these countries receive migrant care workers.

Other international instruments such as the **WHO Global Code of Practice on the International Recruitment of Health Personnel**,ⁱⁱⁱ provide guidelines on ethical recruitment practices that take into consideration both the impact of the care chain on health systems in sending countries – as well as the rights of health workers. (add the footnote iii for the link) Adopted in 2010 at the 63rd World Health Assembly (WHA Res 63.16), the Code calls on states to ensure migrant health personnel enjoy the same legal rights and responsibilities as domestically trained health workforce in terms of employment and conditions of work, as well as urging that policy be based on a sound and robust evidence base. A key global governance instrument in the area, the WHO Global Code is contributing to better understanding and management of health worker migration through improved data, information, and international cooperation.

i http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312288:NO

ii http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:2551460:NO

iii http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf

BOX 3. Regional/subregional rights architecture relevant to migrant women care workers

At the regional and subregional levels, the rights framework is patchy. In general, it does not provide a more in-depth protection than the international one:

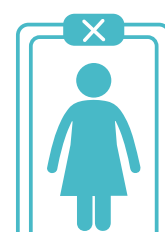
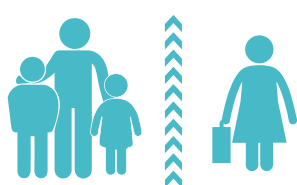
- The European Union and the Council of Europe have detailed guidelines and regulations protecting female domestic workers or migrant workers, but most are in terms of soft law.
- The Organization of the American States and the African Union both provide some general protection and have shown efforts to ensure the right to health for female care workers, but there is significant room for improvement.
- The Association of Southeast Asian Nations has demonstrated attention to the matter, through meetings and workshops, but has not issued any binding document so far.
- Other intergovernmental regional and subregional organizations, including the South Asia Association of Regional Cooperation, the Gulf Cooperation Council, the Economic Community of West African States and the Arab League have all shown interest in engaging with the issue. As yet, no specific documents protecting the right to health of migrant women care workers have been issued.

Forums such as the Global Forum on Migration and Development (GFMD) create voluntary, informal, and non-binding government-led processes that are open to all Member States and Observers of the United Nations “to advance understanding and cooperation on the mutually reinforcing relationship between migration and development and to foster practical and action-oriented outcomes.”ⁱ The GFMD provides opportunities for Member States to discuss common approaches to migration governance and for civil society to engage in key themes, and can provide an important platform to address the health-care needs and contributions of migrants.

The ongoing negotiations of the Global Compact for Safe, Orderly and Regular Migration also offers a new forum to discuss structural trends and facilitate the achievement of the SDGs, including those outlined in Table 2⁵⁵.

Limitations notwithstanding, there exists the potential for a comprehensive set of recommendations for addressing migrant women care workers and their particular needs and vulnerabilities as contributors to health-care systems. WHO has made efforts to set the stage for discussions and proposed actions to go beyond the boundaries of a traditional health agenda towards an integrated agenda for health, employment and inclusive economic growth⁵⁶.

i See: <https://gfmd.org/process>.





In the receiving countries

“Women migrant workers face significant vulnerabilities to health risks that stem from their gender, their immigration status, their employment and living conditions, and workplace contexts.”

Hennebry et al. (Reference 48)

Chapter 2: Key messages

- The demand for care in wealthier and middle-income countries has increased the number of female migrants working in the care sector.
- Destination countries gain from migrant care workers' contributions by resolving unmet needs for care and receiving skills that support health services and systems.
- Migrant care workers, most of whom are women, disproportionately shoulder the burden of care created by the global care crisis and, in so doing, they subsidize health and social welfare systems and economies.
- Many migrant women involved in personal care work have a precarious legal status which can contribute to their experience of harsh or unfair working conditions and may limit their own access to health services and health status.
- Discrimination, and the lack of language and culturally appropriate health-care services, can mean that health care is inaccessible to many migrants. To ensure progress to UHC, and to ensure that this group is not left behind, barriers to access need to be fully understood and addressed.
- Migration and migration status are key determinants of health and health-seeking behaviour for migrant women.
- Gender and migration intersect with other drivers of inequality such as occupational status, income, age, education, location and ethnicity.





This chapter describes the push and pull factors that have led to a rise in migrant women care workers globally. It considers the health implications of care work for migrants and highlights their vulnerabilities as a potentially excluded or underserved group. The nature of work in home-based care, the terms and conditions of employment, and the health impacts for carers are illustrated. The chapter demonstrates that there are significant benefits for labour-importing countries where migrant care workers undertake personal care and compensate for care deficits. However, there is a negative side to this, particularly for migrant care workers themselves, in terms of their lack of legal and other rights and access to health care, separation from their families and the physical and emotional toll that care-giving implies.

Effects on the care economy and health systems

In destination countries, immigration replenishes the supply of labour and skills, promotes entrepreneurship and innovation, eases strain on pension systems, and boosts care for older persons, children and others needing care services⁵⁷. Migrants come because there is a demand for their labour.

Care work has become an expanding sector for migrant workers worldwide^{58,59,60,61,62,63}. The ILO estimates that there are over 150 million migrant workers worldwide, of whom approximately 11.5 million are domestic workers in private homes; for most of them, care constitutes some or all of their duties⁶⁴.

Globally, according to the ILO, most migrant domestic workers (approximately 80%) are concentrated in high-income countries⁶⁵. While the definition of domestic workers can include home-based personal care workers as defined by ISCO code 5322, this is a broader category of care work and is not limited to those who provide health care at home. Nonetheless, many of these domestic workers do provide critical personal care that contributes to the maintenance of health care.

Paid domestic work forms a much higher proportion of all work among migrants than non-migrants (7.7% versus 1.7%). In 2013, more than one in six domestic workers globally was an international migrant. Moreover, as the report by Colombo for the Organisation for Economic Co-operation and Development (OECD) – “Help wanted” – emphasizes, over the previous 10 years, migrants accounted for 47% of the increase in the workforce in the United States of America and 70% in Europe. In Australia, foreign-born workers made up more than 25% of all care workers; in Austria and Israel, this figure rises to 50% and in Italy to 72%⁶⁶.

More women are moving across borders for work

Women are increasingly moving, particularly from lower-income countries and regions to seek employment opportunities abroad, especially in the care sector, to improve both their own lives and those of their families⁶⁷. Of the 11.5 million international migrant domestic workers, 73.4% are women⁶⁸. Domestic work is also the most common form of employment for girls under 16 years⁶⁹. The largest shares of migrant women domestic workers are hosted by countries in South-East Asia and the Pacific (24%), Northern, Southern and Western Europe (22.1%), and the Arab States (19%). These figures should, however, be approached cautiously as a high number of women domestic workers in middle- and low-income countries may not be counted as workers in workforce surveys.

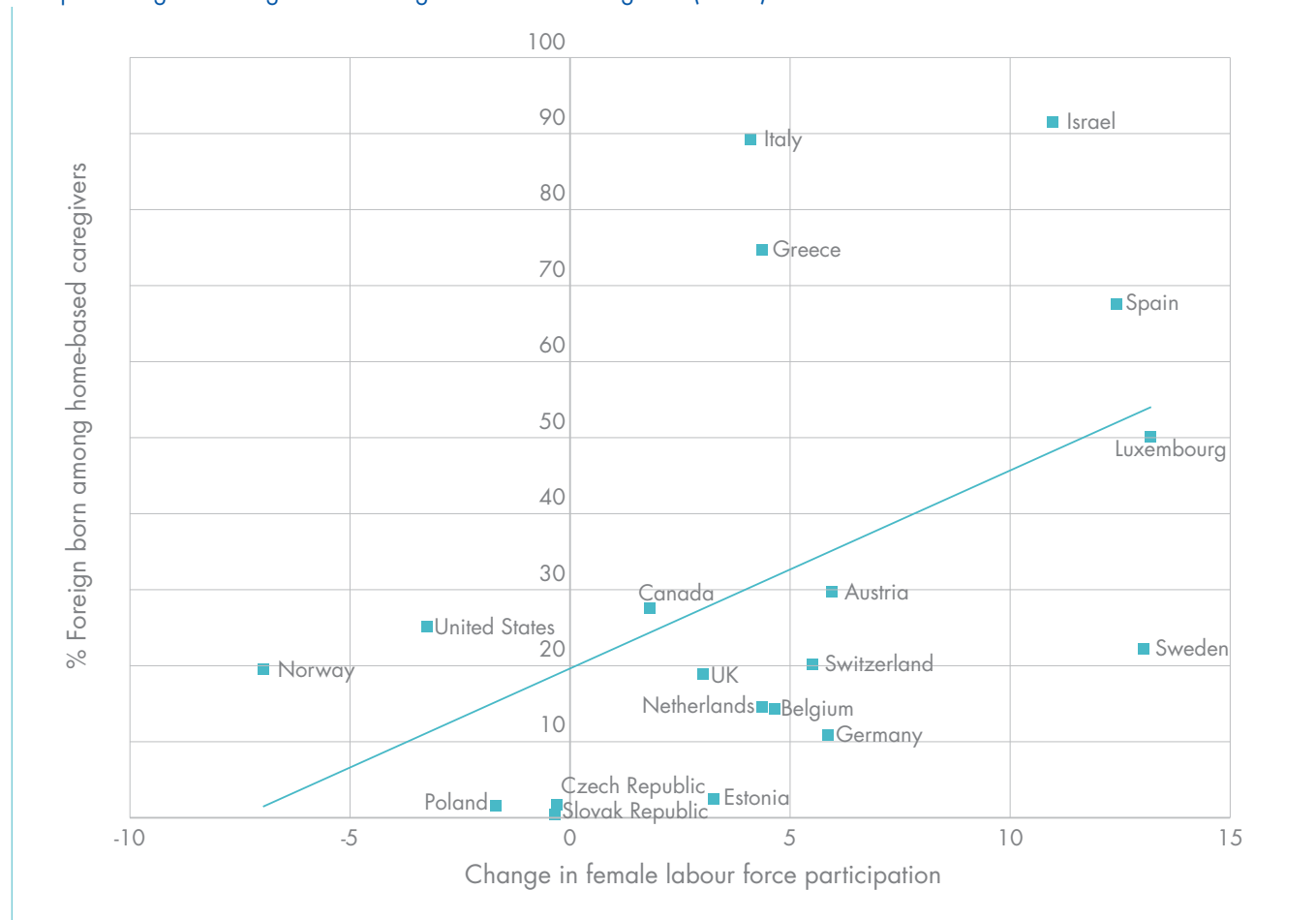
Figure 5 demonstrates that, as the labour force participation of women rises in OECD host countries, the demand for home-based caregivers also appears to rise.

Annex 1 provides more data on the push and pull factors underpinning the rise in migrant care workers in many host economies.

Women migrating into care work: push and pull factors

Women are increasingly migrating independently or as primary household earners to improve their own or their families' well-being, to earn income and send remittances home^{70,71,72}. To women in poorer countries and regions, particularly rural areas, the decision to seek work abroad, though seemingly daunting and perhaps dangerous, appears as a viable alternative to remaining in poverty, situations of violence, inequality and unemployment or underemployment⁷³. Both subtle and overt financial pressures from

Figure 5: Change in women's labour force participation (2000-2015) and percentage of foreign-born among home-based caregivers (2015)



Sources: OECD Migration Outlook 2015, Women in labour force participation rate, and World Bank World Development Indicators 2015.

families, communities and countries of origin also influence such decisions^{74,75,76,77}. In Indonesia and the Philippines, for instance, migrant women workers are popularly portrayed as economic heroes, contributing to national economies and supplementing the budgets of impoverished households⁷⁸. The prospect of “leapfrogging” out of poverty in a few years motivates many women to take jobs as, for example, housemaids in the Gulf countries. Additionally, as the youth bulge matures, rising unemployment and underemployment in many developing countries provides an additional impetus to migrate, particularly for young women and men.

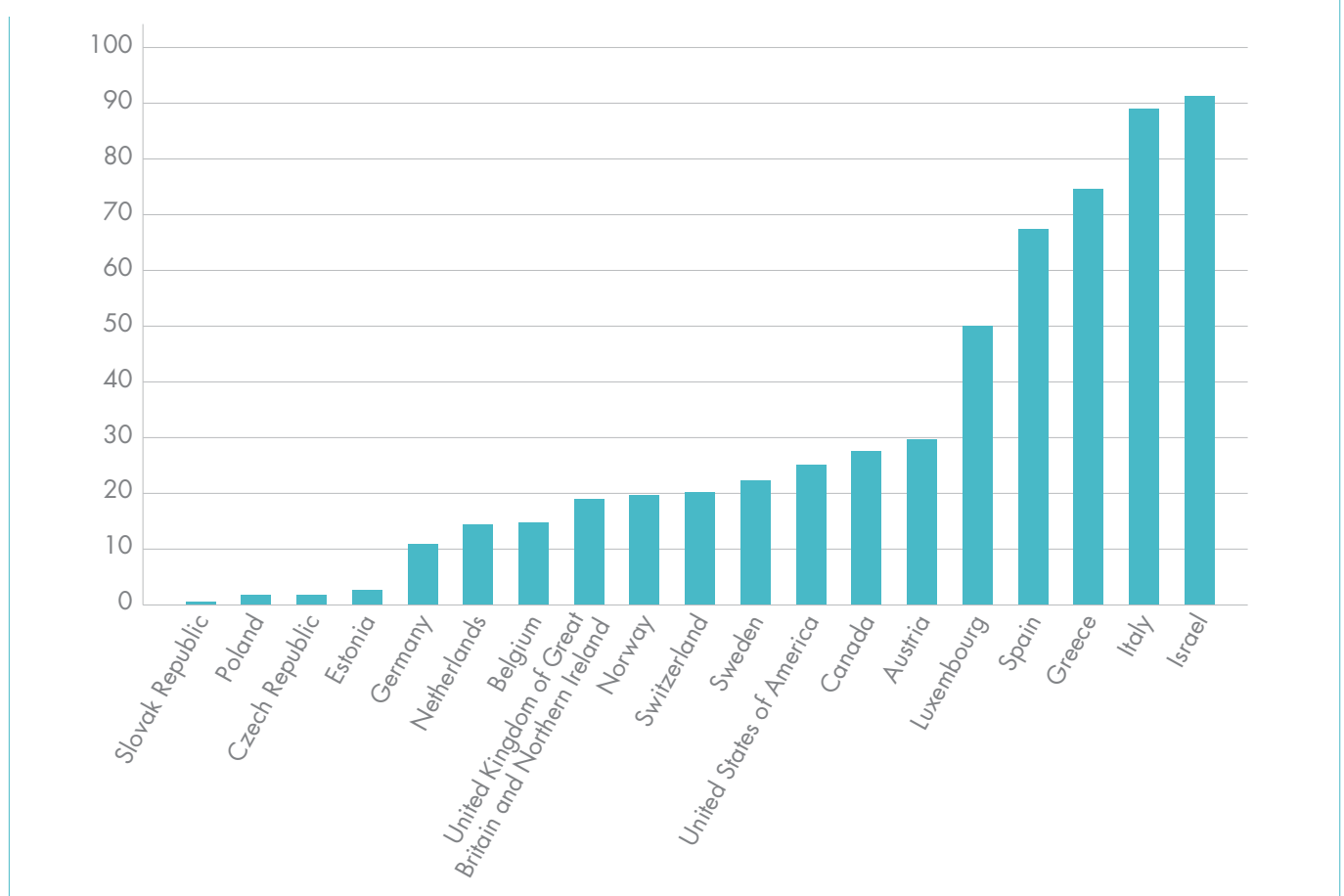
The pull factors for migration are equally varied. Growing demand for specific services, such as those related to both formal and informal care, create a strong impetus to move for women who cannot find economic opportunities at home^{79,80}. Women may migrate or follow other family members without the explicit intention of providing care but eventually take jobs in that sector. One area in which the care deficit (pull factor) in receiving countries is particularly pronounced is long-term care for older persons.

Long-term care provision, unmet need and the increasing role of migrant women

HelpAge International estimates that by 2050 almost 22% of the global population will be over 60 years of age⁸¹. How people age, and the needs they have as they age, will depend on their health status and access to services. The data⁸² for OECD countries show a wide variation in expenditures on long-term care as a proportion of gross domestic product (GDP). This variation – up to a factor of 10 – is much greater than is seen for health-care spending and reflects large differences between formal provision and informal care (usually provided by families) and the share of costs that people are expected to pay out of pocket. Understanding the impact of these differences is crucial to designing long-term care policies that give people the protection and support that they need⁸³.

Figure 5 estimates the percentage of home-based long-term caregivers who are foreign-born workers in a number of OECD countries and demonstrates that in many host countries the foreign-born make up a significant portion of home-based caregivers.

Figure 6: Percentage of foreign-born among home-based caregivers of long-term care



Source: OECD Migration Outlook, 2015:123.

This is particularly true for Greece, Israel, Italy, Luxembourg and Spain where foreign-born persons are 50% or more of the total long-term care workforce. Scheil-Adlung (2015) observes: “Critical shortages of long-term care workers make quality services unavailable for large parts of the global population aged 65 and over”⁸⁴. The extent of the unmet need for long-term care varies worldwide, but in Europe alone the shortage is estimated at around 2.3 million formal long-term care workers. The recent OECD report on long-term care underscores this with: “very low numbers of formal care workers does not necessarily mean that no one is paying for care. In some countries, it is common for undeclared workers (often immigrants) to be hired as carers, and these people would not show up in the statistics” (p.10).⁸⁵ Given the widespread preference for long-term care at home, the demand for care work in private households is rising rapidly, and with it the numbers of migrants working in this sector.

As a key factor that is leading to rising demand for migrant care workers, the ageing of populations in many countries is likely to be relevant for years to come and will even be exacerbated in some countries if current trends continue. Monitoring of demographic trends will be important as they are likely harbingers of the trends in migration.ⁱ

Host countries demand labour for, and benefit from, their care services. Migrant care workers – most of them women – meet these countries’ unmet needs for care and, as a result, contribute to the health and social care systems in those destination countries. However, despite the obvious need for care workers, immigration regulations in many countries fail to recognize care as work, or classify and dismiss it as “unskilled work”. These countries frequently lack provisions in visa categories and allocations for migrants willing to work in these occupations. Moreover, policies in these countries frequently fail to acknowledge that demand for foreign workers is being generated by deficiencies in their own systems of social provision, but instead blame migrants for trying to circumvent immigration rules and regulations. It is a process of “demand and denial”^{86,87}.

This section provides the rationale for Next Step 3 in Chapter 5 – i.e. to promote country action to recognize and support paid and unpaid care work. Without the recognition of the importance of care work and of the critical contributory role that migrants and migrant women play in sustaining health-care systems, and without deliberate efforts to redress unequal treatment through migration governance, the rights of migrant women care workers will go largely unrecognized.

i André Laliberté, personal communication.

Drawbacks for countries along transnational care chains

As the absolute number of persons migrating rises, this creates a “care drain” in poorer parts of the EU and in some developing countries, as well as in the rural areas of countries with large internal (rural-urban) migration (e.g. Brazil, China, Philippines)⁸⁸. The result is a “tilt” of care resources to cities and to the developed countries. Migrants, and the families they leave behind, seek to address the loss of those who provide care by creating “global care chains”, substituting for the care once provided by those who have left by placing children with aunts, grandmothers, other relatives (usually women), and paid caregivers. While these global care chains reveal the resilience of migrants and their families, they are also fragile and often break under the psychological and financial stress of extended separations^{89,90,91,92,93}.

There is an emerging “care deficit” in both home and host countries that requires global solutions that recognize and reward care. Many high-income and middle-income countries are experiencing what some have called a “care crisis”⁹⁴. This crisis is only likely to become more acute in a context where care deficits are emerging for long-term and acute care of the sick and elderly as populations age.

Although more care is needed in many parts of the world, the irony is that care continues to be undervalued and underprovided because it is seen as something that anyone can do and that requires few skills^{95,96,97,98}. Where home care is undertaken because there are no affordable alternatives and where insufficient mechanisms exist to finance and ensure the quality of that care, then cause for concern arises.

Benefits for individual migrant care workers

In addition to the benefits to the receiving country economy and its health system generally, migrants themselves experience benefits from migration. They are able to find work, earn an income and send remittances home to families (see Chapter 3). They can also learn new skills and take on new roles as breadwinners and active participatory agents in their own lives and the lives of others⁹⁹. The literature overall reflects the strength and resolve of migrant women care workers to leave their countries of origin, migrate to new locations, negotiate new structures and contexts, build new relationships and provide care for others. These processes are integral to their health and well-being.

Agency and autonomy

The literature shows how migrant women, including those working as carers, often exhibit agency, autonomy and resilience either through individual empowerment or by participating in formal organizations or informal networks developed through their work situations. They report a sense of increased autonomy through decision-making and freedom of movement related to when and where they migrate or re-migrate, or through increased economic autonomy and the ability to provide assistance at home through remittances and savings^{100,101,102}. They employ strategies to generate sources of strength and resist feelings of marginalization in countries of destination by, for instance, engaging in forward thinking towards an improved future for themselves, their children and families, and maintaining regular family contact by telephone or Internet^{103,104}. This assistance can also promote the resilience of families and relatives who remain in the countries of origin.

A recent IOM analysis concluded that:

“all things considered ... the balance sheet for women [migrants] can be positive, provided migration policies in both countries of origin and destination are formulated with due regard for the particular needs and experiences of migrant women and girls”¹⁰⁵.

This paper also noted that levels of discrimination in destination countries plays an important role in shaping female migration flows, as migrant women are often attracted to countries where gender-equitable norms and practices offer them greater freedom and rights.

Skills and empowerment

Migrant women who become health-care service providers and community health workers can gain a sense of empowerment through becoming professionals. In so doing, they improve their lives and those of others. Community health workers, for instance, acquire new knowledge of health issues which allows them to improve the well-being of their communities and enjoy increased recognition and respect¹⁰⁶. Some report developing international experience and competency in their field and feeling empowered through collective bargaining¹⁰⁷. It seems, however, that institution-based migrant care workers do not enjoy the same opportunities. Many enter this occupational sector without specialized training, and are seldom given opportunities to acquire the kinds of skills that would allow them to provide care with full confidence and knowledge. Instead, particularly when caring for older persons or when dealing with the sick and those with disabilities, they are compelled to administer

In the receiving countries

medicines and perform complicated treatments as best they can, drawing on their own instincts and experience.

The role of community networks

Some migrant women care workers, both individually and collectively, are actively claiming the rights and language of citizenship and civil society and rejecting victimization. They participate in unions, civic immigrant organizations and meetings^{108,109}. Such efforts focus on fighting against maltreatment, deportation and other care worker vulnerabilities, and for non-discrimination and human dignity, the public health needs of migrants, and improvements in working conditions, including compensation and benefits.

Domestic workers' unions and care worker associations seek to improve working conditions and raise awareness of the range of labour undertaken by migrants. In 2011, such coalition-building and advocacy led importantly to the formation of the first global

labour federation led by women, the International Domestic Workers Federation. Through its mobilized support, the ILO Domestic Workers Convention (No.189) was adopted and came into force in 2013^{110,111}. As of August 2017, 24 countries had ratified the Convention¹¹².

Migrant women's organizations, whether international, regional or more local, not only generate political power but also contribute to migrant women's ability to find social and moral support, friendships, education, employment advice/assistance, housing advice and leadership development by creating informal networks of support and care, such as cultural and ethnic-based groups^{113,114,115,116}. Workers in Austria, for example, use ethnic networks to establish social networks. They have also provided mutual moral support which can help them quit live-in work and find alternative jobs and housing. Such networks partially make up for the lack of professional support available¹¹⁷.

Drawbacks for migrant women working as carers

Most of the literature sourced and analysed reveals that lack of citizenship, undocumented immigration and tenuous legal status operate as substantial administrative barriers to accessing health services, including complete denial of access.

Unprotected means undervalued: legal status, visas and labour regulations

Few countries make provision under their immigration laws for migrants planning to take up care work,ⁱ with the result that many migrant women care workers must enter destination countries without visas or other proper documentation and work under constant fear of deportation. Many of their jobs are informal and lack the protection of labour laws, formal contracts and social protection which, in the formal sector, confer full labour rights and access to health care^{118,119,120,121}. Thus, migrant women can lack basic benefits such as social security or other old-age protection, as well as access to health care or health insurance. Recruitment agencies charge exorbitant fees for placements. All these conditions are exacerbated for migrant women care workers who are undocumented and thus feel insecure about reporting abuse and/or making claims for benefits^{122,123,124}.

Although the numbers of undocumented immigrants working in a given occupational category are difficult to determine, it has been estimated that, in the United States of America within the direct care workforce, which includes home health-care workers, approximately one in five immigrants (21%) are undocumented¹²⁵.

There is a pressing need to ensure that they gain legal status, the lack of which puts undocumented immigrants working in the care industry at risk for maltreatment by abusive or unscrupulous employers. In addition, the care industry itself – currently facing a growing labour shortage – is unable to benefit fully from the work of immigrant workers who may want to provide in-home care but who are unable to find a legal path to enter the country or obtain employment once they have arrived there¹²⁶.

In addition to immigration laws, labour laws and policies also present considerable challenges for this population group. Domestic and care work is subject to far less regulation and protection than other occupations, often because it takes place in the private sphere of the household¹²⁷; 40% of countries do not offer protection for domestic workers within national labour laws¹²⁸. Moreover, in many settings, including urban China and urban Peru, a substantial amount of care in the home is undertaken by untrained paid care workers, many of whom have little formal education and receive relatively low wages¹²⁹. Health-care workers are often contracted through private agencies or hired informally to work in private households. Some may be migrant health-care professionals who have been unable to find work in formal health-care settings, perhaps because of non-recognition of their credentials and training, and face significant job downgrading and de-skilling as a result¹³⁰. In her review of long-term care deficits and employment conditions, Scheil-Adlung (2015) estimates that, worldwide, fewer than 15% of home-based long-term care workers are formally employed¹³¹. Another analysis shows that those who are hired informally often lack the statutory labour rights accorded to them through a contract

i With the notable exceptions of Australia, Canada, Israel and Singapore.

– including pensions and benefits – and may receive wages that are significantly lower than those paid for equivalent work in the formal health-care system¹³².

Migration, labour and social protection policies are gradually evolving to meet the rights and needs of home-based carers – particularly migrant care workers – and those they care for. Some mechanisms are already in place. A cluster of international conventions concerning migration, children and families, women’s rights, and domestic work have been developed by the United Nations, UNICEF, WHO and ILO, including the ILO’s Convention 189 on Decent Work for Domestic Workers (2011) and the United Nation’s Millennium Development Goals and subsequent SDGs. These instruments provide the architecture for states to protect migrant women workers and their families to claim rights¹³³. See Chapter 1 for more on rights mechanisms.

Domestic and care worker organizations, as well as religious groups and other civil society advocacy bodies, both international (such

as the International Domestic Workers Federation) and national (such as the National Domestic Workers Alliance in the United States of America), are using these instruments to bring pressure to bear on national and local governments to reform labour laws and regulations and to provide protections for home-based workers, including health-care workers^{134,135,136}. Some model programmes exist in Canada, Chile and in the United States of America¹³⁷. Certain sending countries (most notably Bangladesh, Nepal and Philippines, see Box 4) have entered into bilateral agreements with receiving countries to protect migrant workers and ensure that their rights are recognized. There are nascent efforts to create a policy architecture for portable social security, health care, and old-age provisions and articulating and claiming children’s rights^{138,139,140}.

This uneven legal and regulatory landscape highlights the need to strengthen the protection of the legal immigration status and labour protections of women migrant care workers and to recognize their right to health care (see Next Steps 2 and 3 in Chapter 5).

BOX 4. Bilateral agreements: the case of Bangladesh and Jordan

In 2012, the governments of Bangladesh and Jordan signed a memorandum of understanding (bilateral agreement), in effect enabling Bangladeshi women aged 25–46 years to be legally recruited as domestic workers for households in Jordan. The governments agreed that the Jordanian employers should pay the full cost of recruiting women from Bangladesh, including paying their visa fees and airfare. The agreement also stipulated that the employers should provide employees with private sleeping quarters and food, purchase a life insurance policy for the employee that covers the entire period of employment, and

should open a bank account into which the domestic worker’s salary should be deposited each month.

These types of bilateral agreements overlay existing labour and migration legislation and compensate for the fact that certain sectors, most notably domestic work, are frequently not covered by national labour law. They also provide a framework for redress, both by individual workers and also by states. However, these agreements must be underpinned by consular resources and investment in outreach to foreign workers, along with effective monitoring and dispute resolution mechanisms.

Source: Gammage S, Stevanovic N. Gender, migration and work and care deficits. Background Paper, Expert Group Meeting, UN Women, 2016. Jones K. For a fee: the business of recruiting Bangladeshi women for domestic work in Jordan and Lebanon. ILO Fair Recruitment Initiative, 2015.

Left behind due to poverty, exploitation, discrimination and social exclusion

Much has been written about the poor conditions that care workers, especially migrants, regularly face – including low wages, long working hours with little rest, and inadequate housing and food for those who “live in”^{141,142,143,144,145,146}. Migrant care workers generally encounter harsher working conditions than non-migrants, and face more discrimination and social exclusion, all of which can exacerbate their own health-care deficits.

Women care providers generally earn lower pay compared to those in other occupations deemed low-skilled^{147,148} in part because their work is considered unskilled, and as something they can do instinctively, without special training, and out of kindness or affection rather than for remuneration. Many studies report that care work often entails lack of respect and status, and even verbal, physical and sexual abuse^{149,150,151,152}. In the most extreme instances, when recruiters or employers confiscate workers’ passports¹⁵³ and deduct travel costs and other expenses from their wages (or fail to pay them altogether), carework jobs become a modern form of indenture^{154,155,156}.

Many migrants face the challenge that host countries fail to recognize their training and credentials^{157,158} with the result that they work in home-based care that entails a downgrading of their professional status (e.g. Zimbabwean care workers in the United Kingdom of Great Britain and Northern Ireland)¹⁵⁹.

The exploitative working conditions that migrants commonly experience are linked to a lack of adequate social or labour protections or a failure to implement them. Adding to migrants’ anxiety and mental strain are negative attitudes and gender discrimination related to being women alone^{160,161}, as well as language barriers, downward occupational mobility, requirements to perform specific tasks without adequate training or capacity, lack of access to privacy or paid sick leave/days off/vacations, unlimited hours, limitations on physical mobility, food deprivation, and receiving low wages while coping with the ongoing pressure to send remittances home. One Chinese domestic worker in the United States of America described her financial stress as follows:

“Is not money a kind of stress too? Working overtime for many hours without overtime paid?”¹⁶²

Migrant women care workers also reported psychological and emotional abuse, including bullying, threats of deportation, confiscation of passports and prevention from seeking jobs elsewhere, forced isolation, lack of fair compensation, unlawful deductions, wrongful termination of employment, and sexual abuse^{163,164}.

The physical and mental health status of migrant women care workers

Migrant women care workers’ health is affected by a number of factors. Home-based care workers perform labour in private households where they may be vulnerable to the demands of their employers and are at high risk for economic, social, sexual and physical abuse^{165,166,167}. Recruitment agencies often fail to provide help or protection.

Home-based personal care work is labour-intensive, and can be emotionally as well as physically demanding. It is often carried out in substandard working conditions, without regulation and legal protection. Box 5 provides some insights from a focus group with migrant women care workers in Italy.

The literature documents specific negative physical health consequences of involvement in care work. The most commonly cited are fatigue, hunger (resulting from insufficient food or inability to prepare dishes of their own culture)¹⁶⁸, falls, and muscular-skeletal strains and injuries caused by heavy lifting of bodies and equipment, with some injuries remaining long after returning home¹⁶⁹. Bolivian care workers report that receiving inadequate training left both the women carers and the people they cared for more vulnerable to injury¹⁷⁰. This is consistent with a growing body of research focusing on the injuries to which domestic workers are prone – including contusions, lacerations, burns, amputations, eye injuries, blindness, head injuries, musculoskeletal strains/sprains, chronic hand/wrist pathology, backache and leg pains, and exposure to infectious diseases^{171,172}. Women migrants are often subject to persistent emotional stress, long hours and repetitive strain, all of which may lead to a variety of physical ailments, including reduced immunity and coronary disease, culminating in steadily deteriorating health¹⁷³.

BOX 5. The demanding nature of care work

Psychological illnesses are common among older persons. Migrant care workers often assume positions of responsibility for individuals who may have reduced mental or physical capacities. Yet the care workers themselves have little psychological support and limited opportunity to express their own experiences or talk about their problems. Many care workers are affected by the significant demands of this kind of work. Being on call for 24 hours taking care of those with reduced mental and physical faculties, with little opportunity for rest and leisure or to build their own support networks, can contribute to their own mental stress and mental health

challenges. Often, women being hired for these roles are not health-care professionals and do not have adequate training for such work. Additionally, many women care workers are not aware that caring for the sick and disabled brings with it challenges that can affect their own physical and psychological health. Migrant women may experience even more isolation and limited access to support networks, training and capacity-building. It is not surprising that migrants working under these conditions report high levels of stress and anxiety, depression and worry.

Source: Hennebry et al., 2016:79. Findings from an Italian Focus Group with migrant women care workers, November 2014. Reference 48

Migrant women care workers have poorer reproductive and sexual health and health care than native-born women^{174,175} though much depends on the host country. In parts of Latin America and the Caribbean, for example, women migrants had less access to general health and prenatal controls despite having higher birth rates and rates of contraceptive use than native-born women^{176,177}. Many migrant women care workers also experience poor reproductive and sexual health^{178,179,180}. There is ample evidence that they are subject to physical violence, including sexual harassment/assault and regular beatings. For instance, 44% of Filipino migrants reported knowing another domestic worker who had experienced physical abuse, 27% knew someone who had experienced sexual harassment, and 22.4% knew someone who had been raped^{181,182,183}.

The literature documents the mental and psychological effects of care work. Many studies highlight the experience of stress and anxiety resulting from being forced to work extremely long hours without rest^{184,185,186}. Some of the workers interviewed refer to their work situations as “indentured slavery”¹⁸⁷, while others complain of “going mad”, “being constantly sick in their bodies” and experiencing constant fatigue^{188,189,190,191,192}. Many care workers are affected by significant demands; being on call for 24 hours, with little opportunity for other pursuits, can contribute to mental health problems. It is not surprising that migrants working in these conditions report higher levels of stress and anxiety, depression and worry^{193,194,195}. It is also clear that many of the factors that affect mental health are closely related to physical health; for instance, discrimination may bar migrant women care workers

from accessing health care, which in turn may mean not receiving essential medicines.

Family separation is another major source of increased risk of mental health problems and may prevent migrant workers from integrating within host societies^{196,197,198}. Most migrant women workers, whether providing care or working in other sectors, do not bring dependents with them initially, if ever. Few receiving countries allow unskilled migrants to bring family members with them (if they allow the workers themselves to enter legally in the first place), and visits home can be infrequent as the cost of travel, plus the risk of not being able to re-enter the destination country without a visa, is prohibitive. Separations between migrant women and their children, spouses and other family members can last for years. It is not uncommon for children whose mothers migrate when they are very young not to see them again in person until the children themselves are young adults¹⁹⁹. The psychological and emotional toll of separation can be heightened when the principal task that the migrant undertakes is caring for others. For instance, women migrants from Sri Lanka report that concern about the health and well-being of their families back home compounds their negative experiences of work and life in employers’ households²⁰⁰. Migrant women care workers everywhere encounter difficulties when they finally reunite with their families, or when they transition out of care work into their former professional occupations²⁰¹. Generally, migrant care workers have little psychological support and limited opportunity to express their feelings or talk about their isolation and separation from families²⁰².

In the receiving countries

For many women caregivers, loneliness and sacrificing closeness and the opportunity to care for their own families are part of the trade-off they must accept for an opportunity to provide their families with a modicum of financial security^{203,204}. Many knowingly sacrifice their own health through multiple cycles of migration for poorly-regulated and gruelling work.

Despite some indicative evidence of the health status and determinants of migrant women care workers, there is an overall lack of systematic and comprehensive data on the full range of their

mental and physical health concerns. The links between different types of care work and workers' health need further documentation and attention. Understanding the needs of migrant women care workers, and the emotional and psychological costs of separation, as well as the physical toll that caring can impose, underscores the importance of Next Step 1 – to build a stronger evidence base with disaggregated data on migrant care workers' access to health care to better ensure that service delivery is responsive to their needs, and to ensure that the women themselves are involved directly in this process.



Implications for health systems and for achieving universal health coverage

The literature analysed shows that many migrants face more restricted rights to health care than many other groups in a given locality. The literature points to significant barriers and gaps within health systems, although they vary with regard to the specific barriers facing migrants. As these have implications for the realization of UHC, they are considered as drawbacks to health systems as well as to the individual migrants themselves.

Access barriers exist in all areas of health care, regardless of the type of health system. Gil-Gonzalez et al. (2015) explain that barriers to health services for migrants arise from factors that range from lack of entitlement in non-universal health systems to lack of accessibility in universal ones²⁰⁵; in many contexts both types of barrier are present. Because care work is frequently relegated to the informal sector, employees find that access to health care or insurance is not guaranteed but is granted at the whim of employers. In many circumstances, unexpected high out-of-pocket expenses for health care can be catastrophic for this population group, pushing them further into poverty and ill-health.

Entitlement barriers

Where migrant women care workers depend on employers for health-care insurance and access, they may face highly restricted access to services. Thus a key barrier to access is the inability to obtain health insurance in destination countries. Health insurance exists only on a voluntary basis in some Asian countries and is mandatory only in Latin American countries (the Philippines is the one worker-exporting nation that is an exception, providing access to overseas workers). In the United States of America, in 2010 for example, almost one-quarter of foreign-born workers employed in health-care support jobs (such as nursing, psychiatric or home health aides) lacked health insurance themselves²⁰⁶. Most states in the country have laws that debar undocumented migrants from accessing health and social services. Moreover, even lawfully permanent residents are ineligible for government-assisted health programmes for the first five years after becoming residents, with some states being exceptions²⁰⁷.

Some worker-exporting countries have introduced portable insurance schemes to give migrant women care workers access to health care in their countries of destination. However, the basic benefits package covered, the limited duration of coverage, and the extent of costs covered by those schemes may be insufficient to address actual needs. For instance, for women domestic workers from Sri Lanka, the country-of-origin compulsory welfare insurance scheme does not cover some important health areas and conditions. This leaves many vulnerable if employment rights and health entitlements are not honoured in receiving-country households. Specifically, they can be at risk of not receiving coverage

for medical expenses within receiving countries, for illness and injury sustained in escaping from abusive work situations, and for treatment of sexually transmitted diseases such as HIV. Female migrants working within the domestic sector in the Republic of South Africa have a high level of exposure to HIV/AIDS yet face considerable challenges in accessing health care²⁰⁸.

Access barriers and unmet need

Many women migrants, not just those who are care workers, face barriers to accessing health services²⁰⁹. Inaccessible or difficult-to-access services may include those for reproductive and sexual health^{210,211}, maternal health, abortion and contraception services^{212,213}. Undocumented migrant women in the EU have low contraceptive usage, limited screening for sexually transmitted infections, high abortion rates, and lack of sexual and gynaecological treatment^{214,215}. Many do not take up antenatal care or face delays in receiving it because of payment barriers at hospitals and lack of referrals to gynaecologists, as well as fear of being brought to the attention of the authorities, and a sense of shame²¹⁶. Young women migrants are also often excluded from family planning services in destination countries²¹⁷.

Poverty and financial hardship: These are key barriers to access in many situations. Overall, migrants tend to underuse services in comparison to the general population^{218,219}; when they do use such services, they may incur significant out-of-pocket expenses that they can ill afford. In the regions of Andalusia and Catalonia, Spain, for instance, perinatal care costs migrant women virtually nothing, while the same services in Sweden are estimated to cost around €2685²²⁰. In Khartoum, Sudan, women migrants reported paying higher fees and experiencing more limited access to services than most needed. They had few means of redress as their employers often ignored health problems²²¹. The cost of health care in the United States of America is among the highest in the world, making it almost inaccessible to low-income immigrants²²².

Residency and legal status: The challenges of undocumented and precarious legal status can directly affect migrants' access to health, and other public services. Migrant women care workers may be refused access to emergency services, or may face coercion when billed for services. When categorized administratively as "non-citizens", migrants may be relegated to using lower-quality services than citizens or may seek alternative means of health care. For example, in Australia, difficulty in obtaining "carer visas" impedes access for migrant workers and their relatives²²³. However, even in countries where migrants are legally entitled to access health services regardless of their status, they may still be unable to find services in practice. For instance, pregnant migrants in Mexico report being refused care at hospitals because

In the receiving countries

they lack identification papers and, in Uruguay, some have faced difficulties in accessing health care without an identify card²²⁴. In Spain, unpaid or informal care workers were excluded from fundamental services related to reproductive and sexual rights (such as voluntary abortions) if they lacked residency permits which are granted only to those in formal employment^{225,226}. Trafficked women and sex workers – a migrant group at high risk of experiencing health issues – also had difficulties accessing family planning in Spain²²⁷. In contrast to the common picture, in Argentina, mandatory access to “the right of health, welfare or health care” meant that its migrants used preventive and reproductive health care at the same rates as non-migrants²²⁸. Ironically, when migrants fall into a vicious cycle of ill-health due to adverse working and

living conditions and limited access to health services, they may face rejection of permanent residency or citizen applications on the basis of medical conditions.

Linguistic and cultural differences: Such differences can create barriers to ensuring quality care, even for those who have chronic or long-lasting medical conditions. Women belonging to racial or ethnic minorities are particularly prone to post-migration deterioration in health status, due in part to discrimination and cultural misconceptions within medical services^{229,230}. Cultural differences, lack of knowledge, an absence of culturally appropriate services, and high costs can discourage migrants from seeking health care or may lead to discrimination, harassment, refusal of aid, and excessive fees if they do²³¹.



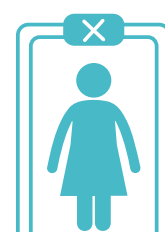
Privacy and confidentiality issues: Privacy and confidentiality are raised as barriers to health care in a number of articles reviewed^{232, 233, 234}. Mandatory health-testing – both before and after migration – can undermine both migrant women care workers' care-seeking and their willingness to make themselves known to the public health system. Some migrants had their citizenship applications rejected when health tests found life-threatening illnesses²³⁵; others reported that test results were provided to recruitment agencies without their consent at both origin and destination²³⁶. Migrant women care workers in the Eastern Mediterranean who test positive for HIV/AIDS or pregnancy often face immediate deportation²³⁷. Some report using home remedies or traditional medicine as strategies for avoiding any interactions with the formal health system²³⁸. Fearing loss of ability to work, or even detention or deportation, many will delay or avoid treatment, thus compromising their own health and well-being²³⁹.

In summary, the literature analysed here reveals that many migrants face more contingent and restricted pathways to access health care. This may be due in part to the general reluctance or inability of women migrants to access health services. The relative exclusion

of migrants, combined with poorer circumstances, can entrench inequalities in their health and well-being. With caring work itself compounding other stressors and psychological factors that distance from their families implies, health outcomes for women migrant care workers can be particularly poor^{240,241}.ⁱ

A significant knowledge gap exists regarding the influences on migrant care workers' health. Moreover, little is known about the relationships between the health and well-being of women who migrate for care work and the health of those left behind (older persons, the chronically ill, disabled and children) as well as those for whom the migrants are paid to provide care. There are knowledge gaps about the vulnerabilities experienced by migrant women care workers, their ability to access health-care systems and related supports (and how they interact with them), and health rights and social protections. This fact highlights the importance of Next Steps 1 on collecting more health status data and engaging with migrants in analysing the challenges and solutions to improving their health, safety and well-being, the designing of appropriate migration, health and social protection policies in both home and host countries.

i Bellagio Declaration and Conference on Migration and the Social Determinants of Health, 2012. See Reference 241. <https://cultureofhealthequity.org/our-work/social-determinants-of-migrant-health>, accessed on 6 October 2017. Also: A conceptual framework for action on the social determinants of health: debates, policy and practice, case studies. World Health Organization, Geneva, 2010





In the sending countries

“The health of a country’s women and children is a moral, political, economic, and social imperative. When women move across national borders, this imperative remains. However, the question of who (which country) is responsible and can be held accountable arises, and needs to be addressed by multiple stakeholders, and transnationally.”

United Nations Commission on Information and Accountability
for Women’s and Children’s Health (May 2011)

Chapter 3: Key messages

- Migration offers an opportunity to earn money and send home remittances. Both national economies and households benefit, gaining foreign exchange, reducing poverty and improving individual and household well-being.
- Migration is a key determinant of health for the families left behind by migrant women.
- Where migrant women and men are carers in their countries of origin, they frequently pass on responsibilities for caring for family members left behind to others, usually girls and older women.
- The out-migration of women to provide care in host countries leads to restructuring of families and is shifting gender roles and responsibilities for income-generation and caring in home countries.
- Lack of sufficient resources and/or a migration status that limits freedom of movement across national borders can result in transnational parenting and transnational families spanning continents.
- Parental absence and separation affect the psychological and emotional well-being of children and older persons left behind, although the context and care provided greatly affects responses to this absence.





Drawing on the existing literature, this chapter examines the major factors affecting family members in the face of women's migration. Researchers do not always agree about the effects of women's migration on the family members left behind, or on their health and well-being. A systematic review on this is long overdue to better inform policy-makers and service-provider planners and managers. This chapter is broadly organized according to the benefits and drawbacks of migration for those left behind. Focusing on the loss of social and emotional care experienced by families left behind, rather than specifically on health and well-being, some analysts argue that, overall, the widespread migration of women results in a deleterious "care drain" or "tilt" of caring resources^{242,243}.ⁱ Others maintain that the impact of women's migration is not so dire and can even be positive, shifting gender roles and earning strategies and affording critical resources for well-being^{244,245,246,247,248}.

Some researchers claim that families from which women migrate for work broadly benefit culturally, socially and economically from remittances, as indicated by improvements in indicators for education, health care, housing and economic stability. Another positive effect cited is the empowerment of women as a result of their increased independence and autonomy and their involvement in workforce employment. However, alongside these positive effects, more negative effects are also cited (e.g. caregiver gap in the left-behind household, mental health

problems of some family members related to the absence of the woman who has migrated). Some even argue that the widespread migration of women in recent decades has served to undermine achievement of the Millennium Development Goals (MDGs) and threatens to curtail potential progress towards the SDGs^{249,250}. A fuller understanding of the costs and benefits can enable policy-makers and planners to respond to, and compensate for, these costs and magnify the gains.

Benefits for economies and households

Paid work as caregivers in the countries, regions and cities receiving women migrants constitutes an essential component of health and social care systems and provides crucial economic opportunities for many women, particularly from rural and less-developed areas²⁵¹.

When individuals migrate for work, they typically send back remittances to families in home countries. The World Bank estimates that remittances make up more than 10% of GDP in over 20 countries worldwide, despite recent declines²⁵².ⁱⁱ The World Bank attributes this decline to "weak economic growth in Europe, the Russian

Federation, and the Gulf Cooperation Council (GCC) countries (cyclical factors), and exchange controls, burdensome regulations, and anti-migrant policies in many countries (structural factors)"²⁵³. These declines notwithstanding, remittance flows to developing countries are larger than official development assistance and more stable than private capital flows. For origin countries, migration reduces unemployment, contributes to rapid poverty alleviation, brings in remittances and diaspora investments, and may result in skills and technology transfer. Not only do remittances provide much-needed cash to households but they also provide foreign exchange to countries. In general, remittances also provide foreign exchange that is critical for importing capital and for investment purposes. Indeed, several countries actively encourage and support out-migration (e.g. Bangladesh, Nepal, Philippines) in an attempt to reduce poverty, address unemployment and underemployment and access foreign exchange.

i The term "care drain" parallels the phenomenon of "brain drain" in relation to women's labour migration (brain drain being coined in the 1960s to describe skilled labour migration as a loss for the origin country). The term was coined to address the lack of women's inclusion in brain-drain debates and to describe women's labour migration as a loss.

ii Data reveal that remittance flows to developing countries fell by 2.4% to US\$ 429 billion in 2016, after a decline of 1% in 2015.

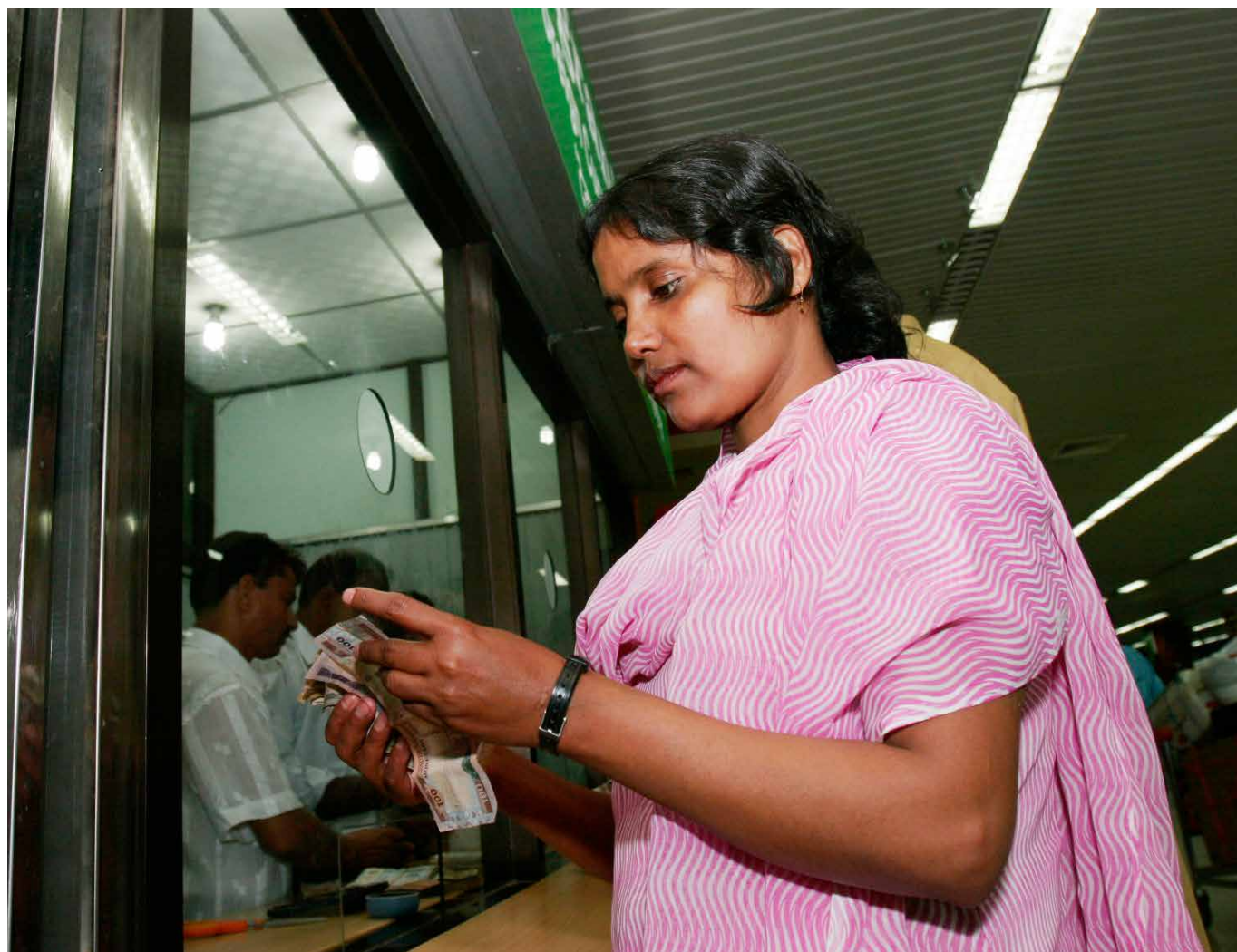
Remittances and their impact on health

The most important incentive to migrate is the undeniable benefit of remittances. This represents money coming into households that may be in, or at the brink of, poverty and need it for their survival. Remittances may also help households that may be somewhat better off but nevertheless rely on the influx of additional funds to buy or build a home, start a business, or ensure that the next generation has advanced education. While some efforts fail because of unscrupulous agents or other transnational disasters as well as damage to migrant women's health, migration appears to be the only option for many women. Remittances serve not only to help their immediate families and communities but, collectively, to raise the economic level of their home countries and regions^{254,255}.

Migration can bring social and cultural as well as monetary remittances to households, leading to improved living conditions, access to health care, and greater financial security in old age. For instance, in rural Bangladesh it was reported that older people with migrant children were nearly one third more likely to enjoy lower morbidity and mortality than those whose children remained in their communities²⁵⁶. Migrant adult children may provide significantly

larger financial transfers during a health crisis, acting as a basic health insurance policy.

The gender dimensions of remittances and the effect on health warrants further research. There is increasing evidence that women migrants frequently send a higher proportion of their earnings back home than do male migrant workers who tend to earn more²⁵⁷. Studies have suggested that, in general, remittances which are received and controlled by women are more likely to be spent on education, health and nutrition^{258,259,260}. In contrast, remittances controlled by men are more likely to be invested in businesses and property^{261,262}. Because of these gendered preferences for different forms of expenditure, women's use of remittances has sometimes been perceived as "unproductive". However, investment in food, education and health is an important factor in raising families above the poverty line²⁶³, and represents an investment in the reproduction of future generations. The hierarchy of needs and health-related expenditures from remittances sent by migrant women care workers needs further research. Add: Box 6 provides more detail – it is a full excerpt from a box in the Lancet's Commission on women, health and sustainable development, 2015 (see Reference 418).



Box 6. Migration and remittances—economic and gender considerations

Between 1960 and 2005, almost 190 million people emigrated to other countries for work. By 2010, the number of international migrants reached 215 million; almost half of these migrants were women.ⁱ Gender affects the extent of migrants' involvement in social networks, remittance patterns, and migration experiences.ⁱⁱ Additionally, migration of women has human and social costs, especially when they leave their children behind, but remittances are a tangible and quantifiable aspect of migration that can be used as a proxy to indicate migrant women's contribution to economic development and health improvement in their countries of origin.ⁱⁱⁱ Remittances by women who have emigrated to work—a large proportion of whom migrate for work in the health sector, especially nursing—have an important but undervalued role in improvement of health, wellbeing, and economic development of communities in their new country and in their country of origin. Worldwide, remittances have increased substantially from roughly US\$80 billion in 1990 to \$489 billion in 2011; low-income and middle-income countries (LMICs) receive about 75% of the world's total remittances.^{iv} Remittances are the second-largest source of external funding for LMICs, increasing from \$68.5 billion in 1990 to \$440.1 billion in 2010.^{iv}

At the microeconomic level, remittances provide financial security for households, having an important role in community poverty reduction and social development.^v Children from households receiving remittances are more likely to be enrolled in school—a crucial determinant of their health, the health of future generations, and long-term national economic growth.^{vi}

Women and men behave differently regarding remittances. Women migrants remit to improve their family's wellbeing^{vii} and

are more reliable remitters than men^{viii}—they transfer funds more frequently, support a wider range of family members, and remit a higher percentage of their income than male migrants.^{ix} Women provide increased support to households during times of economic crisis, counteracting household income.^{viii} Migrant nurses particularly have long been recognised as so-called faithful senders of remittances who make important contributions to the economies of their home countries.ⁱ Women migrants are more likely to send remittances to other female relatives in the household,ⁱⁱ creating a feminised transnational network that channels resources directly between women.^x Migration can alter gender relations and family dynamics in originating households, because female recipients are enabled to have prominent roles as heads of households, managing spending of remittances. Women's increased contribution to household financial and social wellbeing improves gender roles and relationships, enables them to have increased responsibility in the household, increases their participation in community decision making, and generates increased awareness of their status and conditions in the community.^{xi}

In addition to financial remittances, social remittances are a natural product of migration.^x Social remittances are a form of cultural diffusion that occurs through transfer of normative beliefs, values, and ideas that shape systems of practice, including gender roles in the household and participation in social and political groups, systems of practice, and social capital. Social remittances are especially relevant to gender issues; they transform political and social environments in countries of origin and countries of residence by encouragement of entrepreneurship, change of family structures, and generation of awareness of different political and religious ideologies. Additionally, social remittances might help to improve health because migrants tend to become more health-conscious when they are exposed to different health-care opportunities, and then share modern medical knowledge, such as information about contraceptives, with family and friends at home through transnational networks.^{ix}

i World Bank. The international migration of women: fact sheet. <http://go.worldbank.org/SE29Y07880> (accessed May 18, 2015).

ii Ramirez C, Dominguez MG, Morais JM. Crossing borders: remittances, gender, and development. Santo Domingo: UN International Research and Training Institute for the Advancement of Women, 2005.

iii IOM. Gender, migration, and remittances. Geneva: International Organization for Migration, 2010.

iv Migration Policy Institute. The global remittances guide. *Migration Rev* 2011; 39: 45–68.

v Orozco M, Lowell L, Schneider J. Gender specific determinant of remittances: differences in structure and motivation. Washington, DC: World Bank, 2006.

vi Suarez-Orozco C, Rhodes J, Milburn M. Unraveling the immigrant paradox: academic engagement and disengagement among recently arrived immigrant youth. *Youth Soc* 2009; 41: 151–85.

vii Zontini E. Family formation in gendered migrations: Moroccan and Filipino women in Bologna. In: King R, ed. *The Mediterranean passage: migration and new cultural encounters in southern Europe*. Liverpool: Liverpool University Press, 2003: 231–57.

viii Pickbourn LJ. Migration, remittances and intra-household allocation in Northern Ghana: does gender matter? PhD thesis, University of Massachusetts, 2011.

ix Alcalá M, Leidl P. State of the world population 2006: a passage to hope, women and international migration. New York: United Nations Population Fund, 2006.

x Levitt P. Social remittances: a conceptual tool for understanding migration and development. Oxford: University of Oxford, 1996.

xi Basa C, Harcourt W, Zarro A. Remittances and transnational families in Italy and the Philippines: breaking the global care chain. *Gend Dev* 2011; 19: 11–22.

Challenges for families left behind

Care chains and care drains

When women migrate, they leave behind caring responsibilities that need to be fulfilled. In societies where care is not well socialized, market care services are limited or costly, and the burden of care remains largely on women, women migrants tend to rely on women relativesⁱ or, less often, paid non-family members, also usually women,ⁱⁱ to care for their own families left behind²⁶⁴.

This creates a chain effect or what has come to be called a “global care chain”^{265,266,267}. The literature highlights how the “care drain” (created in sending countries, regions, cities, communities and households) can have some harmful effects which offset whatever economic benefits might accrue to those left behind^{268,269,270,271,272}.

Visa rules, poverty and time hamper families from maintaining contact

To maintain contact with their families and, as far as possible, influence and authority over their children, migrant women also turn to strategies dubbed by researchers as “transnational mothering”²⁷³ or “mothering across borders”²⁷⁴. Sometimes, however, because of the nature of immigration laws, earning patterns, the expense of travel and other factors, women’s separations from their children and other family members can extend for long periods, even many years. Such outcomes, even if anticipated, seldom outweigh other motives for women’s decisions to migrate.

Immigration regimes in destination countries and laws that determine whether migrant parents and children can reunite in the destination country or whether parents can enter and exit the country freely (allowing them to return home to visit children regularly) determine strategies for transnational parenting. The frequency of visits also depends on parents’ finances, the cost of transportation, and the terms of employment and labour contracts (e.g. whether or not they provide for paid vacations).

Between or instead of visits, communication between parents and children is crucial and plays a role in health and well-being – particularly mental health – for both sides^{275,276}. Today’s transnational parents can turn to email, cell phones and social media which have the advantage of being instantaneous and, except for email, do not require literacy. However, such communications require access to technology and services at both ends. This may be unavailable because of expense or lack of connectivity, especially in rural areas^{277,278,279}. Even where connections are available, cost is an important consideration; family members at both ends of

the global care chain often cannot afford landlines or cellphones, much less computers, and rates for using Sim or calling cards vary widely depending on demand. In addition, women migrants, including mothers, often have less or even no access to cellphones or laptops because they have live-in jobs where employers either restrict or prohibit their use, or where the women lack privacy or cannot find convenient times to call²⁸⁰.

Migrant women (or their husbands, if the men remain in the sending countries) tend to recruit women relatives to care for children left behind – often their own mothers, aunts or sisters. Not infrequently, these women, although willing to care, may find it difficult to cope with the needs of young children because of their own advanced age, illness or infirmity.

Family forms are not static; they change over time, as do all societal norms and cultural values. In Ghana, for instance, families have expanded and contracted over the years as adults – usually men, but now increasingly women – have migrated or returned home in search of economic opportunities²⁸¹.

Nowadays, it is common for people other than a child’s parents to take over the care of children when the parents go abroad for work. These proxy caretakers can also receive babies who were born abroad and are sent back home to be raisedⁱⁱⁱ. Most of the literature on transnational families focuses on children and their responses to the absence of migrant parents. There is much less research on men and older persons.

Children

Most researchers have been interested in how maternal absence affects children, including asking if it harms them. There is no consensus. Such divergent views result, in part, from the great variety of cases that differ considerably in terms of family and household structures. Some kinship systems are more flexible and adaptable than others when it comes to major disruptions such as migration. Children themselves react to maternal absence in many ways, depending on their temperament, their relationship with the absent parent, the substitute care arrangements and the personalities involved. Their responses to maternal absence may change over time or according to age: adolescents tend to express negative feelings more vocally than younger children²⁸². Longitudinal cohort research on this would be helpful.

Some researchers have focused on the agency and resilience of children in the context of maternal absence due to migration^{283,284}.

i Family carers may be paid or unpaid (in the latter case, sharing in migrants’ remittances to their home households).

ii The reliance on other women results from entrenched social norms and gender stereotypes, which tend to hinder men’s involvement in care duties.

iii These children are sometimes called “posted babies”. (See: Coe C, 2017. Child circulation and West African migrations. In: C Ni Laorie et al. Migration, movement, mobilities. Singapore Springer; pp 389-407)

In the sending countries

They present evidence that many children exercise “reworking” and “resistance”, and conclude that one should not generalize by regarding children only as passive victims in such situations^{285,286}. Care should also be taken to guard against imposing one’s own cultural notions of family on families in sending countries. In many settings, families and households are already extended and multi-generational, and child-rearing is the task not just of biological parents but of many different relatives and even non-relatives. Nevertheless, it is important not to glorify certain types of families by assuming that they are infinitely flexible and capable of adjusting to any or all new circumstances, or that because child-rearing responsibilities are distributed across several family members, a mother’s absence will be less deeply felt^{287,288}. However, most researchers do concur that children in these circumstances are likely to experience, at the very least, a sense of dislocation and the need to make some type of adjustment to new caring arrangements.

Migrants’ children do not always receive the benefits due to them as caregivers may divert remittances to their own children or treat them with less affection and concern²⁸⁹. Mothers’ migration may compel older daughters to assume heavier burdens, transforming them into surrogate parents to their siblings, often at the expense of dropping out of school²⁹⁰. While some girls resent the heavier burden, others accept it and readjust their daily lives in order to “repay” their migrant mothers²⁹¹. The reliance on other females

results from entrenched social norms and gender stereotypes which tend to minimize men’s involvement in care duties^{292,293}.

Even when migrant women succeed in staying in touch, relationships between them and their children and other relatives often become strained, with significant consequences for the mental health and well-being of both the migrants and family members left behind. Ethnographers have reported observing children who refuse to speak to absent parents or find excuses to avoid their calls, and that children sometimes appear to be more distressed after contact than they were before²⁹⁴.

Ethnographic observation and clinical work with children of migrant workers can produce empirical detail that reveals painful disturbances. These include the nature and quality of substitute care, whether a single consistent caregiver is present, how that caregiver interacts with the child and, very significantly, how the caregiver presents the situation to the child. If there are disruptions in care resulting from illness, family conflicts or other situations, a child who is already feeling insecure because of parental absence may suffer even more. If the caregiver favours her own children by redirecting remittances to them or showing them more attention or affection, that too can be harmful to the child with an absent mother or absent parents. Additionally, a child may be harmed if the caregiver presents the child’s situation inaccurately by either promising an imminent return of the parent who does not materialize or, conversely, suggesting that the parent has gone forever. While a promised return allows the child to hope, it may



also, clinicians suggest, prevent the child from fully coming to terms with the loss as he/she might be able to do in the case of a deceased parent²⁹⁵.

Box 7 gives the example of Wilson, an elementary-school-aged boy from Ecuador, to illustrate some of these issues²⁹⁶. While reunification is usually described with relief and joy, it is often interlaced with contradictory emotions²⁹⁷. Feelings of disorientation are prevalently expressed. At times, children report not recognizing the parent and poignantly describe feeling that they are meeting a stranger.

Box 7. Example of a care chain: from child and grandparent perspectives

“Seven-year-old Wilson had been living with his maternal grandmother and four-year-old cousin for two years.... Without sufficient male support, his mother [had] migrated to Italy. Her remittances were the only source of income [for all three of them]. Unlike many other emigrés’ children I studied, Wilson experienced his mother’s emigration as a loss because, I believe, his grandmother limited the development of an alternative representation of his family life. I believe that her constant reminders of her own representation of his family life inhibited his ability to see his situation of substitute care as something normal through a recodification of family roles. Wilson could not view his grandmother as fulfilling the role of a redefined grandmother and his mother as a readjusted mother as other emigrés’ children did because his grandmother declared incessantly that he was not missing anything – she provided him with everything he would need from a mother. To Wilson, these declarations indicated that his mother did not provide for him.... Having developed an extremely close bond with Wilson, his grandmother emphasized her substitution as Wilson’s mother to solidify his attachment to her and prevent Wilson from forgetting her in case he reunited

Young children are rarely involved in making the decision for an adult caregiver to migrate and sometimes learn about it only at the last minute. Yet they do exercise agency as they navigate new care arrangements, although the extent of this will depend on their age and circumstances²⁹⁸.

Researchers such as those at CHAMPSEA (Child Health and Parents in South-East Asia),ⁱ who have conducted some of the most comprehensive and sustained research on migrants’ children to date, consider agency to be a key factor in a child’s ability to navigate reconfigured family and household arrangements.

with his mother.... She had agreed to take care of Wilson and therefore has “given him all her love”, yet her daughter [could] still decide to take him and all that love away. She told me this would break her heart.... [The grandmother’s] concerns triggered kin confusion for Wilson.... Under pressure to see his mother as not a mother, Wilson learned to hide the emotional indicators of his deep connection to his mother ...” (Reference 296)

In this case, Wilson’s grandmother does not appear to be consciously ill-intentioned but, perhaps in her own way, she was seeking to ease what she saw as a difficult emotional time for the child while at the same time protecting her own emotional investment in him. While this relationship was no doubt unique in many ways, it nonetheless points to the kinds of complex emotional knots that may arise in arrangements undertaken to care for emigrés’ children. In other cases, substitute caregivers, however well-intentioned, may be unable to offer children warmth and attention because they too are suffering from the absence of the migrant parent – their own son or daughter – in terms of affection, practical assistance or in some other way.

i Since 2008, CHAMPSEA, housed at the Asian MetaCentre for Population and Sustainable Development Analysis at the National University of Singapore (NUS), has been collecting data on children in four countries with substantial rates of female migration – Indonesia, Philippines, Thailand and Viet Nam. See http://www.populationasia.org/CHAMPSEA/publications_champsea.htm, accessed 22 August 2017).

Influence of caretakers and teachers

Schools are second only to families in shaping how children process the experience of maternal or parental departure, but determining their role is methodologically complicated. If the children of migrants perceive that their situations are unique, that they are the only ones in their towns or villages to be living without one or even both parents, they are likely to feel stigmatized. If parental, and especially maternal, migration is more common in a child's community, the child is less likely to feel stigmatized and may even find support from local schools or other institutions where staff members are familiar with the problems this may cause and are willing to help children adjust.

Garcia & Velasco (2013) studied a school in the highlands of Ecuador where parental migration is very common and described how "the school has been inserted into the global scaffolding of caregiving to those children and adolescents who stay behind"²⁹⁹. They found that the teachers were well aware of how this affected their students:

"We can tell just by observing children's behaviours when he or she has parents living abroad because that face of sorrow does not change, it stays the same,"

one teacher reported. Another said:

"Children of migrant parents seem to be going through a period of grief and seem to be sadder than the children of non-migrant parents; they become quieter, are frequently absent from school, and display signs of deteriorating personal hygiene and diet. They fall asleep in class and seem to be in pain."

These teachers have understood that lessons in geography, history and other social studies subjects "*seem to encourage the students to ask questions and debate migration*", one teacher reported. However, there was also an acknowledgement that teachers were not always best equipped to deal with this, lacking any psychological toolkit that would allow them to approach migration and its impacts holistically.

This positive experience is not always found. Teachers may blame absent parents for their children's disruptive behaviour while doing little to assist the children³⁰⁰. Teachers also make accusations against migrant mothers (for instance, of creating "Euro-orphans" when parents in Eastern European countries leave to take care work jobs in Western Europe)³⁰¹.

Older people: caring and needing care

On 16 December 1991, the UN General Assembly adopted resolution 46/91 containing the United Nations Principles for Older Persons: to add life to the years that have been added to life. Governments were encouraged to incorporate the principles into their national programmes whenever possible. One of the aspects covered was care and its relation to health and well-being.

Many older persons face dual challenges when charged with the care of grandchildren whose parents have migrated, while themselves in need of care. Older persons are frequently the main caregivers in poor households in low- and middle-income countries. Often, they care for other older persons and children. This role should be better recognized and supported³⁰².

At the same time, migration may bring increased responsibility for grandchildren left behind, as well as for the practical burdens of work (such as farming) and daily household tasks that were previously shared by now-absent adult children. Older grandparents in Thailand, for example, were often forced to go back to work to support left-behind grandchildren³⁰³. Grandparents' ability to cope alone with added burdens depends greatly on their age and physical abilities.

A number of recent studies found that parents experience sadness and loneliness when their children migrate³⁰⁴, in some cases severe enough to be labelled depression³⁰⁵. In a study of older Mexicans whose children had migrated, researchers found that they displayed "strong, primarily negative emotional responses: sadness, longing, guilt, worry", particularly if their migrant children were undocumented³⁰⁶. In China, higher levels of depression among older parents with migrant children were found compared with older parents with non-migrant children; the figures were higher for women and older persons who lived alone³⁰⁷. Such emotional strain can have implications for parents' mental and physical health and is likely to be a precursor that influences the extent of need for care in later years³⁰⁸.

The absence of adult children does not necessarily predict a breakdown in their sense of obligation to parents or an ability to care for them. A "cooperative framework" can develop which enables their families to assess the advantages and challenges of migration more effectively than individual decision-making and which may offset any social penalty associated with children's migration^{309,310}.

In the absence of such arrangements, however, left-behind parents are more likely to suffer from lack of care. In rural China, the "one-child policy" has left its demographic toll in the form of families in which adult children have no siblings to cooperate with. Thus, parents who decide to migrate cannot set up the kind of shared arrangements for older parents set up elsewhere (e.g. in Moldova)³¹¹. Instead, older parents must cope on their own. Most rural Chinese engage in internal, rather than international, migration, yet the country's long distances make it difficult if not impossible to return home for parents' emergencies³¹².

The first global Ageing and Development Report, published in 2000 by HelpAge International, noted that "when families are scattered by migration or forced movement, their support cannot always be relied upon"³¹³. In many societies, the social fabric of



© IOM / Tatiana Jordan



© Tom Cheatham / World Bank

traditional family relations is changing due to declining fertility, intense rural-to-urban and international migration and, not less importantly, a change in values and norms that could impair the effectiveness of the traditional intergenerational social contract that helps to generate support for older people. In many lower-income countries, the role of the state and the public sector in general is either weakening or nonexistent. This feature, in combination with widespread poverty and massive inequalities, creates conditions that are unfavourable to the development of even minimal safety nets³¹⁴.

Men: gendered norms in flux

As more women migrate, and the absence of women affects families left behind, a new area of study is focusing on ways in which migration can transform conventional gender roles, producing new

practices and behaviours on the part of both men and women in migrating families. The questions are: how do left-behind fathers negotiate their role as caregivers, and how does this role affect their sense of masculinity?

The practical and psychological consequences of women's absence can exacerbate gender inequalities in sending countries, requiring other women and girls to engage in more caring responsibilities to substitute for those who have left, increasing time burdens and frustrating the achievement of other development objectives. Some researchers contend that husbands left behind to care for their children while their wives migrate for work have an easier time than their female counterparts because they are more likely to seek help from female relatives³¹⁵. Others argue that men may face greater mental health challenges because their masculine identities are often in jeopardy^{316,317}. Some men attempt to find

In the sending countries

or keep jobs outside the home to avoid appearing dependent on their wives' remittances³¹⁸, but this may lead to added difficulties as they try to balance work and care responsibilities. Others risk losing face if word spreads that their wives' employment abroad involves some kind of stigma³¹⁹.ⁱ

More recent research suggests that men's gender roles (like women's) are in flux. The experience of migration may be leading to a softening of the stark sex-differentiated roles in the family, as husbands and wives, and men and women of all ages, trade responsibilities. Although the departure of wives signals new caregiving tasks for husbands, not all men perceive this as a burden or threat to their masculinity. Some of the men interviewed in Italy (after they had migrated to join their wives) "appreciate the care and affective labour required of them as the main parent at home", even if it means juggling work and family responsibilities³²⁰.

One man who stayed behind in Colombo, Sri Lanka, while his wife migrated reported:

"I could rely on other women in the house, and often I certainly did. But for me it was also an occasion to be more present at home, to manage things by myself rather than relying on others ... and also the kids needed my help. I tried to negotiate with my employer in Colombo to work part-time: I told them that I had to be a father and a mother ... given the situation. [H]e did not agree, but I could still manage to stop work two hours early every day in order to cook for the kids and clean the house before the dark time ..." (Gayan, 36, from Sri Lanka. Interviewed in Perugia).

Men such as this were "able to prove their autonomy" by handling children and domestic tasks without relying on women. They saw themselves as "adaptable husbands and fathers", and were not offended by wives taking on the role of breadwinner. Other men were more concerned about the loss of their role as main breadwinners than about becoming caregivers, but in places where families were more egalitarian, women's wage-earning was not problematic. Indeed, some men were eager to marry women who had worked abroad as this would enable them as a couple to become more independent of parental authority. In many places, migration of both women and men had come to be normalized, thereby presenting less of a threat to conventional gender roles. Taking on caregiving duties at home socialized men and prepared them to take jobs as domestic or care workers upon migration³²¹. However, some men who were left behind found their situations emotionally difficult:

"It was hard for me to accept that my wife was looking after other people's children ... by also denying this care to our own children ... this was hard for her but also for me ... because in the end she was away and she could

not see our kids ... but I saw them every day, sharing their crying, listening [to] their questions about where mummy is ... It was not enough to delegate everything to others ... I had to be there ... otherwise to the children it would have appeared as a second betrayal ..." (Xavier, 39, from the Philippines, interviewed in Perugia).

Another father accepted the situation more philosophically:

"Men have to learn to be more sensitive. Your wife is looking after other children ... and you as a father have to double your love in order to give the same treatment those children have on the other side of the ocean to your own children..." (Mendis, 41, from Sri Lanka, interviewed in Milan).

Some researchers have found that migrant men who were themselves working as caregivers in destination countries were more aware of children's bodily needs than men in other occupations³²².

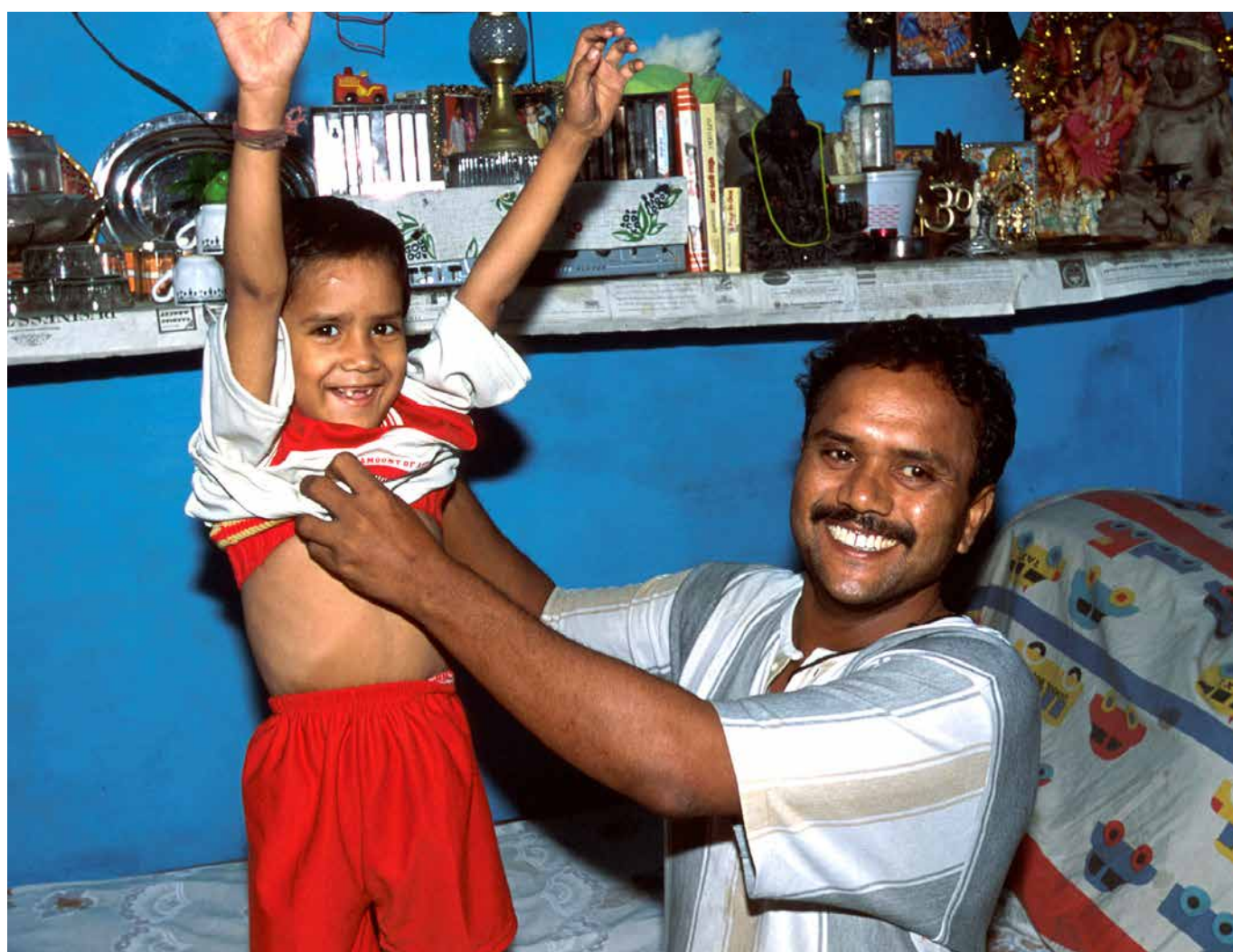
Gender differences between parents have been noted³²³. From research in Mexico, it was found that mothers were more likely to express sadness and longing for absent children as well as considerable concern for how they were faring, and whether they were taking on too much work and not taking care of themselves. Mothers seemed to wear their suffering almost as a "badge of honour" symbolizing their commitment to their families ("familismo"). Fathers tended to be more stoic, suppressing whatever sadness they might feel, but even going so far as avoiding telephone calls with absent children so as not to let down their guard. This led to further distancing between fathers and absent children and, ultimately, to deterioration of their relationships. In contrast to mothers, fathers' primary feelings toward their absent children were guilt and shame.

In other studies, many of the men interviewed realized they were ill-prepared by education and socialization for caring and more intensive fathering roles, but they were nevertheless willing to fulfill their new assignment. Migrant wives sought to help in this regard by sending cultural as well as material remittances to families left behind – conveying what they were learning from their own work about child-rearing, including advice about diet, health care, clothing and equipment – and dealing with emotional issues and acting as "moral instructors"³²⁴.

Such studies suggest that family roles and gender identities should not be presented as immutable, timeless or universal, but as changing over time in response to new circumstances, as does culture generally. As Gallo & Scrinzi (2016)³²⁵ put it:

"migrant men's expectations of conjugal life and the gendered division of labour within the family were significantly transformed by having engaged with shifting cultures of migration – that is, the cultural framework through which the mobility of people is made meaningful

ⁱ Gallo & Scrinzi (2016) note that in Kerala, India, "[n]ursing as an occupation is usually stigmatized by upper castes and non-Christian communities ... and men who are left behind encounter discrimination" (p. 219).

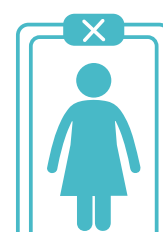
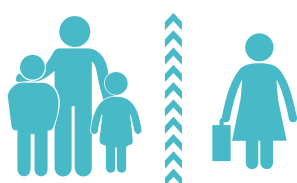


© WHO / SEARO / Pierre Viot

and represented in a specific context in their home countries even before migration”.

Men’s experience of, and responses to, being left-behind differ from women’s. The data show great variation in experiences, making it difficult to generalize about the impact of migration on children and other family members around the globe. Moreover, the research is not uniform, since it is based in several different disciplines – including psychology, sociology, human geography, anthropology and history – and uses a variety of methodologies

ranging from quantitative to ethnographic and even clinical. Yet, taken together, the existing studies do suggest some problem areas that might be addressed through policy innovations; these will be presented in Chapter 4. They also support the need for a more intersectional and nuanced evidence base, some “lived reality” evidence from participatory and qualitative research, and placing greater value on migration as a social determinant of health for those left behind, as well as those moving and cared for in receiving countries. These are all emphasized in the final Chapter on Three Next Steps.





Policies to support the health of migrant women involved in personal care work

“Care is not a patriarchal concern for women, a type of secondary moral question or the work of the least well off in society. Care is a central concern for human life. It is time we begin to change our political and social institutions to reflect this truth.”

Tronto, 1993³²⁶

Chapter 4: Key messages

- Personal care work everywhere should be recognized and valued.
- The contribution that migrant women – in all their diversity – make to an increasingly internationalized care economy should be explicitly acknowledged and systematically researched, as should the impacts, negative and positive, on the families that migrant women leave behind.
- Migration should be acknowledged as a social determinant of health and its connectedness to other determinants fully documented.
- Migration, labour, social protection and health policies need to be modified to ensure that migrant women, and particularly those working in the growing care sector, are not left behind in development processes and in accessing basic services so that their health needs are met and their rights are protected.
- Some policies will require transnational collaboration and response, particularly those that recognize and respond to care deficits and value care.
- Care deficits in the sending countries need to be better addressed to support the health and care needs and rights of family members left behind.
- For attaining UHC, non-discrimination for migrant workers, including for migrant women in care work, must be assured and supported.
- Governments should uphold human rights through their laws and policies, ensuring the protection of their rights as stipulated in SDG8 which embraces decent and productive work for all workers, including migrant workers and women workers as specific and distinct groups requiring protection in the workplace and as priorities in terms of leaving no one behind.
- National governments should take a whole-of-government approach that aims for policy coherence and more multisectoral programmes.





This chapter explores access to health care, and labour and human rights are addressed in the policy landscape of countries most affected at the two ends of care trajectories. It considers how the international, regional and national policy landscapes will need to change to ensure that the needs and rights of migrant women, in all their diversity, are broadly promoted.

Policy coherence and a whole-of-government approach

Different areas of policy – particularly labour/employment, social protection and health policies operate together to shape migrant women care workers' experiences in their host countries, including their experience of health and well-being. The policies also affect those left behind. While many aspects of different policies are connected, they are not always coherent. While acknowledging that each policy area has its own complexities and challenges, restructuring and professionalizing of care work within social welfare and health systems is urgently needed.

Depending on whether and how they align, policies in different domains may help improve or impede the health status and underlying social determinants of migrant women, and the families they leave behind, particularly in terms of access to health services and healthy working conditions. Whole-of-government work on the cross-sectoral responses to migration and health needs to include disaggregated data-gathering, consultation, dialogue, community engagement with the women themselves, policy development and best-practices support and dissemination³²⁷. Gender, the care economy, labour, immigration and social protection sectors are also relevant. These approaches must consider gender, analyze the impact on the care economy and include labour immigration and social protection policies.

Identify and reconsider contradictory policies

Contradictory policies, whether national or regional, significantly shape migrant women's lives, including their experience of care work.

This is apparent in the earlier analysis of labour and immigration policies in Chapter 2. There may be policy incoherence between national immigration policies and care requirements within host countries. For instance, many of the approximately 17,500 internationally-educated nurses (IENs) who migrate to Canada each year (from countries including China, India and Philippines) are denied licensure, preventing them from practising under national and provincial immigration policies and professional regulations. This has influenced increasing numbers of IENs who use two-step immigrant routes to enter the profession (e.g. as international students or permanent economic migrants) or pursue alternative careers in health care (e.g. as personal support or home-based care workers). It may also contribute to the downgrading of skills as persons who are unable to practice with full licensure take on jobs with fewer skill requirements³²⁸.

Another example relates to people who have migrated to Australia and are engaged in care work. Many retain strong links with their extended families in their home countries but, when they seek to bring in family members to provide for their long-term care needs or other forms of assistance, they may be prevented from doing so by immigration policies (see Box 8).

In various locations, although certain types of care visas can be obtained given specific conditions (e.g. the migrant to be cared for has become a resident or citizen), these visas may take years to secure and may take too long to help those needing immediate care. Moreover, visa options are often temporary and

BOX 8. Example of Australian care workers and family reunification

People who have migrated to Australia from abroad often retain strong links with their extended families. For many, family is the primary source of care provision. However, current Australian immigration policies give limited consideration to such transnational links. The only family migration visa currently available to extended family members is the (permanent) Carer Visa (subclass 116) under the Other Family category in the Family Stream of the permanent Migration Programme. This is available for people who provide substantial and continuing

care for a relative (such as a spouse, sibling, grandchild, aunt or uncle) with a long-term or permanent medical condition. However, eligibility conditions are complicated and the visa is difficult to obtain, with long waiting periods of over four years. The temporary Contributory Parent Visa (subclass 173 or 884) may provide support to migrants who are care workers themselves by allowing parents to live in Australia for up to two years, but they generally have no right to bring family members to provide care work at short notice or otherwise.

Source: Department of Immigration and Border Protection (DIBP): Carer visa (subclass 116). 2016: <https://www.border.gov.au/Trav/Visa-1/116>; and Family Visa Queue, 2016: <https://www.border.gov.au/Trav/Brin/Fami/Capping-and-queuing/Other-family-visa-queue> (both accessed 12 October 2016).

may not allow for these caregivers to access the necessary health services for themselves. In many countries, those designated as “non-citizens” cannot access health care and child care³²⁹, or these are prohibitively expensive for non-citizens and the uninsured^{330,331}. They may also lack access to basic workers’ rights, such as sick leave and compensation because they lack regulated contracts³³². Undocumented migrant women care workers may be reliant on their employers and recruitment or placement agencies to uphold their contractual commitments.

In the legal domain, immigration laws become, in effect, family laws³³³. This is because of their impact on families – either expediting, or more likely delaying – family reunification. They dictate who constitutes “the family”, who may come in to join, and when, thus making it difficult for other family members to join them. Equally problematic for undocumented workers is the decision of whether or not to travel back to their home countries to visit family left behind because it is too expensive (they may have to pay smugglers or “coyotes”ⁱ) and/or they may be unable to re-enter the destination country.ⁱⁱ

In some countries, laws regarding citizenship compound the

problem by granting automatic citizenship to children born in the country (*jus soli*) but denying it to migrant children as well as their parents, resulting in “mixed” families where some members are citizens and some are not. In some cases, parents are deported, leaving their younger children behind.

Employment law and migration law and practice can also frequently contradict each other, particularly where employment law is not held to prevail for migrants or where migration status can affect access to statutory labour rights^{334,335,336}. Similarly, the right to social protection is often contingent on migration status and not all workers have the right to accumulate pensions or other social benefits that native workers and citizens hold.

Extensive reform of national laws and regulations governing migrant workers is required to eliminate obstacles that migrants face in trying to maintain employment and family relationships simultaneously. Loosening visa requirements to allow migrant mothers to see their children more frequently, or even bring them to destination countries, might alleviate some of these problems but may cause others. Family reunions in destination countries can often also go awry^{337,338} when members, including children, become aware that, as migrants lacking full citizenship they cannot access most, if not all, of the benefits of destination welfare states – which are based, in theory, on the principles of egalitarianism and universalism but are often exclusionary in practice. Moreover, the process of acquiring permission for minor children to join their migrant parents may sometimes take so long that the children become too old to be eligible to enter the country³³⁹.

i The term “coyote” typically refers to a migrant smuggler in Latin America who is paid to bring potential migrants to Canada and the United States of America. The term is increasingly recognized throughout Latin America and is also used for those smuggling migrants to other higher-income countries in the region.

ii Ironically, researchers interviewing members of the same family in both sending and receiving countries are free to travel back and forth, while the family members themselves are not. As their migrant subjects realize this, they have started asking researchers to act as couriers to family members back home, ferrying messages, gifts and even money to those “left behind”, and bringing back photos, videos and keepsakes in return (Oliveira, forthcoming).

Whole-of-government approach

Related to this lack of policy coherence, a major challenge is that many policies in the domains of migration, citizenship, labour and employment, health, and social protection are siloed. This can exacerbate the risks and vulnerabilities of migrant women care workers, and their families left behind, and can have negative health implications^{340,341}. The literature often distinguishes between different domains which, in practice, are deeply intertwined.

Care is not a single policy issue but rather involves immigration, employment and health policies³⁴². Multisectoral dimensions involving social and health services and protections, as well as legal and labour considerations, require attention. Given the multi-level factors shaping care-worker experiences, health and well-being, there is clearly a need to move beyond siloed programme and policy efforts to address these multiple and intersecting issues.

A number of authors and reports reviewed call for measures to improve the availability of service supports that address the health and social needs of migrant women^{343,344,345,346}. They also emphasize the importance of social protection and ensuring the rights of migrant women care workers³⁴⁷. Legal considerations included the enforcement of strict laws to curb the trafficking or indentured servitude of women^{348,349,350}, or enforcement of existing labour law, or ensuring non-differential treatment of native and non-native workers^{351,352,353} as well as the need for all countries to ratify and implement the ILO Domestic Worker's Convention which promotes decent work for domestic workers^{354,355}. This convention includes terms of employment, occupational safety and health, migrant labour, social security and gender-specific provisions such as maternity entitlements. These government sectors should cooperate to reshape governance structures.

Other priorities relevant to labour and employment include: registering all recruitment agencies to ensure protection of vulnerable citizens³⁵⁶ⁱ, changing employment contracts to ensure basic rights and protections for care workers;ⁱⁱ allowing for open work permits that do not bind care workers, based on migrant status, to employers; improving pay and working conditions for care workers; penalizing workplace abuse and harassment; conducting a national migration survey to understand gender and employment differences; and streamlining processes for care-worker training and recognition of credentials.

Key recommendations in this regard include: developing and strengthening bilateral agreements between labour-sending and labour-receiving countries to protect the rights of care workers^{357, 358}; improving implementation of existing measures and policy initiatives, and strengthening coordination and partnership across government agencies and between stakeholders^{359,360}; working towards balancing domestic care needs against international markets to prevent care drain that exacerbates care deficits; supporting the empowerment of migrant workers and communities to raise their awareness of their rights and entitlements; and establishing consistency between policies to better detect and eradicate policy contradictions relevant to issues including migration, trafficking, gender equality and health assistance³⁶¹.

Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity³⁶². A whole-of-government approach integrates collaborative efforts of departments and agencies of a government to achieve unity of effort in terms of a shared goal. A whole-of-society approach engages people outside government and, more importantly, outside insular policy communities and the political establishment³⁶³.

i See also the Fair Recruitment initiative of the International Labour Organization (<http://www.ilo.ch/global/topics/fair-recruitment/lang-en/index.htm>, accessed 25 August 2017).

ii For example, the Philippines Republic Act 10022 (2007 and 2010) required compulsory insurance through recruitment agencies, and created a method for employees to file complaints against employers. It also increased measures to reduce illegal recruitment.

Towards transnational social protection

Receiving countries and regions should acknowledge that their economies and their health and social care systems ultimately benefit from receiving migrant care labour, and that care deficits in the global north are being resolved often at the expense of widening care deficits in the global south. Receiving country governments should also acknowledge that sending countries and regions incur costs as a result of the out-migration of women who become paid caregivers abroad and who, in effect, subsidize the care systems of those areas by providing low-cost care labour. This is particularly important in contexts where women migrant care workers are denied access to health care, disability aids or social security protections. This means that their families and communities of origin must not only carry on without the benefit of their caring labour but, if and when migrants return in ill-health and/or old age, those families and communities must bear the burden of caring for them.

The portability of social protection, social security and pensions must be ensured across sectors and borders. Social protection (which can include: occupational injury, disability insurance, health insurance, paid sick leave, occupational health and safety, health, pension, and unemployment provisioning) at all stages of migration and care work is essential to the ability of women migrants to safeguard their health and well-being while ensuring the care of others (i.e. care recipients as well as family in their countries of origin).

Cross-border arrangements are emerging

Migrant domestic and care workers are compelled to develop cross-border social security arrangements for their own benefit and that of their families³⁶⁴. The migrant care workers are becoming an integral part of the social security systems of their country of employment; thus, those systems, as a result of the presence of these workers, are becoming transnational in character. Work with Ghanaian and Filipina domestic workers in the Netherlands reveals that, by excluding foreign migrants from their national social insurance systems and services, host countries deny migrants access to social safety nets and entitlements that render them more dependent on employers “increasing the possibility and scope of their exploitation”³⁶⁵.

Similar findings are reported for Germany³⁶⁶. Here, the failure to resolve care burdens and place immigration reform higher on the domestic policy agenda has led to widespread clandestine care work in a twilight zone of undeclared work. This is an open secret as it is the topic of extensive discussions among the people and in the media. The authors assert that undeclared care migration is an “integral part of German welfare state policies”, and includes both “compliance and complicity” with the need to resolve care needs and meet care deficits.

Moving towards portable pension systems and universal access to social protection regardless of national origin would be one step to resolving this challenge. Since care workers have been imported largely to resolve care deficits which are a feature of rising economic and demographic dependency rates, and their labour contributes to lowering these dependency ratios, it would seem a matter of social justice to ensure their right to pensions and social security through their labour attachment. This is particularly important in those contexts where home governments actively promote and facilitate migration.

Initiatives are emerging for pension portability and compatibility that allow workers to accrue pensions in one country and cash them in situ or in other countries. A recent ILO report examines migrants’ access to social protection under a number of bilateral labour agreements (BLAs) in order to provide policy-makers with guidelines for extending social protection to migrants and designing better migration policies³⁶⁷. This reportⁱ presents the results of a mapping of bilateral and multilateral social security agreements in 120 countries and reviews legislation granting equality of treatment between nationals and non-nationals. It promotes the inclusion of social security provisions into BLAs and memoranda of understanding to ensure the organization of migration for employment, drawing particular attention to provisions on equality of treatment between migrants and non-migrants within social security mechanisms. It also draws attention to the fact that, although social security provisions are entering BLAs, only 30% of the BLAs and memoranda of understanding analysed included provisions for social security including health benefits (mainly in Europe and the Americas)³⁶⁸. In some cases, the agreements are sector-specific, identifying particular sectors that have experienced exclusion from social security and pensions benefits; the example of the Seasonal Agricultural Workers Program in Canada for agricultural workers from Mexico and Central America stands out. In other cases, these agreements cover all sectors and explicitly mandate the non-differential treatment of native and non-native workers.

One example of a cross-sectoral approach is that of the Sri Lanka Bureau of Foreign Employment (SLBFE) which has established the Overseas Workers Welfare Fund (OWWF) for Sri Lankan workers in the Republic of Korea. Sri Lankans leaving the country to undertake work in the Republic of Korea can register with the OWWF and be eligible for some social security benefits. The Fund covers contingencies of death and disability, as well as some

i The report also provides a more in-depth legal analysis of migrant workers’ access to social protection under BLAs or Memoranda of Understanding (MoUs) for 9 corridors, 15 countries, namely: Canada-Mexico, Spain-Morocco, Spain-Ecuador, France-Mauritius, France-Tunisia, Philippines-Saudi Arabia, Qatar-Sri Lanka and Republic of Korea-Sri Lanka, South Africa-Zimbabwe, as well as migrant’s access to social protection in Belgium.

costs related to repatriation. Coverage is, however, provided only for a period of two years and benefits are received upon returning to Sri Lanka; in most of the cases, benefits have to be claimed within six months³⁶⁹. Given that the maximum employment period under the employment permit system for foreign workers is 4 years and 10 months, workers who intend to work for this period in the Republic of Korea may lose OWWF coverage if they do not return to Sri Lanka within 2 years of their departure. These types of agreements can easily be adapted to cover migrant care workers but this would require greater formality in their recruitment and placement and greater adherence to national labour laws.

In Chile, migrants have a right to universal social protection regardless of their immigration status. Chile is a Party to ILO Convention No. 189 on Decent Work for Domestic Workers. Chile is part of Mercado Común del Sur (MERCOSUR) which fosters

free movement of people across national bordersⁱ and through which portable pension benefits have been established through bilateral agreements. Migrants who are formally employed accrue all social protection rights available to nationals. Migrants who are not working, or are informally employed, are largely confined to the solidarity pillar of the social protection system, but by law they cannot be excluded from services.

Even under more broad-based agreements, high levels of informality, particularly for private home-based care work, will frustrate attempts to ensure access to social security and pensions benefits for migrant workers. It therefore becomes critical for policy-makers to ratify and apply relevant international labour standards as well as to adopt unilateral measures to enhance migrant workers' access to social protection.

Towards transnational access to health system coverage

Similar attempts to resolve access to health care are emerging from multilateral and bilateral agreements. Low-income and middle-income countries, along with high-income countries, are now contending with the challenges of transnational social protection.

Within the EU, European migrants have rights to cross-border health care and social protection.

In the Americas, the Mexican government has extended its national health insurance to cover its migrants abroad: “family members still living in Mexico get comprehensive coverage, while people living outside the country can get their primary care at community health centers in California (and when they have a major health problem, they get their catastrophic coverage in Mexico)”³⁷⁰. Similarly, in Guatemala, a health insurance scheme is emerging whereby migrant workers pay a fee into a system organized by the IOM so that their families back home can access a specified health-care system³⁷¹.

In the Asia Pacific/ASEAN region, almost 11% of the Philippines population live or work outside the country. When they leave the country, migrant workers are required to enrol with a programme called PhilHealth. PhilHealth's reimbursable benefits are often insufficient to cover the medical costs incurred abroad³⁷². To address this concern, bilateral labour agreements are being negotiated by the Philippines authorities to ensure that all countries recruiting Filipino migrants comply with the Migrant Workers and Overseas Filipinos Act (1995) which requires overseas employers to provide the same health insurance benefits to Filipino migrant workers as are provided for their locally-hired employees. The

Indonesian government is negotiating similar bilateral agreements that include minimum standards for wages and benefits and access to health care or health insurance for Indonesians working overseas. Many comparable programmes are emerging.

An analysis of the inclusion of migrants in the universal health care systems of five ASEAN countries with diverse migration profiles concludes that all five countries, whether receiving or sending, have health-care schemes and systems that cover migrants to varying extents³⁷³. Thailand, for instance, allows undocumented migrants to opt into its Compulsory Migrant Health Insurance scheme. Malaysia and Singapore offer limited health care to migrants but have yet to determine how to fully include migrants in their government-run universal health care systems. However, all these countries “continue to face implementation challenges” and will need to improve their health-care systems substantially to ensure the full inclusion of migrants and, in particular, undocumented migrants.

Gaps to be addressed

Even in countries with universal social protection and higher rates of formal employment for migrant care workers, coverage gaps may still exist. These social protection gaps are “compounded by gender, with lack of parental benefits, maternity leave, poor access to maternal health systems and are; and heightened due

ⁱ On 30 August 2002, Brazil, which held the rotating presidency at the time, proposed a migration amnesty for MERCOSUR nationals living elsewhere in the bloc without authorization. As a result of this agreement, between 2004 and 2013, approximately 2 million South Americans obtained a temporary residence permit in one of the nine countries implementing the agreement (IOM, 2014).

to pregnancy, etc., affecting women workers specifically”³⁷⁴. Even where there are managed migration programmes with significant involvement, employers are primarily tasked with providing access to health insurance and information about access to health services. Employers, particularly those representing private households, may also act as translators, provide transportation and take workers to clinics and medical services. This is highly problematic where labour

regulations permit employers to replace sick or injured workers.

The type and quality of employment and the degree of informality are likely to affect a migrant worker’s right to social protection. Where this interacts with migration status, particularly if an individual is undocumented or irregular, it may significantly reduce any health-seeking behaviour^{375,376}.

Non-discrimination and social participation to achieve universal health coverage

National Health Policies, Strategies and Plans (NHPSPs) are critical governance mechanisms to achieve progressive realization of UHC and the right to health. The discussion above shows that there remains an imperative to redefine universal health care rights beyond the basis of citizenship and “reimagine UHC systems that transcend national borders” (Guinto et al., 2015).

States Parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966, Article 12) are legally bound to achieve “full realization of the right to health” for all (WHO Policy on Universal Health Coverage; SDG Goal 3). It also responds to General Comment No. 3 (1990) of the ICESCR which stresses the provision of “essential primary care” to all, and General Comment No. 14 (2000) which asserts that the right to health includes access to “preventive, curative and palliative health services”, specifically including “illegal [sic] immigrants”. Universal health coverage cannot be considered to have been achieved in countries where these two criteria are not met. According to the Migrant Integration Policy Index (MIPEX)ⁱ survey of 38 countries³⁷⁷ (IOM, 2016), only a handful of countries currently meet these criteria.

In terms of migrant women care workers and barriers and facilitating factors to the effective coverage with health services, the Tanahashi Framework can be useful. The Next Steps in Chapter 5 refer to this. The Tanahashi Framework (1978) can be used to identify the reasons why some subpopulations are accessing and benefiting and others not. This relates to the considerable share of health inequities that are associated with factors that lie in the remit of the health sector. The health system has a fundamental role in striving towards “leaving no one behind by ensuring that it does not contribute to, or exacerbate, inequities”. It should be designed in a way that ensures the availability, accessibility, acceptability and effective coverage with quality services and financial protections, often referred to as AAAQ. This is referred to in ICESCR General Comment No. 14.

Health systems and health policy reform figure prominently in the examples reported in the literature and underscore the need

for universal access to basic health care for migrant women care workers and their families, including care for sexual, reproductive and psychosocial health. Most examples emphasize the need to enhance health service delivery approaches in order to be more responsive to the needs and rights of migrant women care workers (e.g. non-discriminatory and responsive to gender and diversity). For instance, the eradication of discriminatory attitudes based on the stereotyping of migrant women is highlighted as fundamental to reducing barriers to access³⁷⁸. One example reviewed in the literature demonstrates how migrant care workers who are culturally and linguistically diverse can access various multicultural health programmes in Australia, including those that support mental health³⁷⁹. However, access to these programmes is limited to migrants with permanent residency status. Also important in bridging the gaps between diverse populations and health are community health workers, country commitments to migrant-inclusive and focused policies and programmes that improve access to health services for migrant workers (see Box 9), and supportive networks such as the Philippine Migrant Health Network (see Box 10).

International human rights provide a normative framework for accountability and a platform for mobilization around many aspects of development, including health, social protection, labour, migration and gender equality. International human rights principles and standards are also a cornerstone of the SDG 2030 Agenda (see Boxes 1 and 2).

The human rights approach to health is implicitly recognized in the national laws, regulations and policies of many Member States. For others, the right to health is explicit, written into constitutions and national laws, often through articles on equality and the prohibition of withholding services (e.g. on the basis of gender, age or other grounds, including migration status).

Human rights law places on all states a special obligation to prevent all internationally prohibited forms of discrimination in the provision of health care and health services, especially with respect to the core obligations created by the right to health (General Comment 14). For more on human rights, see the following section.

ⁱ See: <http://old.mipex.eu/>, accessed 25 August 2017.

Box 9. Example: the importance of community health workers in the United States of America

Approximately 120 000 community health workers (CHWs) were active in the United States of America in 2005. A significant proportion were immigrants and/or of Latin American origin or descent; 82% were women. CHWs are also known as lay health workers, outreach workers and health promoters. They work either for pay or as volunteers in connection with the local health-care system, and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. As a group, they are a bridge between

health and social services and the community, facilitating access to services and improving the quality and cultural competence of service delivery. In the United States of America, where more than 42.4 million people are immigrants (13.3% of the population), the role of CHWs in maintaining healthy migrant populations is more important now than ever before. They substantively mitigate the challenges immigrants face when seeking health care.

Sources: American Public Health Association. Community Health Workers. 2016

(<https://www.apha.org/apha-communities/member-sections/community-health-workers>, accessed September 2016).

Camarota SQ, Zeigler K. Immigrants in the United States. Washington, DC: Center for Immigration Studies; 2016.

Findley S, Matos S. Bridging the gap: how community health workers promote the health of immigrants. Oxford: Oxford University Press; 2015.

U.S. Department of Health and Human Services. Community Health Worker National Workforce Study: an annotated bibliography.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions; 2007.

Box 10. Example: the Philippine Migrant Health Network

The Philippine Migrant Health Network was created in 2014. It comprises various stakeholder agencies concerned with the advancement of migrant health. The network developed a Strategic Plan for 2016–2020, focused on increasing access to quality health-care services and strengthening the regulatory measures for health services for OFWs. An increasing focus on gender-specific issues, such as the rights of domestic workers,

is being adopted in research conducted by nongovernmental organizations such as Philippine Migrants Rights Watch, ACHIEVE and the Center for Migrant Advocacy. These NGOs collaborate with each other and advocate for OFWs' rights. The Center for Migrant Advocacy provides programmes and support in accessing critical health and other legal and migration services for migrant domestic workers.

Sources: ACHIEVE & Vrije Universiteit Medical Center Metamedical Health Care and Culture. Women and Migration: The Mental Health Nexus

A Research on Individual and Structural Determinants of Stress and Mental Health Problems of Filipino Women Migrant Domestic Workers.

Quezon City: Action for Health Initiatives; 2011.

Center for Migrant Advocacy. Activities and Events. October 2016. (<https://centerformigrantadvocacy.com/events-and-activities/>, accessed 7 October 2017).

Commission on Filipino Overseas. Highlights of the Migration and Health Meeting, October 2016.

(<http://www.cfo.gov.ph/news/cfo-news-and-events/3295-highlights-of-the-migration-and-health-network-meeting-2.html>, accessed 7 October 2017).

Philippine Migrants Rights Watch. About Us. Manila. October 2016.

(<http://www.pmrw.org.ph/p/the-philippine-migrants-rights-watch-is.html>, accessed 7 October 2017).

Reflecting the forces of discrimination prevalent in the wider society, health care settings are common environments where people can experience stigma and discrimination. Such experience is determined by a number of intersecting factors, either separately or in combination, including one's race/ethnicity, socioeconomic status, age, gender, mental health condition and sexual orientation.

Health status (e.g. person living with HIV) as well as legal and migrant status can also be sources of discrimination. Policies and programmes to promote non-discrimination across all intersecting drivers of inequalities are needed, now more than ever, to realize the right to health of this population group, and their dignity alongside other members of their community.

Migrant women and men often face discrimination, abuse and neglect. They are sometimes denied access to health care because they lack legal status in the country they have moved to, lack documentation, lack valid visas and lack health insurance. However, prevailing dominant gender norms in many places mean that migrant women bear the brunt of discrimination in many aspects of society. Migrant women also face often having to take unregulated and precarious forms of care work and experience harsh or unfair working conditions.ⁱ The evidence has shown that feelings of anxiety, fear and stigma relating to migrant status are experienced by many migrant women care workers, and can be markers of the discrimination that they regularly face at work and in their host communities.

International human and labour rights mechanisms

Robust new sources of data are needed to provide greater insight into the impact of discrimination, including the misconceptions and prejudices that ultimately damage health.

At international level, countries have adopted and ratified a number of key overarching human rights conventions and treaties. Once adopted, governments should uphold human rights through mechanisms and architecture in their national laws and policies. In addition to international and national instruments, some regional intergovernmental treaties and regulations exist but these are chiefly non-binding.

Without a doubt, an increasing proliferation of bilateral and multilateral agreements on the rights to social protection exist that define contributions and benefits for migrant workers and ensure the portability of these benefits across national borders. A number of conventions and recommendations exist that enshrine the rights of migrants to social protection in host countries.

Key conventions such as the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Familiesⁱⁱ refer to the right to social security but, as of August 2017, have been ratified only by 51 countries.

CEDAW contains several articles directly relevant to migrant workers (Article 6 on human trafficking of women and exploitation of prostitution of women, Article 9 on nationality of women and Article 15.4 on freedom of movement and domicile) including those

i According to the ILO, decent work involves opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives and equality of opportunity and treatment for all women and men (ILO, 2016)

ii See: https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-13&chapter=4&clang=_en, accessed 29 August 2017.

working in health and health care (Article 12).ⁱⁱⁱ CEDAW has also adopted General Recommendation No. 26 on Women Migrant Workers which is intended to contribute to the “fulfilment of the obligations of States Parties to respect, protect and fulfil the human rights of women migrant workers, alongside the legal obligations contained in other treaties, the commitments made under the plans of action of world conferences and the important work of migration-focused treaty bodies – especially the Committee on the Protection of the Rights of All Migrant Workers and Members of their Families.”^{iv} This Recommendation includes a number of important recommendations about the terms and conditions of employment, access to justice mechanisms and rights to organize and freely associate in host countries, as well as concerns about access to health care and health services or disproportionate exposure to health risks as a result of their labour market insertion.

Several other ILO conventions are specific to migrant workers, such as ILO Convention No. 97 on Migration for Employment, and ILO Convention No. 143 which contains supplemental provisions to alleviate the conditions that lead to the abuse of irregular labourers. Both of these conventions were put in place after the Second World War in response to the large numbers of displaced workers without rights labouring under conditions of exploitation. Similarly, ILO Convention No. 189 on Decent Work for Domestic Workers also provides guidance and stipulations for improving the terms and conditions of employment for domestic workers that can also be applied to home health-care workers.

Among the variety of human and labour rights instruments and recommendations, the ILO Recommendation on national social protection floors, adopted in June 2012,^v was ground-breaking in that it established commitments to guarantee social protection for all, workers and non-workers alike. In the view of van Ginnekan, this “constitutes an important step towards the right to social security, including social security for migrants and their families”³⁸⁰.

ILO Recommendation 204 on the formalization of informal work focuses disproportionately on access to health and other social security programmes. As van Ginnekan (2013) notes, the extent to which migrants are covered will depend on whether states have ratified the ILO and United Nations conventions on migrant workers and what they have defined in their national legislation. In most contexts in Europe, Canada and parts of Asia, health care is available for all regular and irregular migrants and, most frequently, for children³⁸¹. Yet in many contexts, even in Europe, migrants in an irregular situation do not have access to cost-free medical care except for emergency services^{382,383,384,385}.

iii See Henneby et al. (2016) for analysis of CEDAW in the context of migrant women’s rights.

iv See: http://www2.ohchr.org/english/bodies/cedaw/docs/GR_26_on_women_migrant_workers_en.pdf, accessed 29 August 2017.

v Social Protection Floors Recommendation no. 202, 2012

Replicating, strengthening and expanding the type of policy reforms outlined in this chapter will require strong political will and necessitate integrated and coherent policy-making from agencies outside the health sector that govern migration and labour policies.

Rights, accountability and participation

A human rights-based approach to health emphasizes accountability, participation and non-discrimination. The United Nations Commission on Information and Accountability for Women's and Children's Health begins with: "The health of a country's women and children is a moral, political, economic, and social imperative." When women move across national borders, this imperative remains. However, the question of which country is responsible and can be held accountable needs to be addressed by multiple stakeholders and transnationally³⁸⁶.

There is significant potential to use the SDG framework to expand claims on duty-bearers, including states, to simultaneously address health and care deficits and worker rights in labour-receiving as well as sending countries. Where goals and targets are explicitly linked to existing norms and conventions, there is the potential for claims-making by migrant women care workers themselves, and their allies, to protect the terms and conditions of employment and uphold their human rights, including their labour, health and other rights. These commitments are more likely to be upheld where the system of indicators monitoring their fulfilment includes explicit links to existing norms and conventions and treaty bodies with established mechanisms for civil society, union and private sector oversight and input. National governments and their legislatures are responsible for making the SDGs subject to democratic processes and oversight.

Women's voices and participation must be central to all actions aimed at transforming women's economic empowerment – i.e. nothing done for women without women³⁸⁷. The same must apply to UHC and SDG5.

The delinking of some of the most relevant SDGs from established conventions and treaty bodies may present a challenge for civil society oversight and ultimately for state accountability relating

to migration and care deficits. While Goal 8 has some explicit references to key conventions and norms, Goal 5 does not.

Social participation concerns the meaningful participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health. All persons and groups are entitled to active, free and meaningful participation in, contribution to and enjoyment of civil, economic, social, cultural and political development in which human rights and fundamental freedoms can be realized. Human rights law recognizes the participation of the population in all health-related decision-making at community, national and international levels³⁸⁸.

Migrant women, including care workers, already engage in local groups linked to health and social services in order to contribute their perspectives; this has been key in the formation of the International Domestic Workers Federation and with groups such as the Platform for International Cooperation on Undocumented Migrants (PICUM)ⁱ in Europe and Desis Rising Up and Moving (DRUM) in New York.^{ii,iii} This type of activism and claiming of rights should be encouraged and supported. As rights holders, migrant women's voices must be heard.

Properly facilitated and safely managed, participatory techniques such as Photo Voice³⁸⁹ and Participatory Video^{iv} can help provide much-needed data as well as empower socially excluded and invisible groups, ensuring that their perspectives are included and reach the policy-makers. These techniques can also be used to build up programmes of community-based monitoring and oversight of commitments to uphold and defend rights. This follows the recommendation of the World Humanitarian Summit which called for a "participation revolution".

Civil society organizations in sending, receiving and transit countries should be positioned and supported to take a more prominent role as leaders and to come up with solutions to problems on the ground. Where necessary, they should act as "disrupters" willing to challenge the status quo and stand up for human rights through the World Health Assembly.

The meaningful social participation of migrant women care workers is emphasized in Next Steps 2.

i See <http://picum.org/en>, accessed 20 August 2017.

ii See <http://idwdfed.org/en>, accessed 20 August 2017.

iii See <http://www.drumnyc.org/about-us/>, accessed 20 August 2017.

iv See Step 1, Chapter 5

Care work, gender and intersecting drivers of inequalities

In her analysis (2012) of migrant care work in Europe, Anderson highlights this gender dimension. She points out that the growing need for carers is not only the result of an increased number of people reaching old age with dependency needs; it is also the result of the ongoing transformation of the female role in society³⁹⁰.

As with any aspect of health and well-being, it is important to consider how gender norms, roles and relations affect what women and men are expected to do in a given society (in the household, community and workplace)³⁹¹.

Migrant women care workers are not a homogenous group and should not be treated as such. While the gendered determinants of health and other issues are important to capture, understand and address, it is necessary to consider diversity by looking beyond gender^{392,393,394,395,396,397,398}. It is increasingly recognized that an intersectionality lens is essential to comprehend fully the complexity of gender, health and migration³⁹⁹.

Intersectionality considers how gender combines and interacts with factors such as age, race, ethnicity, sexual orientation, class/ economic status and country of origin (migrant status) to shape the experiences of women migrants, including their labour choices, life circumstances, health determinants, health outcomes and care and other needs. Exploring the gender dynamics of migration in a way informed by intersectionality also includes taking into account how processes of power such as patriarchy, globalization, neoliberalism and racism shape gendered social relations and norms. These in turn determine different roles, responsibilities, opportunities, health and access to resources and services^{400,401,402}. An example from Manila illustrates this⁴⁰³:

“A university-educated Filipino lesbian woman from Manila working as a caregiver in a small town may have a different set of responses to her experiences of de-skilling, downward mobility and isolation than a rural-born Indonesian woman with elementary education and four children who works as domestic labourer ... who may be overwhelmed by an urban atmosphere, but who may have access to a larger community of support than someone working in a small town”.

A more integrated analysis of women migrant care workers is needed from the perspectives of gender, equity and human rights. In the past, these three dimensions have been treated separately for analysing different aspects of a health issue. However, an integrated analysis which looks more cohesively at the needs and experiences of a population group situated in its context will be

more comprehensive and holistic and will draw more attention to the necessary processes of transformational change.

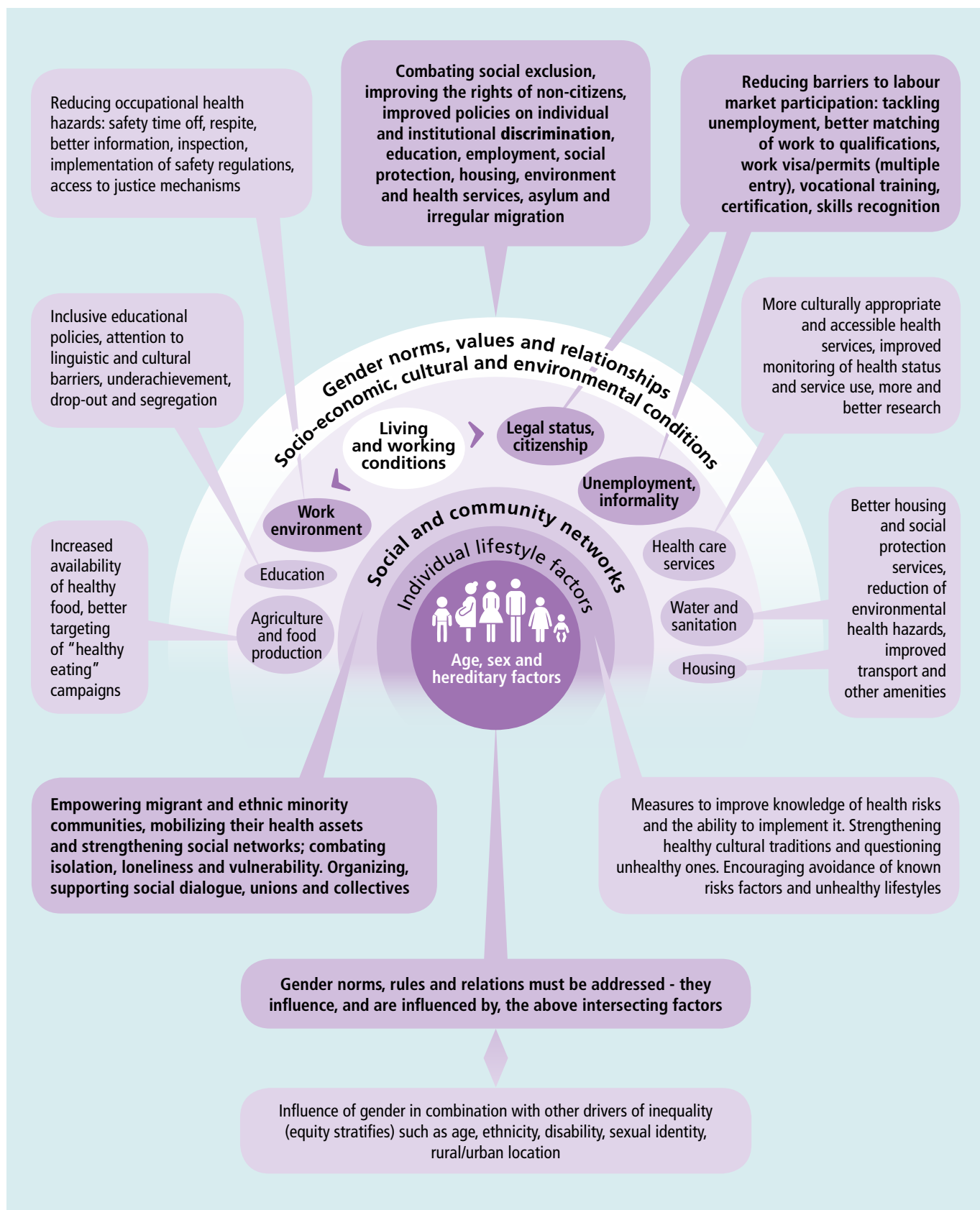
Possibly the most pressing health-related issue emerging from the literature review relates to adverse living and working conditions (and their causes, among which policies are central). In analysing the social determinants of health, researchers find that the responsibility for the lack of well-being frequently lies outside of the health sector, namely in the increase of migrant women care workers' exposure and vulnerability to risk factors for ill-health as a result of their employment or migration status. Figure 7 presents the SDH conceptual framework adapted for migrant women care workers.

The literature reviewed for this report shows the need to take account of the relationship between migration, gender, other intersections of diversity, and care work in specific contexts⁴⁰⁴. Some reports draw attention to the need to adopt a transnational and global public goods perspective. Resolving care deficits in host countries should not exacerbate care deficits in home countries. Addressing care deficits through the SDG framework in both home and host countries can mitigate some of the costs of care deficits and care drains.

Adopting a more holistic approach based on understanding the nature of care work and the particular exclusions that migrant care workers face is integral to ensuring the health and well-being of migrant women care workers, and to enhancing public health more generally.

Overall, the literature highlights the need to design service delivery to take account of the multitude of factors that affect migrant women care workers health. These factors include their living conditions, their economic situation and potential inability to afford services and medicines, their precarious situation with regard to lack of entitlements (which may deter them from seeking care at all), and their potentially limited knowledge of how to navigate the health system. Likewise, the need for integrated service delivery to respond to a range of health issues, including mental health, emerges as a priority area. This is due to migrants' accumulated vulnerability and exposure to risk factors, ranging from everyday working conditions to abuse and violence. There is a pressing need to consider migrants in decision-making on reforms leading towards UHC, and to do so in a way that ensures the primacy of human rights and global public health in entitlement decisions for both migrant women care workers and their families.

Figure 7. Social determinants of health diagram adapted for migrant women care workers



Source: WHO Regional Office for Europe, 2010 – Reference 397. The figure was elaborated for migrant health by T. Koller, with content additions from D. Ingleby, S. Gammage and M. Manandhar, and layout changes by E. Cherchi. The inner rainbow comes from Dahlgren and Whitehead, 1991

Framing transnational care work as a global public good

In view of the improvement of health through personal care work, one potential approach could be to treat transnational care work and care workers as a global public good, as noted in Chapter 1. Applying this concept appears relevant because of the role of migrant women care workers in health systems and in meeting care needs.

The concept of global public good (GPG) has been proposed as a rationale and guide for promoting global health. It can be used to identify areas in which global collective action is needed, specify where the costs and benefits will rest, and communicate to the public why spending to promote health thousands of kilometers around the world is not a waste of their tax money^{405,406}. GPGs are goods and services whose benefits cross borders and are global in scope. The scope of potential GPGs for health is wide, but can be broadly divided between:

- those which address in-country health problems and have cross-country externalities (primarily communicable disease control, but perhaps also noncommunicable disease control to the extent that it has economic effects);
- those which address the cross-border transmission of factors and goods influencing health risks (e.g. food safety, tobacco marketing and international trade in narcotics).

Within each of these categories, GPGs may then be classified in three broad areas:

1. Knowledge and technologies.
2. Policy and regulatory régimes (the collective nature of policies, whether in health or other sectors, makes them public goods).
3. Health systems act as access goods (e.g. eliminating polio depends on the existence of a functioning health system to deliver vaccines and to identify and treat cases). Health systems may thus be treated as if they were GPGs.

A recent paper estimating the additional resources needed to strengthen comprehensive health service delivery towards the attainment of SDG3 and UHC in low-income and middle-income countries reported that “a key public health concern is the shortfall of health workers in a context of global health shortage of health skills”⁴⁰⁷. The authors also state: “Health workers and infrastructure are a public necessity, not luxuries”. The same should apply to care workers – many of them migrant women – in view of the unfolding evidence base on the important role they play in promoting and protecting the health and well-being of the people they care for.

The value of care work is not only economic. The availability of personal care work to many different people also contributes to

their health and well-being, whether in sending countries or in receiving ones. Analysis of the social return on investment in care work should extend beyond GDP to include broader indicators of well-being such as Genuine Progress Indicators (GPI).ⁱ Such indicators can reveal the contribution that unpaid and paid care work make in terms of economic value and advancing health in both sending and host countries.

In terms of health improvement through personal care work, and in the context of leaving no one behind, one approach would be to treat transnational care work and care workers as a social public good, if not a GPG. In the context of this report’s focus, and taking transnational care chains and the care migrant women contribute to public health systems as a health-related GPG, the two areas of policy and regulatory regimes, as well as the nature of health systems, are relevant. This will require collective and coordinated action to be taken by governments at the international and regional, as well as national, levels. Moreover, framing care work as a social or global public good could help counter negative narratives about migrants and migration that are increasingly gaining hold in media, public and political discourse. In the case of migrant workers, including migrant women care workers, it could be argued that “only by acting together, by cooperating across borders, can problems like these [in the case of this report, the transnational care paradox] be effectively and efficiently addressed”⁴⁰⁸.

In terms of meeting the needs and fulfilling the rights of migrant women care workers, it is increasingly apparent that we have collectively been short-sighted in our policies and migration frameworks. We have also failed to understand the complex relationships between care work and global health. The 2030 Agenda, with many highly relevant SDGs, provides an opportunity for a re-framing to generate concrete policy actions as a contribution to our commitment to leaving no one behind.

The increasing global crisis in care means that the movement of women to fill care gaps and provide care for all populations is essential to global public health, health systems and well-being. However, the effects of this movement on the health of migrant women care workers and their families means it currently comes at too high a price⁴⁰⁹. The complex needs of migrant women care workers, as both recipients and providers of health care, thus require immediate recognition and action. Ensuring that their rights are upheld is also a critical task ahead.

ⁱ The GPI enables more “genuine” economic welfare of societies, making links between how populations are doing both economically and socially. It includes measurements of unpaid household work and volunteer work (UN, 2015).

Chapter 5 reiterates the commitments enshrined in Goal 5.4 of the SDGs and calls for the recognition of care work, paid and unpaid and by all types of carers, including migrants (Step 3). It is proposed that the value of care should be elevated to that of a public good to emphasize its importance to the health and well-being of individuals, the maintenance of households and families, the cushioning of care and other service provision within health systems, and its transnational dynamic.

Critical and innovative strategies, approaches and tools are needed to create more effective levers for transformative change. Migrant women must be empowered to take leadership roles across sectors, agencies and stakeholders. Many are already doing this but more need to be empowered to contribute. Migrant women care workers must themselves guide the reshaping and strengthening of global and local governance structures through collective decision-making mechanisms. Their voices must be heard and brought to the fore to provide evidence that can inform the creation of new policies and practices to better reflect the complexities of migrants' lives.

This analysis is also shaped by commitments to the principles of human rights, the Tanahashi Framework on health service coverage and evaluation, the United Nations Migration Governance Framework⁴¹⁰, the Framework of priorities and guiding principles

to promote the health of refugees and migrants (see Table 3) which was noted with appreciation by WHO Member States in Resolution WHA70.15 of the Seventieth World Health Assembly in May 2017, the concept of progressive universalism, and the 2030 SDG Agendaⁱ with its overarching goal of leaving no one behind. Table 3 summarizes the 12 priorities of the WHO migration framework, all of which are relevant to migrant women care workers.

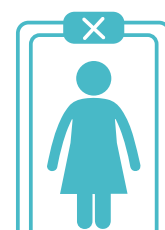
The final chapter sets out three next steps to focus coordinated action, with rationale, strategies and actions, and links to key principles (human rights), frameworks and the SDGs.

In this context, policy-makers and citizens everywhere face a global care paradox: the workers who provide essential care (largely in the wealthier cities and regions of the world) are not themselves being cared for, and their families, whether accompanying or left behind, also tend to lack essential care resources. Because of the predominantly poor working conditions and the specific emotional demands of their jobs, migrant care workers, perhaps more than other migrants, experience the pain of separation from families left behind very sharply and thus are in great need of mental health services and other types of care⁴¹¹. Meanwhile, their children, who also suffer from separation, have little access to social and mental health services⁴¹².

i See: Sustainable Development Goals (<http://www.undp.org/content/undp/en/home/sustainable-development-goals.html>, accessed 7 October 2017).

TABLE 3. The 12 priorities of the Framework of priorities and guiding principles to promote the health of refugees and migrants

1	Advocate mainstreaming refugee and migrant health in the global, regional and country agendas and contingency planning.
2	Promote refugee- and migrant-sensitive health policies, legal and social protection and programme interventions that incorporate a public health approach and that can provide equitable, affordable, and acceptable access to essential health promotion, disease prevention and high-quality services, including palliative care.
3	Enhance capacity to address the social determinants of health to ensure effective health responses and health protection in countries of origin, transit and destination.
4	Strengthen health monitoring and health information systems.
5	Accelerate progress towards achieving the SDGs, including UHC.
6	Reduce mortality and morbidity among refugees and migrants through short- and long-term public health interventions.
7	Protect and improve the health and well-being of women, children and adolescents living in refugee and migrant settings.
8	Promote continuity and quality of care.
9	Develop, reinforce and implement occupational health safety measures.
10	Promote gender equality and empower refugee and migrant women and girls through recognizing gender differences, roles, needs and related power structures among all relevant stakeholders, and mainstreaming gender into humanitarian responses and longer-term policy development and interventions. Also consider implementing the recommendations of the High-Level Commission on Health Employment and Economic Growth (2016) which call for tackling gender concerns in the health reform process and the health labour market.
11	Support measures to improve communication and counter xenophobia.
12	Strengthen partnerships, intersectoral, intercountry and interagency coordination and collaboration mechanisms.





Three next steps

“Universal health coverage is a human right, and ultimately a political choice ... it is the responsibility of every country and national government to pursue it.”

Dr. Tedros Adhanom Ghebreyesus, Director-General, WHO ⁱ

“Of the many global challenges we face, human mobility is one of the most paradoxical and misrepresented.” ⁱⁱ

António Guterres, UN Secretary-General, Remarks to United Nations General Assembly Side Event on Refugees and Migrants “follow-up to the New York Declaration: one year on”. 20 September 2017



ⁱ See: <http://who.int/mediacentre/commentaries/2017/universal-health-coverage/en/>, accessed 20 August 2017.

ⁱⁱ See: <https://www.un.org/sg/en/content/sg/speeches/2017-09-20/sgs-follow-new-york-declaration-remarks>, accessed October 6 2017



In light of the preceding analysis, this final chapter presents three next steps (see Table 4) towards meeting the health needs and related rights of migrant women care workers and their families who remain behind, being mindful of all their diversity and complexity as subpopulations.

These three steps aim to advance the building of gender-transformative and equity-focused health systems that progressively realize the right to health for migrant women care workers, particularly through achieving UHC with a focus on non-discrimination and social participation.

The steps are framed on: human rights-based approaches to health (UN ICESCR 2000, General Comment 14 on Availability, Accessibility, Acceptability and Quality); the structural social determinants of health (Figure 3); and the Tanahashi model (1978) of effective health service coverage and evaluation from both demand and supply sides (covering dimensions of availability, accessibility, acceptability, contact and utilization). Also incorporated are:

- Resolution WHA70.15 adopted at the Seventieth World Health Assembly, and the Framework of priorities and guiding principles to promote the health of refugees and migrants, and as part of continuing advocacy for migrant health to be explicitly included in the Global Compact for Safe, Orderly and Regular Migration;
- the report of the United Nations Chief Executives Board for coordination of the High Level Committee on Programmes (HLCP) at its 32nd session “Equality and non-discrimination at the heart of sustainable development – a shared framework for action”ⁱ (2016).




These three steps, and many of the strategies proposed within them, apply to all migrants and left-behind populations and not just to women migrants engaged in care work, within a holistic framework of health and social care systems which puts rights-holders at the centre.

UHC is at the centre of current efforts to strengthen health systems and improve the level and distribution of health services^{413,414}. An accompanying paper to this report provides more information⁴¹⁵. A key UHC concern related to migrant women care workers is that they should be able to access high-priority services without discrimination and/or incurring prohibitive out-of-pocket payments. Their participation in planning and monitoring services, and promoting accountability, is also important.

The evidence presented in this report has highlighted the importance of work on gender, equity, rights and non-discrimination in national and subnational health systems. It is particularly relevant to Steps 1 and 2 summarized in Table 4.

ⁱ See: CEB_2016_6_HLCP32_Add.1_CEB UN System-Wide Equality Framework-Final-as endorsed by CEB.pdf; and CEB_2016_6_HLCP32-Final-as endorsed by CEB.pdf,

Table 4. Summary of the three “next steps”

	<p>1. Generate evidence</p> <p>Build a strong equity-centred evidence base on this diverse population group across the transnational care chains (the work they do, their living and working conditions, how this affects their lives and their own health determinants and outcomes, as well as what happens to the families they leave behind in sending countries) by using:</p> <ol style="list-style-type: none"> a. mixed (quantitative and qualitative data) research methods, including barrier analysis and participatory tools; b. an intersectional and diversity lens for disaggregated data based on the underlying drivers of inequalities.
	<p>2. Improve access through non-discrimination and participation</p> <ol style="list-style-type: none"> a. Progressively realize the right to health of this population group, and contribute to UHC, through ensuring their access to all health and social services without discrimination, and regardless of their citizenship, and legal or economic status. b. Better understand, and equitably address, barriers to the health and well-being of this population group, and protect them, and the family members left behind, against health risks and vulnerabilities. c. Ensure their meaningful voice and participation in policy development, and programme planning, needs assessment, evaluation and monitoring. d. Build the capacity of this population group to enhance the health and well-being of their clients, as well as themselves and their families, and empower them in the process.
	<p>3. Value care as a public good and harmonize policies</p> <ol style="list-style-type: none"> a. Acknowledge care work as essential to health and well-being within broad health and social protection systems at global, regional, country and community levels. b. Member States and the United Nations system should use the evidence base (Step 1) to articulate explicitly the positive contribution of migrant care workers to health and well-being in public discourse, and use it to counter xenophobic narratives. c. Develop and/or strengthen agreements between sending and receiving countries and regions that help address inequitable care provision and capacities. d. Initiate and intensify intersectoral harmonization of relevant policies across government, and strengthen and fund their implementation. e. Take a whole-of-society approach by involving interagency and multistakeholder collaboration.

Step 1. Generate evidence

The New York Declaration for Refugees and Migrants calls for strengthening of health information systems and improved data collection, particularly by national authorities. Strong country information systems are needed to enable effective global monitoring of the state of migrant women care workers' health and their health determinants.

To better comprehend the lives, needs and vulnerabilities of women migrant care workers as a diverse population group, a strong and comprehensive evidence base across transnational care chains is needed. More information should be gathered on the work these women do (paid and unpaid, in the home and elsewhere, formally within the health system and informally outside but supporting health and social care systems), their living and working conditions, and how this affects their lives and their own health determinants and outcomes. Similar data should be generated on what happens to the family members, households and economies that the migrant women care workers leave behind in sending countries.

Strong equity-orientated health information systems must be developed to ensure that countries know who is being left behind in the SDGs, and to track progress towards UHC for SDG3. Equity-orientated health information systems:

- have data collection practices, databases and platforms that facilitate quantitative data disaggregation by relevant dimensions of inequality (including gender, socioeconomic status and migrant status) across a wide selection of health topics;
- have the knowledge, expertise and resources to conduct and interpret standardized analyses of health inequalities; and
- produce regular high-quality reports on the state of inequality, with data visualizations on who is being missed.

Routine databases can be used to extract quantitative data on all relevant indicators, including the intersecting drivers of inequality (see below). When necessary, new work can be commissioned and conducted. More mixed-method research and intersectional and longitudinal quantitative and qualitative data are needed on the impacts of migration on family members left behind when women (and men) migrate – including research and data on the roles of men, masculinities and changing stereotypes of caring.

WHO's assistance to countries to undertake analysis for better integration of gender, equity and rights into their work involves mixed-method evidence for equity-orientated health information systems (i.e. the collection, analysis and reporting of health data). This country support package contains elements of quantitative and qualitative data collection and analysis methods for use at country level to enhance the evidence base on health equity. The package emphasizes tools such as: (a) the Health Equity Assessment Toolkit Plus (HEAT Plus – a software application to

facilitate the assessment of within-country health inequalities); (b) Innov8 (an 8-step analytical process for reviewing national health programmes, informed by gender, equity and human rights, and supporting the operationalization of the SDGs' "leave no one behind" commitment)ⁱⁱ; and (c) a barrier analysis.ⁱⁱⁱ These tools are now being robustly tested in a number of countries to operationalize the generation of evidence for the analysis and interpretation of the situation of subpopulations – potentially including women migrant care workers – and to inform appropriate responses.

Qualitative data supplements quantitative assessments of who is being missed. Qualitative sources provide in-depth understanding of contexts, norms and values, and beliefs and practices that affect health determinants and outcomes, including care-seeking behaviours affecting access to services and ultimately to UHC. Qualitative sources are particularly powerful in explaining the differences in exposure to risk factors, access and outcomes. They can help unpack the demand-side barriers that subpopulations face, including those related to gender, and the supply-side bottlenecks that have an impact on equitable coverage.

Ensuring equitable access to the full range of health services for all migrants, regardless of their legal status, will require barrier analyses^{iv} to be conducted and interpreted and appropriate policy and programmatic responses to be developed. It is crucial to identify practical challenges in accessing services (including transport, inconvenient opening times, and administrative barriers such as documentation requirements) that may prevent migrants from obtaining access to the health care to which they are entitled. Strategies for equitably addressing barriers include:

- providing clear information about entitlements to care, and where and how to access it, across countries in transnational care chains;
- tackling differences in the health literacy of migrants, using interpreters and mediators; and
- developing tools to conceptualize, implement and monitor policies and programmes that reflect the needs and rights of care workers accessing services.

i See: Hosseinpoor A, Nambiar D, Schlotheuber A, Reidpath D, Ross Z. Health Equity Assessment Toolkit (HEAT): software for exploring and comparing health inequalities in countries. *BMC Medical Research Methodology*. 2016;16:141 (http://www.who.int/gho/health_equity/assessment_toolkit/en/), http://www.who.int/gho/health_equity/manual/en/, http://www.who.int/gho/health_equity/statistical_codes/en/, and <http://who.int/features/2017/health-equity/en/>, all accessed 25 August 2017).

ii See: <http://www.who.int/life-course/publications/innov8-technical-handbook/en/>, accessed 25 August 2017.

iii Examples include: Greece (http://www.euro.who.int/__data/assets/pdf_file/0006/287997/Barriers-and-facilitating-factors-in-access-to-health-services-in-Greece-rev1.pdf), and Moldova (http://www.euro.who.int/__data/assets/pdf_file/0018/183510/e96775-final.pdf).

iv See above.

v One example is to adapt and apply the "Carer's Compass" needs/rights approach for migrant (women) care workers (see Annex 2).

The use of participatory tools is also relevant to articulating the nuanced “lived experiences” of diverse migrant women care workers, as well as their community self-help/support groups and their families, and will bring us closer to “people-centred” systems. In addition to producing data products, participatory tools have important process outcomes such as amplifying the voices of marginalized population groups as rights-holders to policy-makers, and catalyzing community group and individual empowerment through capacity-building and direct engagement with state systems. Some examples that have been used in the area of health and/or with marginalized population groups are PhotoVoice,ⁱ Participatory Video,ⁱⁱ and Participatory Ethnographic Evaluation Research (PEER).ⁱⁱⁱ This will require partnering with community groups and networks to conduct research and community-based monitoring tools involving migrant women care workers and others. WHO is now working on the addition of adapted participatory methods to enhance meaningful social participation as part of the country support package.

Adopting an intersectional and diversity lens will help to generate disaggregated data on key drivers of inequality that intersect with migration status, gender and care work – including age, ethnicity/race, urban/rural location, disability/ability, class/caste etc.

Other types of evidence beyond health services and coverage will also need to be generated, including:

- quantification of the fiscal space related to care work looking at, for instance, expenditures, tax revenues, GDP and GPI;
- quantification of how care work migration affects care deficits from the perspectives of receiving and sending countries;

- improvement of data on remittances generated from care work, and particularly on how they are used by households and family members for health-related expenditures; and
- linking of time-series labour force and household survey data to UHC data to show relationships between care work, poverty, gender and health relationships.

Strengthening the evidence base on migrant women care workers will require coordinated multistakeholder efforts. Within government, sectors should improve and harmonize measurements and should work collaboratively and regularly across key areas (e.g. health, labour, immigration, justice/law, social welfare, education, housing etc.). Other relevant international organizations (e.g. United Nations, WHO, IOM, ILO, UNHRC,^{iv} UNDP^v etc.^{vi}), regional intergovernmental^{vii} and nongovernmental bodies, leading international nongovernmental organizations and civil society groups and networks should also be involved. The development of a harmonized information system on migrants working in the care economy will need:

- a multi-step consensus-building process among key stakeholders to harmonize efforts for: mapping data sources; developing indicators; clarifying and reviewing relevant ICSO codes; identifying good practices, gaps and priorities; and planning for the development of country capacity to analyse and interpret data;
- a regular interagency global/regional report on migrants in different areas of paid and unpaid care (and other) work;
- adequate protection protocols developed and in place to safeguard data; and
- adequate funding to implement and monitor programmes.

i The PhotoVoice methodology can be found at: <https://photovoice.org/>, accessed 25 August 2017.

ii For more information, see: <http://insightshare.org/resources/> and: <http://insightshare.org/wp-content/uploads/2017/06/Participatory-Video-C.LunchT.RobertsInsightShare.pdf>, both accessed 25 August 2017.

iii See: http://www.options.co.uk/sites/default/files/peer_article_ssm.pdf, accessed 25 August 2017.

iv UNHRC = United Nations Human Rights Council.

v UNDP = United Nations Development Programme.

vi An example of United Nations coordination is the Global Migration Group (GMG), led by UN Women, which is working on a proposal for voluntary guidelines on the treatment of migrants in vulnerable situations.

vii Such as the African Union, Association of South East Asian Nations, Council of Europe, European Union, Organisation for Economic Co-operation and Development, Organization of American States and South Asia Association of Regional Collaboration.

Step 2. Improve access through non-discrimination and participation

In many parts of the world, “we are witnessing, with great concern, increasingly xenophobic and racist responses to refugees and migrants”, according to the New York Declaration. This health-damaging hostility needs to be counteracted immediately, including by addressing the interacting forms of discrimination faced by migrant women carers and other groups. Patriarchy, homophobia and ableism (discrimination in favour of “able-bodied” persons) should be explicitly recognized as important systems of power that interact with xenophobia and racism.

In this context, Member States should work across sectors to realize the right to health of this population group as rights-holders, and contribute to UHC through ensuring access to all health and social services without discrimination and regardless of their citizenship, and legal or socioeconomic status.

This will require coverage of, and access to, the full range of quality and affordable primary and emergency health services for migrants, including care workers, ensuring continuity of care and unimpeded access to diagnostic and preventive services. This should be backed by mainstreaming diversity-sensitive approaches in health-service delivery and avoiding “treatment ghettos” for migrants detached from regular health systems. Where appropriate, small, targeted units to access specific groups (e.g. migrant women in care work) could be considered.

Standards for diversity-sensitive care should be developed and complied with, including allowing migrant patients to have effective access to complaint procedures. This requires recognition of the diversity of migrant populations in terms of gender, social situation, financial and educational resources, language proficiency, cultural background, work or domestic situation, specific vulnerabilities, etc.

It will be important to strengthen protection of the human rights of migrant women care workers, to respect their dignity and to ensure their health and the health of their families and communities. This will require evaluation of the extent to which Member States comply with human rights commitments and laws relating to the right to health, including via universal periodic review (UPR). An example in the European Region is the Migration Integration Policy Index (MIPEX).ⁱ

Member States should initiate, strengthen and implement effective anti-discrimination campaigns addressing the experiences of migrant women care workers. Evidence shows that, although certain attitudes may be persistent across population subgroups, they can be shifted⁴¹⁶.

i See: <http://www.mipex.eu/>, accessed 25 August 2017.

Strategies can include:

- developing global, regional and national anti-discrimination campaigns around migrants involved in health and well-being, integrating gender, equity and human rights and ensuring that they act as platforms for future health and social change;ⁱⁱ
- monitoring and addressing different forms of discrimination faced by migrant populations, including during interactions with health services (overt and inadvertent forms of discrimination, perpetuated by both individuals and institutional structures);
- sharing of practical guidance and indicators by WHO and other international organizations with persons seeking to better address intersecting forms of discrimination;
- urgent ratification by States, and in particular receiving States, of the International Convention on the Protection of Migrant Workers and their Family (ICRMW) and ILO Conventions Nos. 143 and 189, to address the marginalization and discrimination of care workers – particularly irregular migrants, women and girls – through a General Comment (regional/subregional organizations should ensure full application of the provisions therein); and
- application of ratified basic conventions to the situation of migrant women care workers and reminding States Parties about their existing obligations to this vulnerable category to be addressed by the ILO Committee of Experts on the Application of Conventions and Regulations.

To implement UHC in an equitable health system, it will be important to ensure that migrants, including migrant women care workers, participate and have a meaningful voice. This can be done by developing mechanisms to involve migrants in participatory research and data collection (see examples in Next Step 1), as well as needs assessments, development of solutions to issues raised in barrier analyses, outreach activities, training, community-based monitoring and services evaluation. Involvement can be at individual or group levels and can be linked to opportunities for employment, education, societal engagement, empowerment and advocacy,ⁱⁱⁱ through:

- establishing and/or supporting and connecting community social groups/networks/spaces for migrant women care

ii Include goals and timelines based on evidence-based effective components (e.g. involving different audiences, combating false beliefs derived from news coverage and social media, invoking empathy, focusing on attitude and behaviour changes, meeting local needs and various forms of discrimination faced by migrant populations, evaluation, and considering the country context to alleviate fears about loss of identity, culture and economic insecurity among receiving-country nationals. See: Pedersen A, Attwell J, Heveli D. 2005. Prediction of negative attitudes towards Australian asylum seekers: false beliefs, nationalism and self-esteem. *Australian Journal of Psychology*; 57(3):148-160

iii Example from Germany: the “With Migrants for Migrants” programme recruits, trains and supports migrants to become cultural mediators who help other migrants to navigate the German health system.

workers that foster learning, expression/voice, sociopolitical cohesion and well-being, exchange (e.g. of health information and resources), collective decision-making and mobilizing funds and actions;

- supporting resource centres to provide migrant women care workers with legal and health support in sending, transit and destination countries, as well during reintegration on their return home (in the resource centres, there can be host counselling and meetings of self-help and financial planning groups, encouraging social interaction); and
- providing, or connecting women migrants with ongoing skills development, vocational training, opportunities for upskilling, basic skills (e.g. first aid, occupational safety for domestic workers) and progressively advanced training.

As noted in Chapter 1, implementing the 2030 Agenda requires policy integration and improved coherence and complementarity, within and across policy domains and consistent with a whole-of-society approach. Relevant government sectors (including health, labour/employment, social protection, law, education and housing) should come together to design, implement and monitor interventions, develop knowledge and expertise, and become advocates for change. Health ministries can play a leadership role

in liaising with other sectors and building broad alliances to ensure that harmonized cross-government policies and programmes are developed. Multistakeholder partnerships of government agencies, civil society, businesses and local communities also need to work together to create effective legal and institutional frameworks and sustainable mechanisms that support migrant families and their children in whichever part of the transnational care chain they live.

Much of the literature, and most national policies dealing with the (im)migration of women care workers, view them primarily from the perspective of the care needs of receiving countries (e.g. Colombo, 2011). More attention is needed to the care and health needs, and associated rights, of those left behind in sending countries who are still largely invisible and ignored. These people often face minimal access to quality health care because of poverty, lower levels of welfare state development, and the brain drain of medical professionals from their countries. They are also deprived of the care of a family member (or members) who has migrated as a result of the care drain. The health status (including the mental health status) of families left behind must be factored into the global calculus of care needs. This will impede progress towards the SDGs in those sending countries, including through UHC.



Step 3. Value care as a public good and harmonize policies

In our increasingly globalized world, health improvement requires collective as well as individual action, and international as well as national policies, strategies and regulatory frameworks. This report has focused on transforming the rights and health of women migrant care workers who contribute to health systems, household labour and social cohesion in many ways.

Few gender-sensitive policies exist that enable women to integrate their social, biological and occupational roles, function to their full capacity and realise their fundamental human rights⁴¹⁸.

The situation presented in this report is that personal care work is undervalued across the world. This now needs to be explicitly recognized as essential labour that promotes global public health. Personal care work is an essential resource that supports health systems, resolves deficits and inequalities in health-care provision, and promotes and supports individual and collective well-being. All forms of care work, particularly unpaid and domestic forms of care, should be seen as foundational to the economic and social development of societies, thus requiring that the health and well-being of care workers needs to be promoted and protected. This is particularly relevant in the context of the global shortfall of health workers and the high level of investment needed to address the financing gap.

Members States, the United Nations system and key gatekeepers of public opinion are urged to use the evidence base to articulate explicitly in public discourse the positive contribution made by migrant women care workers to health and well-being, and to counter xenophobic narratives directly. They should enhance the public's and policy-makers' understanding of the value of care work to the wider society, economies and health systems, as well as the need to improve living and working conditions, employment opportunities and skills training for all care workers, including migrant care workers. Receiving countries/regions should acknowledge and address the social, psychological and economic costs (including care deficits) that sending regions incur as a result of out-migration of women who become paid caregivers abroad.

Mindful of the disproportionately substantial role that women play in all aspects of care work, advocacy is needed for a more equal distribution of care responsibilities in households and societies, with policies that support this followed up by programmatic implementation. More attention must also be paid to building and enhancing care workers' participation, capacities and resilience. This requires the incorporation of programmatic elements to strengthen health-promoting assets in communities, support health-supporting traditions and build social and intergenerational cohesion⁴¹⁷.

Cross-government collaboration is needed to harmonize policies to reduce the social exclusion faced by many care workers, including migrant women care workers. Intersectoral efforts are needed to address the contractual conditions of women migrant care workers, enabling them to communicate and connect regularly with their families (e.g. access to and adequate time for phone calls and Internet, paid vacations, air fares or other transportation costs for annual visits home). National immigration regimes should allow care workers to enter and exit the country legally, with no risk of losing employment, and should ideally provide a path to citizenship for migrant care workers and their dependents. Investment should be increased in physical and social infrastructure and the public provision of quality child care, education and care for older disabled and chronically sick people, including palliative and long-term care.

Key stakeholders in global health governance should ensure that initiatives include organizations and groups that deal with issues related to care work migration while promoting gender, equity, human rights and the Leave No One Behind agenda of the SDGs.ⁱ Strategies for this include:

- establishment of an international gender-balanced platform on health-worker mobility (proposed in the WHO High-Level Commission Report, with ILO, IOM and OECD), ILO conventions, and the WHO Global Code of Practice on the International Recruitment of Health Personnelⁱⁱ, with a view to collaborating for mutual benefit between origin and destination countries and maximizing the benefits of health worker mobility while minimizing its disadvantages;
- adherence to the WHO Global Code of Practice on the International Recruitment of Health Personnel for all migrant care workers, with efforts to prioritize attention to gender, equity and human rights concerns, particularly in the distribution of care workers from (and in) underserved communities;
- formation of codevelopment partnerships between sending and receiving countries, with appropriate redistribution of economic and other resources,ⁱⁱⁱ and pursuit of bilateral and regional initiatives to ensure transnational basic social protection for all migrant women care workers across countries through the establishment and maintenance of social protection floors (i.e. ILO Social Protection Floors Recommendation, No. 202) – as for all workers regardless of sex, nationality, race, employment

i For instance: Caritas International, Women in Migration Network: Platform for International Cooperation on Undocumented Migrants: Global Migration Group (GMG).

ii See page 28, Box 2

iii As an example, in the case of Ecuador as a sending country, the receiving country would be Spain.

status or migration status – and establishment of an interagency working groupⁱ to guide countries in building comprehensive social protection systems for mobile and diverse populations;ⁱⁱ

- use of the ILOs Fair Recruitment Initiative (developed with GMG, social partners and stakeholders) to inform efforts to address gaps in regulation and enforcement and to promote standard-based recruitment practices, including in workers' organizations.ⁱⁱⁱ

Ultimately the global and national health leadership needs to foster the interconnected collaboration of government agencies, civil society, business and local communities to work together to ensure that migrant women care workers (and other migrants and marginalized groups) are not left behind by the sustainable development process. The health system needs to play its part in creating and supporting effective legal and institutional frameworks, a non-discriminatory and inclusive environment, and employment opportunities with safe and decent working conditions. As part of efforts to achieve UHC, the health sector must work to build sustainable mechanisms across health systems – with strong links to social protection – to support migrant women care workers and their family members. The transnational nature of care should be considered a public good that provides benefits across borders, is global in scope and warrants recognition, value and a framework for collective action.

The status of migrant women care workers needs to be understood in both receiving and sending countries; they are both providers and consumers of health and social care in both home and host countries. It is critical that governments and health systems recognize the value of the contributions of migrant women care workers and meet their own obligations as duty-bearers to these workers.

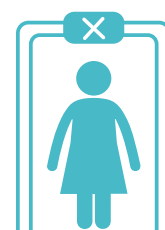
An important recent Commission in the journal, the *Lancet*, emphasised women's contribution in the health care work force, and their crucial roles in the health care of families and communities⁴¹⁹. This is described as driving the wealth and health of nations. However, this still goes underappreciated. Analysing data from 32 countries (accounting for 52% of the world's population), the authors estimated that the financial value of women's contributions in the health system in 2010 was 2.35% of global gross domestic product (GDP) for unpaid work and 2.47% for paid work – the equivalent of US\$3.052 trillion.

Governments are urged to recognize and support paid and unpaid care work, to protect migrant women care workers against rights violations, and to promote international, regional and country action to ensure access to health for all in an ethical and transparent governance model. Without such political leadership and vision, accompanied by robust evidence, strategies and tools for promoting intersectoral action, and the empowerment of migrant women themselves, we will not sustain change.

i The interagency group should involve ILO, UNICEF and WHO.

ii An example would be the multilateral binding agreement among ASEAN Member States on taxation options for migrants and their dependents to entitle them to "citizen-equivalent" social benefits in their host country.

iii Examples could be the International Domestic Workers Federation (IDWF) and the International Trade Union Confederation (ITUC).



References

- 1 Bachelet M. Gender and migration: care workers at the interface of migration and development. Address by UN Women Executive Director Michelle Bachelet at the event “Gender and Migration: Care Workers at the Interface of Migration and Development” during the Fourth United Nations Conference on the Least Developed Countries (LDC-IV), Istanbul, 11 May 2011 (<http://www.unwomen.org/en/news/stories/2011/5/gender-and-migration-care-workers-at-the-interface-of-migration-and-development>, accessed 20 August 2017).
- 2 A world on the move. IOM’s 65th anniversary. Geneva: International Organization for Migration; 2016 (<https://www.iom.int/65th>, accessed 20 August 2017).
- 3 International Migration 2015 (Wall chart). New York (NY): United Nations, Department of Economic and Social Affairs; 2015 (<http://bit.ly/1O8Z98W>, accessed 20 August 2017).
- 4 O’Neil T, Fleury A, Foresti M. Women on the move: migration, gender equality and the 2030 Agenda for Sustainable Development. ODI Briefing. London: Overseas Development Institute; 2016.
- 5 Barragan E, Dhavan P, Fortier JP, Mosca D, Weekers J, Wickramage KP. Migration and health in the sustainable development goals. In: Migration in the 2030 Agenda. Geneva: International Organization for Migration; 2017:39–57.
- 6 World Development Report, 2012. Washington (DC). The World Bank.
- 7 Samman E., Presler-Marshall E, Jones N. Women’s Work, Mothers, children and the global childcare crisis. London: Overseas Development Institute; 2016.
- 8 Gammage S, Stevanovic N. Gender, migration and work and care deficits. UN Women. Background Paper for Expert Group Meeting, Sixty-first session of the Commission on the Status of Women, November 2016.
- 9 Gammage S, Stevanovic N, 2016. See Reference 8.
- 10 Spencer S, Martin S, Bourgeault I, O’Shea E. The role of migrant care workers in aging societies. Report on research findings in the United Kingdom, Ireland, Canada and the United States. IOM migration research series No. 41. Geneva: International Organization for Migration; 2010 (<http://publications.iom.int/books/mrs-ndeg41-role-migrant-care-workers-ageing-societies>, accessed 20 August 2017).
- 11 Barragan E et al., 2017. See Reference 5.
- 12 Harman S. Ebola, gender and conspicuously invisible women in global health governance. *Third World Q.* 2016;37(3):524–41.
- 13 Kofman E, Raghuram P. Gendered migrations and global social reproduction. Basingstoke: Palgrave Macmillan; 2015.
- 14 Lutz H, Palenga-Möllenbeck E. Care work migration in Germany: semi-compliance and complicity. *Soc Pol Soc.*, themed issue on “Domestic and care work at the intersection of welfare, gender and migration regimes: some European experiences”. 2010(3):419–30.
- 15 Hildegard T. Care workers with migration backgrounds in formal care services in Germany: a multi-level intersectional analysis. *Int J Care Caring.* 2017;1(2):191–207. doi:10.1332/239788217X14944099147786.
- 16 Brown BB. The impact of male labour migration on women in Botswana. *African Affairs.* 1983;2(328):367–88.
- 17 Haile AG, Siegmann KA. Masculinity at work: intersectionality and identity constructions of migrant domestic workers in the Netherlands. In: Truong T-D, Gasper D, Handmaker J, Bergh SI, editors. *Migration, Gender and Social Justice.* Berlin: Springer; 2014:105–19.
- 18 Manalansan IV MF. Queering the chain of care paradigm. *The Scholar and Feminist Online.* 2008;3:1–5.
- 19 Dumitru S. From “brain drain” to “care drain”: women’s labor migration and methodological sexism. *Womens Stud Int Forum.* 2014;47(Part B):203–12.
- 20 Gallo E, Scrinzi F. Migration, masculinities and reproductive labor: men of the home. New York (NY): Palgrave Macmillan; 2016.

- 21 Christensen K, Guldvik I. Migrant care workers' lived experiences in the UK and Norway. Report of the research project: Welfare policy and care work: cross-national Norwegian/UK study of migrants in care work. London: Kings College London; 2013 (<https://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2013/reports/Christensen-and-Guldvik-2013-Migrant-care-workers.pdf>, accessed 28 August 2017).
- 22 Haile AG, Siegmann KA, 2014. See Reference 17.
- 23 UN Secretary General's High Level Panel on Women's Economic Empowerment: second report. New York (NY): United Nations; 2017 (www.womensEconomicEmpowerment.org, accessed 20 August 2017).
- 24 Hankivsky O, Grace D, Hunting G, Giesbrecht M, Fridkin A, Rudrum S, et al. An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *Int J Equity Health*. 2014;13:119 (<http://bit.ly/2riKSQo>, accessed 20 August 2017).
- 25 De Jong S. Intersectional global citizenship: gendered and racialized renderings. *Politics, Groups, and Identities*. 2013;1(3):402–16.
- 26 De Jong S. Female migrants as “mediators between two worlds”: spatio-temporal articulations of intersectional positions. *Journal of Diversity and Gender Studies*. 2015;2(12):111–26.
- 27 Mahon R, Michel S. Out of focus: migrant women caregivers as seen by the ILO and the OECD. In: Michel S, Peng I, editors, *Gender, migration and the work of care: a multi-scalar approach to the Pacific rim*. New York (NY): Palgrave Macmillan; 2017.
- 28 Jayasuriya R, Opeskin B. The migration of women domestic workers from Sri Lanka: protecting the rights of children left behind. *Cornell International Law Journal*. 2015;48:101–71.
- 29 Colombo F. *Help Wanted? Providing and paying for long-term care*. Paris: Organization for Economic Co-operation and Development; 2011.
- 30 *World Report on Ageing and Health*. Geneva: World Health Organization; 2015 (<http://www.who.int/ageing/publications/world-report-2015/en/>, accessed 20 August 2017).
- 31 Scheil-Adlung X. Long-term care protection for older persons: a review of coverage deficits in 46 countries. *Extension of Social Security, Working Paper 50*. Geneva: International Labour Organization; 2015.
- 32 Czaika M, De Haas H. The globalization of migration: has the world become more migratory? *Int Migr Rev*. 2014;48:283–323. doi:10.1111/imre.12095 (2014:299).
- 33 UN DESA, 2015. See Reference 3.
- 34 Scheil-Adlung X, 2015. See Reference 31.
- 35 Scheil-Adlung X, 2015. See Reference 31.
- 36 Lamura G, Chiatti C, Barbabella F, Di Rosa M. Migrant long-term care work in the European Union: opportunities, challenges and main policy options. Paper presented at the Conference on Filling the Gap in Long-term Professional Care Through Systematic Migration Policies, Geneva, 23–24 October 2013. Luxembourg: European Union; 2014. https://www.researchgate.net/publication/258859028_Migrant_long-term_care_work_in_the_European_Union_Opportunities_challenges_and_main_policy_options
- 37 UN Secretary General's High Level Panel on Women's Economic Empowerment, 2017. New York. See Reference 23.
- 38 Czaika M, de Haas H. See Reference 32.
- 39 *Closing the gap in a generation: health equity through action on the social determinants of health: final report of the Commission on Social Determinants of Health*. Geneva: World Health Organization; 2008.
- 40 Bachelet M, 2011. See Reference 1.
- 41 *Domestic workers across the world: global and regional statistics and the extent of legal protection*. Geneva: International Labour Organization; 2013 (http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_173363.pdf, accessed 20 August 2017).
- 42 Budlender D. The statistical evidence on care and non-care work across six countries. *Gender and Development Programme Paper No. 4*. Geneva: United Nations Research Institute for Social Development; 2008.
- 43 Razavi S, Staab S. *Global variations in the political and social economy of care – worlds apart?* New York (NY): Routledge; 2010:1 – 28.
- 44 Duffy M. Reproducing labor inequalities: challenges for feminists conceptualizing care at the intersections of gender, race, and class. *Gend Soc*. 2005;19(1):66–82.
- 45 Smith RD. Global public goods and health. *Bull World Health Org*. 2003;81(7).
- 46 Smith RD, MacKellar L. Global public goods and the global health agenda: problems, priorities and potential. *Global Health*. 2007;3(9). doi:10.1186/1744-8603-3-9.

- 47 Lutz H. *The new maids: transnational women and the care economy*. London: Zed Books; 2011.
- 48 Hennebry J, Williams K, Walton-Roberts M. *Women working worldwide: a situational analysis of women migrant workers*. New York (NY): UN Women; 2016.
- 49 Hennebry J, McLaughlin J, Preibisch K. Out of the loop: (in) access to health care for migrant workers in Canada. *JIMI*. 2016;17(2):521–38.
- 50 Hennebry J, Holliday J, Moniruzzaman M. *At what cost? Women migrant workers, remittances and development*. New York (NY): UN Women; 2017 (<http://www.unwomen.org/en/digital-library/publications#sthash.BU2TBE1H.dpuf>, accessed 20 August 2017).
- 51 *Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage*. Geneva: World Health Organization; 2014.
- 52 Pan American Health Organization. *Strategy for universal access to health and universal health coverage*. 66th Session of the Regional Committee of WHO for the Americas. CD53/5, Rev 2. 2 October 2014.
- 53 *Beyond the barriers: framing evidence on health system strengthening to improve the health of migrants experiencing poverty and social exclusion*. Geneva: World Health Organization; (forthcoming).
- 54 Barragan E et al., 2017. See Reference 5.
- 55 Girard L. *Achieving gender equality through migration governance opportunities and solutions in support of the sustainable development agenda*. In: *Migration in the 2030 Agenda*. Geneva: International Organization for Migration; 2017:59–69.
- 56 *Working for health and growth: investing in the health workforce*. Report of the High Level Commission on Health, Employment and Economic Growth. Geneva: World Health Organization; 2016.
- 57 *Migration and remittances: recent developments and outlook*. Special topic: Global Compact on Migration, Migration and Development, Brief 27. Washington (DC): The World Bank; 2017.
- 58 Amrith M. *The invisible labour of female migrants in the care sector*. Policy Report, No. 03/06. Barcelona: United Nations University Institute on Globalization, Culture and Mobility; 2015.
- 59 Benería L, Deere CD, Kabeer N. *Gender and international migration: globalization, development, and governance*. *Fem Econ*. 2012;18(2):1–34.
- 60 Michel S, Peng I. *All in the family? Migrants, nationhood, and care regimes in Asia and North America*. *J Eur Soc Policy*. 2012;22:406–18.
- 61 Triandafyllidou A, editor. *Irregular migrant domestic workers in Europe: Who cares?* Farnham: Ashgate; 2013.
- 62 Williams F. *Claiming and framing in the making of care policies. The recognition and redistribution of care*. Geneva: United Nations Research Institute for Social Development; 2010.
- 63 Yeates N. *The globalisation of paid care labour migration: policy issues, approaches and responses*. *International Labour Review*. 2010;149(4):423–40.
- 64 *Domestic workers across the world: global and regional statistics and the extent of legal protection*. Geneva: International Labour Organization; 2015.
- 65 *ILO global estimates on migrant workers: results and methodology: Special focus on migrant domestic workers*. 2015. Geneva: International Labour Organization; 2015 (http://www.ilo.org/wcmsp5/groups/public/---dgreports/-dcomm/documents/publication/wcms_436343.pdf; accessed 21 August 2017).
- 66 Colombo F, 2016. See Reference 29.
- 67 ILO, 2015. See Reference 65.
- 68 ILO, 2015. See Reference 65.
- 69 *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966. Geneva: United Nations Office of the High Commissioner for Human Rights.
- 70 Arizpe L. *Mexican agricultural development policy and its impact on rural women*. *Migration, women and social development*. Berlin: Springer; 2014:96–113..
- 71 Donato KM, Gabaccia D. *Gender and international migration*. New York (NY): Russell Sage Foundation; 2015.
- 72 *The female face of migration. Advocacy and best practices for women who migrate and the families they leave behind*. Vatican City State: Caritas Internationalis; 2012.
- 73 Gammage S, Stevanovic N, 2016. See Reference 8.
- 74 Curran SR, Saguy AC. *Migration and cultural change: a role for gender and social networks?* *J Int Womens Stud*. 2013;2(3):54–77.
- 75 Francisco V, Magalit Rodriguez R. *Countertopographies of migrant women: transnational families, space, and labor as solidarity*. *WorkingUSA*. 2014;17(3):357–72.
- 76 Jayaweera H, Shlala EH. *Access to healthcare, insurance provision and health status of Sri Lankan migrant domestic workers*. Colombo: Centre for Women’s Research; 2015.

- 77 Yeates N. Globalising care economies and migrant workers: explorations in global care chains. Basingstoke: Palgrave Macmillan; 2009.
- 78 Spitzer DL, Piper N. Retrenched and returned: Filipino migrant workers during times of crisis. *Sociology*. 2014;48(5):1007–23.
- 79 Bartha A, Fedyuk O, Zentai V. Low-skilled migration: immigrant workers in European domestic care. In: Beblavy M, Maselli I, Veselkova M, editors. *Green, Pink, or Silver II. The future of labor in Europe*. Brussels: Center for European Policy Studies; 2015;237–57.
- 80 Carrasco LN. Transnational family life among Peruvian migrants in Chile: multiple commitments and the role of social remittances. *J Comp Fam Stud*. 2016;31(2):187–204.
- 81 Global AgeWatch Index 2015. Insight report. London: HelpAge International; 2015.
- 82 Long-term care, website. Paris: Organisation for Economic Co-operation and Development (<http://www.oecd.org/els/health-systems/long-term-care.htm>, accessed 21 August 2017).
- 83 Muir T. Measuring social protection for long-term care. *Health Working Papers*, No. 93. Paris: Organisation for Economic Co-operation and Development; 2015 (<http://dx.doi.org/10.1787/a411500a-en>, accessed 21 August 2017).
- 84 Scheil-Adlung X, 2015. See Reference 31.
- 85 Muir T, 2015. See Reference 83.
- 86 Spotlight Berlin: illegal immigrants and the health care dilemma. *Deutsche Welle (Germany)*, 26 February 2009 (<http://www.dw.com/en/spotlight-berlin-illegal-immigrants-and-the-health-care-dilemma/a-4056861>, accessed 21 August 2017).
- 87 Michel S, Peng I, 2012. See Reference 60.
- 88 Liu B, Zhang Y, Li Y. Reconciling work and family: issues and policies in China. *Conditions of Work and Employment Series*, No. 22. Geneva: International Labour Office; 2009 (http://www.ilo.org/beijing/what-we-do/publications/WCMS_141729/lang-en/index.htm, accessed 21 August 2017).
- 89 Ehrenreich B, Hochschild AR. *Global woman: nannies, maids, and sex workers in the new economy*. New York (NY): Macmillan; 2003.
- 90 Hondagneu-Sotelo P, Avila E. “Here, but I’m there”: the meanings of Latina transnational motherhood. *Gend Soc*. 1997;11(5):548–71.
- 91 Yeates N, 2009. See Reference 77.
- 92 Yeates N. Bringing gendered transnational labourers and households into commodity chain analysis: a global care chains perspective. Paper presented to the Colloquium on Gender, Households, and Global Commodity Chains, Binghamton, New York, 14–15 October 2011.
- 93 Yeates N. Global care chains: a state-of-the-art review and future directions in care transnationalization research. *Global Networks*. 2012;12(2):135–54.
- 94 Samman E, Presler-Marshall E, Jones N, 2016. See Reference 7.
- 95 Folbre N. Valuing care. In: Folbre N, editor. *For love and money: care provision in the United States*. New York (NY): Russell Sage Foundation; 2012.
- 96 Folbre N. *The invisible heart economics and family values*. New York (NY): The New Press; 2002.
- 97 Folbre N. “Holding hands at midnight”: the paradox of caring labour. *Fem Econ*. 1995;1(1):73–92.
- 98 Picchio A, editor. *Unpaid work and the economy: a gender analysis of the standards of living*. New York (NY): Routledge Frontiers of Political Economy; 2006.
- 99 Girard L, 2017. See Reference 55.
- 100 Civil society defies a hostile climate to help Gulf migrants. In: *Migrant-Rights [website]*, 2015 (<https://www.migrant-rights.org/2015/08/civil-society-defies-a-hostile-climate-to-help-gulf-migrants/>, accessed 21 August 2017).
- 101 Mapping of resources in host and origin countries, including NGOs, helplines and rights-based organizations. In: *Migrant-Rights [website]*, 2015 (<https://www.migrant-rights.org/resources/>, accessed 21 August 2017).
- 102 Mather C. “Yes, we did it!” How the world’s domestic workers won their international rights and recognition. Cambridge (MA): *Women in Informal Employment: Globalizing and Organizing*; 2013.
- 103 Hondagneu-Sotelo P, Avila E, 1997. See Reference 90.
- 104 Hewett H. Mothering across borders: narratives of immigrant mothers in the United States. *Womens Stud Q*. 2009;37(3/4):121–39.
- 105 Girard L, 2017. See Reference 99.
- 106 Findley S, Matos S. *Bridging the gap: how community health workers promote the health of immigrants*. Oxford: Oxford University Press; 2015.
- 107 Domestic workers organizing [website]. Cambridge (MA): *Women in Informal Employment: Globalizing and Organizing* (<http://wiego.org/organizing/domestic-workers-organizing>, accessed 21 August 2017).

- 108 Cranford C, Chun JJ. Immigrant women and home-based elder care in Oakland, California's Chinatown. In: Michel S, Peng I, editors, *Gender, migration and the work of care: a multi-scalar approach to the Pacific rim*. New York (NY): Palgrave Macmillan; 2017.
- 109 Boris E, Undén M. The intimate knows no boundaries: global circuits of domestic worker organizing. In: Michel S, Peng I, editors, *Gender, migration and the work of care: a multi-scalar approach to the Pacific rim*. New York (NY): Palgrave Macmillan; 2017.
- 110 Boris E, Fish J. "Slaves no more": Making global labour standards for domestic workers. *Feminist Studies*. 2014;40(2):411–43.
- 111 Boris E, Undén M, 2017. See Reference 109.
- 112 Ratifications of C189 – Domestic Workers Convention, 2011 (No. 189). Geneva: International Labour Organization (http://www.ilo.org/dyn/normlex/en/f?p=1000:11300:0::N O:11300:P11300_INSTRUMENT_ID:2551460, accessed 21 August 2017).
- 113 Chun JJ. Building political agency and movement leadership: the grassroots organizing model of Asian immigrant women advocates. *Citizenship Studies*. 2016;20:379–95.
- 114 Chun JJ, Cranford C. From sweatshops to homes: how immigrant women became paid care workers in Oakland, California's Chinatown. Presentation at international workshop on The Global Migration of Gendered Care Work, University of Vienna, Austria, 5 July 2016.
- 115 Cranford C. Toward particularism with security: immigration, race and the organization of personal support services in Los Angeles. In: Romero M, Preston V, Giles W, editors. *When care work goes global: locating the social relations of domestic work*. Farnham: Ashgate; 2013:226.
- 116 Commission on Filipinos Overseas. Highlights of the migration and health meeting, October 2016. Press release (<http://www.cfo.gov.ph/news/cfo-news-and-events/3295-highlights-of-the-migration-and-health-network-meeting-2.html>, accessed 21 August 2017).
- 117 Kontos M, Shinozaki K, Morokvasic M, Catarino C, Satola A. Migrant domestic and care workers. In: Kontos M, editor. *Integration of female immigrants in labour market and society: a comparative analysis. Summary, results and recommendations*. EU Project: Integration of Female Immigrants in Labour Market and Society. Frankfurt: Goethe University; 2009.
- 118 Van Walsum S. International migrant domestic workers, national welfare states and transnational social security arrangements. In: Meghani Z, editor. *Women migrant workers, ethical, political and legal problems*. New York (NY) and London: Routledge; 2016:131–53.
- 119 Triandafyllidou A, 2013. See Reference 61.
- 120 Meghani Z. Trapped in a web of immigration and employment laws: female undocumented home health workers in the US. In: Meghani Z, editor. *Women migrant workers, ethical, political and legal problems*. New York (NY) and London: Routledge; 2016:24–53.
- 121 Foreign-born health-care workers in the United States. Washington (DC): Migration Policy Institute; 2007 (<http://www.migrationpolicy.org/article/foreign-born-health-care-workers-united-states-o>, accessed 21 August 2017).
- 122 Castañeda X, Ruelas MR, Felt E, Schenker M. Health of migrants: working towards a better future. *Infectious disease clinics of North America*. 2011;25(2):421–33.
- 123 Castañeda X, Rodriguez-Lainz A. Studying migrant populations. In: Schenker MB, Castañeda X, Rodriguez-Lainz A, editors. *Migration and health: a research methods handbook*. Oakland (CA): University of California Press; 2014.
- 124 Salami B, Oluwakemi A, Okeke-Ihejirika P. Migrant nurses and care workers' rights in Canada. Working Paper 2016-9. UNRISD, Geneva; 2016. [http://www.unrisd.org/80256B3C005BCCF9/httpNetITFramePDF?ReadForm&parentunid=7EEBA6386981AC8FC125800B00295658&parentdoctype=paper&netitpath=80256B3C005BCCF9/\(httpAuxPages\)/7EEBA6386981AC8FC125800B00295658/\\$file/Salami%20et%20al.pdf](http://www.unrisd.org/80256B3C005BCCF9/httpNetITFramePDF?ReadForm&parentunid=7EEBA6386981AC8FC125800B00295658&parentdoctype=paper&netitpath=80256B3C005BCCF9/(httpAuxPages)/7EEBA6386981AC8FC125800B00295658/$file/Salami%20et%20al.pdf), accessed 13 October 2017.
- 125 Martin P. *Importing poverty? Immigration and the changing face of rural America*. New Haven (CT): Yale University Press; 2009 (<http://yalepress.yale.edu/yupbooks/book.asp?isbn=9780300139174>, accessed 21 August 2017).
- 126 Hess C, Henrici J. Increasing pathways to legal status for immigrant in-home care workers. Report No. 1924. Washington (DC): Institute for Women's Policy Research; 2013 (<http://www.iwpr.org/publications/pubs/increasing-pathways-to-legal-status-for-immigrant-in-home-care-workers>, accessed 21 August 2017).
- 127 Temin M, Montgomery MR, Engebretsen S, Barker KM. *Girls on the move: adolescent girls and migration in the developing world. A Girls Count report on adolescent girls*. New York (NY): Population Council; 2013.

- 128 ILO, 2015. See Reference 64.
- 129 High-Level Commission on Health Employment and Economic Growth. Final Report of the Expert Group. Geneva: World Health Organization; 2016 (<http://bit.ly/2qmESqy>, accessed 21 August 2017).
- 130 Crushed hopes: underemployment and deskilling among skilled migrant women. Geneva: International Organization for Migration; 2013 (https://publications.iom.int/system/files/pdf/crushed_hopes_3jan2013.pdf, accessed 21 August 2017).
- 131 Scheil-Adlung X, 2015. See Reference 31.
- 132 Spencer S, Martin S, Bourgeault I, O'Shea E. The role of migrant care workers in aging societies. Report on research findings in the United Kingdom, Ireland, Canada and the United States. IOM Migration Research Series, No. 41. Geneva: International Organization for Migration; 2010 (<http://publications.iom.int/books/mrs-ndeg41-role-migrant-care-workers-ageing-societies>, accessed 21 August 2017).
- 133 Jayasuriya R, Opeskin B, 2015. See Reference 28.
- 134 Boris E, Fish J, 2014. See Reference 110.
- 135 Boris E, Undén M. See Reference 109.
- 136 Fish J, Shumpert M. From grassroots to global. In: Michel S, Peng I, editors. *Gender, migration and the work of care: a multi-scalar approach to the Pacific rim*. New York (NY): Palgrave Macmillan; 2017.
- 137 Boyd M. Closing the open door? Canada's changing policy for migrant caregivers. In Michel S, Peng I, editors. *Gender, migration and the work of care: a multi-scalar approach to the Pacific rim*. New York (NY): Palgrave Macmillan; 2017.
- 138 Guinto RL, Curran UZ, Suphanchaimat S, Pocock NS. Universal health coverage in "One ASEAN": are migrants included? *Glob Health Action*. 2015;8:25749. doi:10.3402/gha.v8.25749.
- 139 Levitt P. Why we need transnational social protection for migrants. New York (NY): Sapiens; 5 April 2017 (<http://www.sapiens.org/culture/transnational-social-protection/>, accessed 21 August 2017).
- 140 Jayasuriva R, Opeskin B, 2015. See Reference 133.
- 141 Van Walsum S, 2016. See Reference 118.
- 142 Triandafyllidou A, 2013. See Reference 61.
- 143 Meghani Z, 2016. See Reference 118.
- 144 Del Rio C, Alonso-Villar O. Occupational segregation of immigrant women in Spain. *Feminist Economics*. 2012;18(2):91–124.
- 145 Varia N. Dispatches: new protection for Saudi Arabia's domestic workers. Human Rights Watch, 19 February 2014 (<https://www.hrw.org/news/2014/02/19/dispatches-new-protection-saudi-arabias-domestic-workers>, accessed 21 August 2017).
- 146 Varia N. Sanctioned buses: the case of migrant domestic workers. *Human Rights Brief*. 2007;14(3):17–20.
- 147 Razavi S, Staab S, 2010. See Reference 43.
- 148 England P, Budig M, Folbre N. Wages of virtue: the relative pay of care work. *Social Problems*. 2002;49(4):455–73.
- 149 Sönmez S, Apostopoulos Y, Tran D, Rentrop S. Human rights and health disparities for migrant workers in the UAE. *Health Hum Rights*. 2011;13(2):1–19.
- 150 Jureidini R. Irregular workers in Egypt: migrant and refugee domestic workers. *Int J Multicult Soc*. 2009;11(2):75–90.
- 151 Abu-Habib L. The use and abuse of female domestic workers from Sri Lanka in Lebanon. *Gender & Development*. 1998;6(1):52–6 (<https://doi.org/10.1080/741922630>, accessed 21 August 2017).
- 152 Huang S, Yeoh BSA. Emotional labour and transnational domestic work: the moving geographies of "maid abuse" in Singapore. *Mobilities*. 2007;2(2):195–217
- 153 Fernandez B. Household help? Ethiopian women domestic workers' labor migration to the Gulf countries. *Asian Pac Migr J*. 2011;20:433–57.
- 154 Varia N, 2014. See Reference 146.
- 155 Varia N, 2007. See Reference 146.
- 156 Jureidini R, Moukarbel N. Female Sri Lankan domestic workers in Lebanon. A case of "contract slavery"? *J Ethn Migr Stud*. 2004;30(4):581–607.
- 157 IOM, 2013. See Reference 130.
- 158 Akresh I. Occupational trajectories of legal US immigrants: downgrading and recovery. *Pop Dev Rev*. 2008;34:435–56.
- 159 McGregor J. Joining the BBC (British Bottom Cleaners): Zimbabwean migrants and the UK care industry. *J Ethn Migr Stud*. 2007;33(5):801–24.
- 160 Gunduz ZY. The feminization of migration: care and the new emotional imperialism. *Monthly Review*. 2013;65(7):32.
- 161 Bauer G, Österle A. Migrant care labour: the commodification and redistribution of care and emotional work. *Soc Policy Soc*. 2013;12(3):1–13.

- 162 Toronto University. Case study. California: discrimination and language barriers limit work options for Chinese migrants, conducted by Young Shin, Executive Director of Asian Immigrant Women's Advocates (AIWA) staff MuTing Cen and Dennis Yee for facilitating the research. Graduate students Chi Cheng Wat and Justin Kong conducted interviews and Chi Cheng Wat, Justin Kong, Michael Lee and Angela Hick transcribed, translated and/or coded them. 2016.
- 163 Fernandez B, 2011. See Reference 153.
- 164 Cederqvist M, Sallaz E. Live-in caregivers and intimidation in the workplace. Ville de Québec: Ministère de la Famille du Québec; 2014 (<https://www.mfa.gouv.qc.ca/fr/publication/Documents/2014-11-30.8-Memoire.pdf>, accessed 21 August 2017).
- 165 Spitzer DL, Torres S. Gender-based barriers to settlement and integration for live-in-caregivers: a review of the literature. CERIS Working Paper, No. 71. Toronto: The Ontario Metropolis Centre; 2008.
- 166 Spitzer DL. Work, worries and weariness: towards an embodied and engendered migrant health. In: Spitzer DL, editor. *Engendering migrant health: Canadian perspectives*. Toronto: University of Toronto Press; 2011.
- 167 Migrant domestic workers: promoting occupational health and safety. Geneva: International Labour Organization; 2015.
- 168 Tungohan E. From migrant to citizen: learning from the experiences of former caregivers transitioning out of the live-in caregiver program. Toronto: Gabriela Transitions Experiences Survey; 2014 <http://www.gatesurvey.com/wp-content/uploads/2014/07/GATES-Preliminary-Analysis-201407221.pdf>, accessed 29 August 2017).
- 169 Malhotra R, Arambepola C, Tarun S, De Silva V, Kishore J, Ostbye T. Health issues of female foreign domestic workers: a systematic review of the scientific and gray literature. *Int J Occup Environ Health*. 2013;19(4):261–77.
- 170 Bastia T. Looking after granny: a transnational ethic of care and responsibility. *Geoforum*, 2015;64:121–29.
- 171 ILO, 2015. See Reference 64.
- 172 Ahonen EQ, López-Jacob MJ, Vázquez ML, Porthé V, Gil-González D, García AM, et al. Invisible work, unseen hazards: the health of women immigrant household service workers in Spain. *Am J Ind Med*. 2010;53(4):405–16. <https://doi.org/10.1002/ajim.20710>.
- 173 Spitzer DL. Engendered movements: migration, gender and health in a globalized world. In: Gideon J, editor. *Handbook on gender and health*. Cheltenham: Edward Elgar Publishing; 2016:251–67.
- 174 Mora L. Gender, reproductive rights and international migration. Meeting of Experts on Population, Inequalities and Human Rights. Santiago: CEPAL; 2006 (<http://www.cepal.org/celade/noticias/paginas/6/27116/moral.pdf>, accessed 29 August 2017).
- 175 Health of migrants (CD55/11). 55th Directing Council – 68th Session of the Regional Committee of WHO for the Americas. Washington (DC): Pan American Health Organization; 2016.
- 176 Cerrutti M. Gender and intra-regional migration in South America. New York (NY): United Nations Development Programme; 2009.
- 177 Fernandez Casanueva C. Central American migration to Mexico and the United States: the Influence of gender on destinations and destinies. La Jolla (CA): Center for Comparative Immigration Studies; 2009 (<http://ccis.ucsd.edu/wp-content/uploads/2009/11/WP182.pdf>,
- 178 Bedri N, Ibrahim Abdelmoneim S, Tambal N, Adam S. Factors influencing access of women migrant domestic workers to sexual and reproductive health (SRH) services at Khartoum State: the case of Ethiopian migrant domestic workers. *Ahfad Journal*. 2015;32(2).
- 179 Mora L, 2006. See Reference 174.
- 180 Moreno Beltran A, Ballesteros Peña A. The consequences of the implementation of the Royal Decree-Law of sanitary regulation RD 16/2012 on migrant women's health [Las consecuencias de la aplicación del Real Decreto-Ley de Regulación Sanitaria RD 16/2012 sobre la salud de las mujeres inmigradas]. *Investigaciones Feministas*. 2014;5:317–41
- 181 ACHIEVE & Vrije Univeiteit Medical Center Metamedical Health Care and Culture. Women and migration: the mental health nexus a research on individual and structural determinants of stress and mental health problems of Filipino women migrant domestic workers. Quezon City: Action for Health Initiatives; 2011.
- 182 About us. Manila: Philippine Migrants Rights Watch; 2016 (<http://www.pmrw.org.ph/p/the-philippine-migrants-rights-watch-is.html>, 29 August 2017).
- 183 Wong A. Identifying work-related stressors and abuses and assessing their impact on the health of migrant domestic workers in Singapore. Singapore: Humanitarian Organization for Migration Economics; 2010.

- 184 Varia N, 2014. See Reference 145.
- 185 Varia N, 2007. See Reference 146.
- 186 Lin C, Tsai F, Wang SJ, Hwang JP, Fuh JL. Comparison of the burdens of family caregivers and foreign paid caregivers of the individuals with dementia. *International Psychogeriatrics*. 2012;24(12):1953–61. <https://doi.org/10.1017/S1041610212001354>.
- 187 Jureidini R, Moukarbel N, 2004. See Reference 156.
- 188 Grabska K, Del Franco N, de Regt M. Time to look at girls: adolescent girls' migration in the south. Geneva: Swiss Network for International Studies (SNIS) and Partners; 2016 (<http://www.snis.ch/multimedia/files>, accessed 29 August 2017).
- 189 Bauer G, Österle A, 2013. See Reference 161.
- 190 Degiuli F. A job with no boundaries: home eldercare work in Italy. *Eur J Wom Stud*. 2007;14(3):193–207.
- 191 Döhner H, Lüdecke D, Eickhoff V. Migrant workers in home care for older people in Germany: the use and problems of legal and irregular care. *GeroBilim: Journal on Social & Psychological Gerontology*. 2008;1(8):2–13.
- 192 Boris E, Fish J, 2014. See Reference 110.
- 193 Hennebry J, K, 2016. See Reference 49.
- 194 Bakan A, Stasiulis D. Negotiating citizenship: migrant women in Canada and the global system. Toronto: University of Toronto Press; 2005.
- 195 Tungohan E, 2014. See Reference 168.
- 196 Shishehgar S, Gholizadeh L, DiGiacomo M, Green A, Davidson PM. Health and socio-cultural experiences of refugee women: an integrative review. *J Immigr Minor Health*. 2015;1–15.
- 197 Gil-González D, Carrasco-Portiño M, Vives-Cases C, Agudelo-Suárez AA, Castejón BR, Ronda-Pérez E. Is health a right for all? An umbrella review of the barriers to health care access faced by migrants. *Ethn Health*. 2015;20(5):523–41.
- 198 Jacka T. Rural women in urban China: gender, migration, and social change. New York (NY): Routledge; 2014.
- 199 Suarez-Orozco C. Understanding and serving the children of immigrants. *Harv Educ Rev*. 2001;71(3):579–89.
- 200 Malhotra R et al., 2013. See Reference 169.
- 201 De Leon C. Post-reunification reconciliation among Pinay domestic workers and adult daughters in Canada. *Canadian Woman Studies*. 2009;27(2/3):68–72.
- 202 Hennebry J, McLaughlin J, Preibisch K, 2016. See Reference 49.
- 203 Caballe-Climent L. Undocumented migrant mothers and health cuts in Madrid: a gendered process of exclusion. *Eur J Wom Stud*. 2016;1–13.
- 204 Fernandez B, 2011. See Reference 153.
- 205 Gil-González D, Carrasco-Portiño M et al., 2015. See Reference 197.
- 206 Migration Policy Institute, 2007. See Reference 121.
- 207 Ku L, Jewers M. Health care for immigrant families: current policies and issues. Washington (DC): Migration Policy Institute; 2013.
- 208 Dinat N, Peberdy S. Restless worlds of work, health and migration; domestic workers in Johannesburg. *Development South Africa*. 2007;4(1):186–203.
- 209 Hennebry J, McLaughlin J, Preibisch K, 2016. See Reference 49.
- 210 COLMEX, UN Women. Migrant Female Workers in the Mexico's Southern Border: Towards a Research Agenda. Mexico City: Un Women; 2015 (http://www2.unwomen.org/-/media/field%20office%20mexico/documentos/publicaciones/2017/migracion%2007/08%20las%20trabajadoras%20migrantes_160717.pdf?la=es&vs=911; accessed 29 August 2017).
- 211 Davies AA, Basten A, Frattini C. Migration: a social determinant of the health of migrants. *Eurohealth*. 2009;16(1):10–2.
- 212 Smith RD, MacKellar L, 2007. See Reference 46.
- 213 Kvamme E, Ytrehus C. Barriers to health care access among undocumented migrant women in Norway. *Society, Health and Vulnerability*. 2015;6(1):28668. <http://dx.doi.org/10.3402/shv.v6.28668>.
- 214 Schoevers M. Health problems and problems accessing health care of undocumented female immigrants in the Netherlands. PhD thesis. Nijmegen: Radboud University; 2011.
- 215 Woodward D, Smith RD. Global public goods and health: concepts and issues. In: Smith RD, Beaglehole R, Woodward D, Drager N, editors. *Global public goods for health: a health economic and public health perspective*. Oxford: Oxford University Press; 2003.
- 216 Schoevers M, Loeffen M, Van den Muijsenbergh M, Lagro-Janssen A. Health care utilisation and problems in accessing health care of female undocumented immigrants in the Netherlands. *Int J Public Health*. 2010;55:421–28. doi: 10.1007/S00038-010-0151-6.

- 217 Carrasco LN, 2016. See Reference 80.
- 218 Hacker K, Anies M, Folb BL, Zallman L. Barriers to health care for undocumented immigrants: a literature review. *Risk Manag Healthc Policy*. 2015;8:175.
- 219 Gil-Gonzalez D et al., 2015. See Reference 197.
- 220 Keygnaert I, Guieu A, Ooms G, Vettenburg N, Temmerman M, Roelens K. Sexual and reproductive health of migrants: does the EU care? *Health Policy*. 2014;114(2):215–25.
- 221 Grabska K, Del Franco N, De Regt M, 2016. See Reference 188.
- 222 Squires D, Anderson C. U.S. health care from a global perspective: spending, use of services, prices, and health in 13 countries. *Issue Brief (Commonw Fund)*. 2015;1–15.
- 223 Other family visa queue. Canberra: Department of Immigration and Border Protection; 2016 (<https://www.border.gov.au/Trav/Brin/Fami/Capping-and-queuing/Other-family-visa-queue>, accessed 12 October 2016).
- 224 Migrant well-being and development: South America. Working Paper for the World Migration Report 2013. Geneva: International Organization for Migration; 2013 (https://www.iom.int/files/live/sites/iom/files/What-We-Do/wmr2013/en/Working-Paper_BuenosAires_final.pdf, accessed 29 August 2017).
- 225 Calavita K. Gender, migration and law: crossing borders and bridging disciplines. *Int Migr Rev*. 2006;40(1):104–32.
- 226 Morero Beltran A, Ballesteros Pena A, 2014. See Reference 180.
- 227 Caballe-Climent L, 2016. See Reference 174.
- 228 Mora, L, 2006. See Reference 174.
- 229 Spitzer DL, 2011. See Reference 166.
- 230 Keygnaert I, Guieu A, Ooms G, Vettenburg N, Temmerman M, Roelens K. Sexual and reproductive health of migrants: does the EU care? *Health Policy*. 2014;114(2):215–25.
- 231 Österle A, Bauer G. The legalization of rotational 24-hour care work in Austria: implications for migrant care workers. *Social Politics*. 2016;23(2):192–213. doi:10.1093/sp/jxv001.
- 232 Canchela J. Support surges for ailing caregiver. *The Philippine Reporter*, 2008 (<http://www.philreporter.com/Issue-07-1-15-08/support.htm>, accessed 29 September 2016).
- 233 Keung N. Ottawa urged to grant permanent status to migrant workers on arrival. *Toronto Star*, 11 September 2016 (<https://www.thestar.com/news/immigration/2016/09/11/ottawa-urged-to-grant-permanent-status-to-migrant-workers-upon-arrival.html>, accessed 29 August 2017).
- 234 Cariker B. Health requirement for Middle East visas. *Expat Family Health*, 24 May 2013 (<https://expatfamilyhealth.com/health-requirements-work-visas/health-requirements-for-middle-east-visas/>, accessed 29 August 2017).
- 235 Canchela J, 2008. See Reference 232.
- 236 Philippine Migrants Rights Watch. 2016. See Reference 182.
- 237 Cariker B, 2016. See Reference 234.
- 238 Democratic Socialist Republic of Sri Lanka: family poverty drives a cycle of migration and ill health. WHO Case Study. Geneva: World Health Organization; 2016.
- 239 Cariker B, 2016. See Reference 234.
- 240 Ingleby D. Ethnicity, migration and the “Social Determinants of Health” agenda. *Psychosocial Intervention*. 2012;21(3):331–41. 2012 (<http://www.sciencedirect.com/science/article/pii/S113205591270087X>, accessed 2 October 2017)
- 241 Bellagio Declaration and Conference on Migration and the Social Determinants of Health, 2012. Conference Report. (<https://cultureoftheequity.org/our-work/social-determinants-of-migrant-health/>, accessed 9 October 2017).
- 242 Michel S. Beyond the Global Brain Drain: the Global Care Drain. *The Globalist*, 20 October 2010 (<https://www.theglobalist.com/beyond-the-global-brain-drain-the-global-care-drain/>, accessed 29 August 2017).
- 243 Dumitru S, 2014. See Reference 19.
- 244 Hoang LA, Lam Y, Yeoh BS, 2015. Transnational migration, changing care arrangements and left-behind children’s responses in Southeast Asia. *Children’s Geographies*; 13(3):263–77. doi:10.1080/14733285.2015.972653
- 245 Graham E, Jordan L, Yeoh BSA. Parental migration and the mental health of those who stay behind to care for children in South-East Asia. *Soc Sci Med*. 2014;(132):225–35. doi:10.1016/j.socscimed.2014.10.060.
- 246 Graham E, Yeoh BSA. Introduction: Child health and migrant parents in South-East Asia: risk and resilience among primary school-aged children. *Asian Pac Migr J*. 2013;22(3):297–314 [Open Access].
- 247 Asis MMB, Ruiz-Marave C. Leaving a legacy: parental migration and school outcomes among young children in the Philippines. *Asian Pac Migr J*. 2013;2(3):349–76 [Open Access].
- 248 Jampaklay A, Vapattanawong P. The subjective well-being of children in transnational and non-migrant households: evidence from Thailand. *Asian Pac Migr J*. 2013;22(3):377–400 [Open Access].

- 249 Badasu D, Michel S. On a collision course. Meghani Z, editor. *Women migrant workers, ethical, political and legal problems*. New York (NY): Routledge; 2016:75–100.
- 250 Hennebry J, Hoiday J, Moniruzzaman M, 2017. See Reference 50.
- 251 Bartha A, Fedyuk O, Zentai V, 2015. See Reference 79.
- 252 The World Bank, 2017. See Reference 57.
- 253 The World Bank, 2017. See Reference 57.
- 254 Kelegama S, Weeraratne B. Migration and economic remittances: impact on development. In: Triandafyllidou A, editor. *Routledge Handbook of Immigration and Refugee Studies*. Abingdon: Routledge; 2016.
- 255 Cortina J, Ochoa-Reza E. Women, children and migration: developmental considerations. In: Cortina J, Ochoa-Reza E, editors. *New perspectives on international migration and development*. New York (NY): Columbia University Press; 2013.
- 256 Kuhn R. A longitudinal analysis of health and mortality in a migrant-sending region of Bangladesh. In: Jatrana S, Toyota M, Yeoh BSA, editors. *Migration and health in Asia*. London: Routledge; 2005.
- 257 IOM, 2017. Gender, migration and remittances. Geneva. (<https://www.iom.int/sites/default/files/about-iom/Gender-migration-remittances-infosheet.pdf>, accessed 9 October 2017).
- 258 Orozco M. Gender remittances: preliminary notes about senders and recipients in Latin America and the Caribbean. Paper presented at the Commission on the Status of Women, Fiftieth session, High-level panel on 'The Gender Dimensions of International Migration' submitted by Inter-American Dialogue, New York, 27 February–10 March, 2006 (<http://www.un.org/womenwatch/daw/csw/csw50/statements/CSW%20HLP%20Manuel%20Orozco.pdf>, accessed 29 August 2017).
- 259 Guzman JC, Morrison AR, Sjöblom M. The impact of remittances and gender on household expenditure patterns: evidence from Ghana. In: Morrison A, Schiff M, Sjöblom M, editors. *The international migration of women*. Washington (DC): The World Bank; 2007.
- 260 Survey on remittances 2007: gender perspectives. Working Books on Migration, No. 24. Guatemala: International Organization for Migration, United Nations International Research and Training Institute for the Advancement of Women; 2007.
- 261 Escrivá A, Ribas N. *Migration and Development: A study on remittances and other transnational practices in Spain*. Cordoba: Consejo Superior de Investigaciones Científicas e Instituto de Estudios Sociales de Andalucía; 20104.
- 262 IOM and UN-INSTRAW 2007. See Reference 260.
- 263 Orozco M, Lowell L, Schneider J. Gender-specific determinants of remittances: differences in structures and motivation. Washington (DC): The World Bank; 2009.
- 264 Parreñas R. *Children of global migration: transnational families and gendered woes*. Redwood City (CA): Stanford University Press; 2005.
- 265 Hochschild AR. Global care chains and emotional surplus value. In: Hutton W, Giddens A, editors. *On the edge: living with global capitalism*. London: Jonathan Cape; 2000.
- 266 Parrenas R. *The global servants: Filipina (im)migrant domestic workers in Rome and Los Angeles*. Doctoral dissertation. University of California – Berkeley; 1998.
- 267 Parrenas R. Migrant Filipina domestic workers and the international division of reproductive labour. *Gend Soc*. 2000;14(4):560–80.
- 268 Mazzucato V, Cebotari V, Veale A, White A, Grassi M, Vivet J. International parental migration and the psychological well-being of children in Ghana, Nigeria, and Angola. *Soc Sci Med*. 2015;132:215–24.
- 269 Suarez-Orozco C, Todorova ILG, Louie J. Making up for lost time: the experience of separation and reunion among immigrant parents. *Family Process*. 2002;41:625–43.
- 270 Pinto-Jayawardena K. *Left behind, left out: the impact on children and families of mothers migrating for work abroad*. Summary report. Colombo: Save the Children Sri Lanka; 2006.
- 271 Ukwatta S. *The economic and social impacts of the migration of transnational Sri Lankan domestic workers on children and families left behind*. PhD dissertation. Adelaide: University of Adelaide; 2010 (<https://digital.library.adelaide.edu.au/dspace/bitstream/2440/63080/8/02whole.pdf>, accessed 29 August 2017).
- 272 Nguyen CV. Does parental migration really benefit left-behind children? Comparative evidence from Ethiopia, India, Peru and Vietnam. *Soc Sci Med*. 2016;153:230–9.
- 273 Hondagneu-Sotelo P, Avila E, 1997. See Reference 90.
- 274 Hewett H. *Mothering across Borders: Narratives of Immigrant Mothers in the United States*. *Women's Studies Quarterly*. 37, 3/4: 121–39. 2009.

- 275 Hondagneu-Sotelo and Avila E, 1997. See Reference 90.
- 276 Hewett H, 2009. See Reference 104.
- 277 Warschauer M. *Technology and social inclusion: rethinking the digital divide*. Cambridge (MA): MIT Press; 2003.
- 278 Hoang LA, Yeoh BSA. Sustaining families across transnational spaces: Vietnamese migrant parents and their left-behind children. *Asian Studies Review*. 2012;36(3):307–25.
- 279 Oliviera G. Caring for your children: how Mexican migrant mothers experience care and the ideals of motherhood. In: Michel S, Peng I, editors. *Gender, migration and the work of care: a multi-scalar approach to the Pacific rim*. New York (NY): Palgrave Macmillan; 2017.
- 280 Asma K. “I was sold”: abuse and exploitation of migrant domestic workers in Oman. *Human Rights Watch*, 13 July 2016 (<https://www.hrw.org/report/2016/07/13/i-was-sold/abuse-and-exploitation-migrant-domestic-workers-oman>, accessed 29 August 2017).
- 281 Coe C. How children feel about their parents’ migration: a history of the reciprocity of care in Ghana. In: Coe C, Reynolds RR, Boehm DA, Hess JM, Rae-Espinoza H, editors. *Everyday ruptures: children, youth, and migration in global perspective*. Nashville (TN): Vanderbilt University Press; 2011:97–114.
- 282 Hoang LA, Yeoh BSA, 2015. See Reference 244.
- 283 Shepler S. Transnational fosterage: the novel care arrangements between Guinean caregivers and Ivorian and Liberian children fleeing war. In: Coe C, Reynolds RR, Boehm DA, Hess JM, Rae-Espinoza H, editors. *Everyday ruptures: children, youth, and migration in global perspective*. Nashville (TN): Vanderbilt University Press; 2011:63–78.
- 284 Forde M. Modes of transnational relatedness: Caribbean migrants’ networks of child care and ritual kinship. In: Coe C, Reynolds RR, Boehm DA, Hess JM, Rae-Espinoza H, editors. *Everyday ruptures: children, youth, and migration in global perspective*. Nashville (TN): Vanderbilt University Press; 2011:79–96.
- 285 Katz C. *Growing up global: economic restructuring and children’s everyday lives*. Minneapolis (MN): University of Minnesota Press; 2004.
- 286 Hoang LA, Yeoh BSA, 2015. See Reference 244.
- 287 Coe C et al., 2010. See Reference 281.
- 288 Suarez-Orozco C et al., 2002. See Reference 269.
- 289 Coe C, 2010. See Reference 281.
- 290 Parreñas R, 2005. See Reference 264.
- 291 Hoang LA, Lam T, Yeoh BSA, Graham E, 2015. See Reference 244.
- 292 Ehrenreich B, Hochschild AR. *Global woman: Nannies, maids, and sex workers in the new economy*. Macmillan. 2003.
- 293 Parreñas R, 2005. See Reference 264.
- 294 Garcia AE, Velasco SA. Family and school reconfiguration: the case of Ecuadorian highland migration to Spain. In: Cortina J, Ochoa-Reza E, editors. *New perspectives on international migration and development*. New York (NY): Columbia University Press; 2013.
- 295 Coe C, 2010. See Reference 281.
- 296 Rae-Espinosa H. The children of émigrés in Ecuador: narratives of cultural reproduction and emotion in transnational social fields. In: Coe C, Reynolds RR, Boehm DA, Hess JM, Rae-Espinoza H, editors. *Everyday ruptures: children, youth, and migration in global perspective*. Nashville (TN): Vanderbilt University Press; 2011:115–40.
- 297 Suarez-Orozco C, Todorova ILG, Louie J, 2002. See Reference 269.
- 298 Katz C, 2004. See Reference 285.
- 299 Garcia AE, Velasco SA, 2013. Family and school reunification: the case of Ecuadorian Highland migration to Spain. In: Cortina J, Ochoa-Reza E, editors. *New perspectives on international migration and development*. New York (NY): Colombia University Press; 2013:113–380.
- 300 Parreñas R, 2005. See Reference 264.
- 301 Lutz H. Euro-orphans and the stigmatization of migrant motherhood. In: Ergas Y, Jenson J, Michel S, editors. *Reassembling motherhood: procreation and care in a globalized world*. New York (NY): Columbia University Press; 2017.
- 302 Global AgeWatch Index 2015. See Reference 81.
- 303 Kusakabe K. Reconciling work and family: issues and policies in Thailand. *Conditions of Work and Employment Series*, No. 14. Geneva: International Labour Organization; 2006 (http://www.ilo.org/travail/whatwedo/publications/WCMS_TRAVAIL_PUB_14/lang--en/index.htm, accessed 29 August 2017).
- 304 Baldassar LC, Baldock V, Wilding R, editors. *Families caring across borders: migration, ageing and transnational caregiving*. Basingstoke: Palgrave Macmillan; 2007.

- 305 He G, Xie J, Zhou J, Zhong Z, Qin C, Ding S. Depression in left-behind elderly in rural China: prevalence and associated factors. *Geriatr Gerontol Int*. 2016;16(5):638–43.
- 306 Fuller HR. The emotional toll of out-migration on mothers and fathers left behind in Mexico. *Int Migr*. 2017;55(3):156–72.
- 307 He G et al., 2016. See Reference 305.
- 308 Baldassar L, Baldock C, Wilding R, 2007. See Reference 304.
- 309 Kuhn R, Everett B, Silvey R. The effects of children's migration on elderly kin's health: a counterfactual approach. *Demography*. 2011;48(1):183–209. doi:10.1007/s13524-010-0002-3.
- 310 Böhme M, Persian R, Stöhr T. Alone but better off? Adult child migration and health of elderly parents in Moldova. *J Health Econ*. 2015;39(C):211–27.
- 311 Böhme M, Persian R and Stöhr T, 2015. See Reference 310.
- 312 He G, et al., 2016. See Reference 305.
- 313 Global Ageing Report, 2000. London: HelpAge International; 2000.
- 314 Doha International Institute for Family Studies and Development/UNFPA. Report of a UNFPA Seminar on Family Support Networks and Population Ageing, Doha, Qatar, 3–4 June 2009.
- 315 Parreñas R, 2005. See Reference 264.
- 316 Pingol A. Remaking masculinities: identity, power, and gender dynamics in families with migrant wives and househusbands. Quezon City: University Center for Women's Studies; 2001.
- 317 Hoang LA, Yeoh BSA, 2011. Breadwinning wives and 'left behind' husbands: men and masculinities in the Vietnamese transnational family. *Gender and Society*: 2011; 259(6); 717–739
- 318 Hoang LA, Yeoh BSA, 2011. See Reference 317.
- 319 Gallo E, Scrinzi F, 2016. See Reference 20.
- 320 Gallo E, Scrinzi F, 2016. See Reference 319.
- 321 Gallo E, Scrinzi F, 2016. See Reference 319.
- 322 Gallo E, Scrinzi F, 2016. See Reference 319.
- 323 Fuller H, 2017. See Reference 306.
- 324 Gallo and Scrinzi. 2016. See Reference 319.
- 325 Gallo and Scrinzi. 2016. See Reference 319.
- 326 Tronto JC. Moral boundaries. A political argument for an ethic of care. London: Routledge;1993.
- 327 Barragan E, et al., 2017. See Reference 5.
- 328 IOM, 2013. See Reference 130.
- 329 Ku L, Jewers M, 2013. See Reference 207.
- 330 Squires D, Anderson C, 2015. See Reference 222.
- 331 Sivadasan K, Zhang C. Improving healthcare insurance for migrant workers in China: cover the missing 220 million migrants. How to bridge the missing gap?" MPA Thesis submission. Cambridge (MA): John F. Kennedy School of Government, Harvard University; 2014.
- 332 Rojas-Wiesner M, DeVargas M. Strategic invisibility as everyday politics for a life with dignity: Guatemalan Women migrants' experiences of insecurity at Mexico's southern border. In Truong T, Gasper D, Handmaker J, Bergh S, editors. *Migration, gender and social justice: perspectives on human insecurity*. Berlin: Springer; 2014.
- 333 Van Walsum S. Transnational mothering, national immigration policy, and European law. The experience of the Netherlands. In: Benhabib S, Resnik J, editors. *Migrations and mobilities: citizenship, borders, and gender*. New York (NY): New York University Press; 2009.
- 334 Calavita K, 2006. See Reference 225.
- 335 Lutz H, Palenga-Möllenbeck E, 2010. See Reference 14.
- 336 Léon M. Migration and care work in Spain: the domestic sector revisited. *Soc Pol Soc.*, themed issue on "Domestic and care work at the intersection of welfare, gender and migration regimes: some European experiences". 2010(3):409–18.
- 337 Lutz H, 2011. See Reference 47.
- 338 Pratt G. Families apart: Migrant mothers and the conflicts of labor and love. U of Minnesota Press. 2012.
- 339 Parreñas RS, Parreñas R. Servants of globalization: migration and domestic work. Redwood City (CA): Stanford University Press; 2015.
- 340 Caballe-Climent L, 2016. See Reference 203.
- 341 Jayaweera H, Shlala EH, 2015. See Reference 76.
- 342 Anderson B. Who needs them? Care work, migration and public policy. *Cuadernos de Relaciones Laborales*. 2012;30(1):45–61.
- 343 Caballe-Climent L, 2016. See Reference 340.
- 344 Pérez-Molina JA, Pulido F, 2014. Assessment of the impact of the new health legislation on illegal immigrants in Spain: The case of human immunodeficiency virus infection. *Enferm Infecc Microbiol Clin*, 30(8): 472–8. 2014.

- 345 Sönmez S, Apostopoulos Y, Tran D, Rentrop S, 2011. See Reference 149.
- 346 Health of migrants – the way forward. Report of a Global Consultation, Madrid, Spain, 3–5 March 2010. Geneva: World Health Organization; 2010 (http://www.who.int/hac/events/consultation_report_health_migrants_colour_web.pdf, accessed 29 August 2017).
- 347 Social protection for domestic workers: key policy trends and statistics. Social Protection Policy Paper, No. 16. Geneva: International Labour Organization; 2016 (http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/publication/wcms_458933.pdf, accessed 29 August 2017).
- 348 Human Rights Watch. , 2016. See Reference 280.
- 349 Frantz E. Jordan's unfree workforce: state-sponsored bonded labour in the Arab Region. *J Dev Stud.* 2013;49(8):1072–87.
- 350 Jureidini R, Moukarbel N, 2004. See Reference 156.
- 351 Indispensable yet unprotected: working conditions of Indian domestic workers at home and abroad. Geneva: International Labour Organization; 2015 (http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_378058.pdf, accessed 29 August 2017).
- 352 Griffin L. Unravelling rights: illegal migrant domestic workers in South Africa. *South African Review of Sociology.* 2011;42(2).
- 353 Maid to order: ending abuses against migrant domestic workers in Singapore. New York (NY): Human Rights Watch; 2005.
- 354 Mather C, 2013. See Reference 102.
- 355 Chun J., 2016. See Reference 113.
- 356 Country migration report, the Philippines 2013. Makati City: International Organization for Migration; 2013.
- 357 Review of the effectiveness of the MOUs in managing labour migration between Thailand and neighbouring countries. Geneva: International Labour Organization; 2015.
- 358 Facilitating exploitation: a review of labour laws for migrant domestic workers in Gulf Cooperation Council countries. Brussels: International Trade Union Confederation; 2014 (http://www.ituc-csi.org/IMG/pdf/gcc_legal_and_policy_brief_domestic_workers_final_text_clean_282_29.pdf, accessed 4 September 2017).
- 359 Wickramasekara P. Issues paper: promoting international cooperation and partnerships in addressing international labour migration between Asia and the GCC. Inter-regional Expert's Meeting on Realizing a Fair Migration Agenda: Labour Flows between Asia and the Arab States, Kathmandu, 3-4 December 2014. Geneva: International Labour Organization; 2015.
- 360 Zahra M. The legal framework of the sponsorship systems of the Gulf Cooperation Council countries: a comparative examination. Explanatory note, No. 10/2015. Gulf Labour Markets and Migration. Fiesole and Jeddah: European University Institute and Gulf Research Center; 2015 (http://gulfmigration.eu/media/pubs/exno/GLMM_EN_2015_10.pdf, accessed 4 September 2017)
- 361 Jones K. For a fee: the business of recruiting Bangladeshi women for domestic work in Jordan and Lebanon. Fair Recruitment Initiative. Geneva: International Labour Organization; 2015.
- 362 Helsinki statement on Health in all Policies. Statement from the 8th Global Conference on Health Promotion, Helsinki, 10-14 June 2013. Geneva: World Health Organization (http://www.who.int/healthpromotion/conferences/8gchp/statement_2013/en/, accessed 4 September 2017).
- 363 Papademetriou DG, Benton M. From fragmentation to integration: towards a whole-of-society approach to receiving and settling newcomers in Europe. Washington (DC) and Brussels: Migration Policy Institute; 2016 (<http://www.migrationpolicy.org/research/towards-whole-society-approach-receiving-and-settling-newcomers-europe>, accessed 4 September 2017).
- 364 Van Walsum S, 2016. See Reference 118.
- 365 Van Walsum S, 2016. See Reference 333.
- 366 Lutz H, Palenga-Möllenberg E, 2010. See Reference 14.
- 367 van Panhuys C, Kazi-Aoul S, Binette G. Migrant access to social protection under bilateral labour agreements: a review of 120 countries and nine bilateral arrangements. ESS Working Paper, No. 57. Geneva: International Labour Organization; 2017.
- 368 Wickramasekara P, 2015. See Reference 359.
- 369 Del Rosario T. Best practices in social insurance for migrant workers: the case of Sri Lanka. Working Paper, No. 12. ILO Asian Region Programme Governance of International Labour Migration. Geneva: International Labour Organization; 2008.

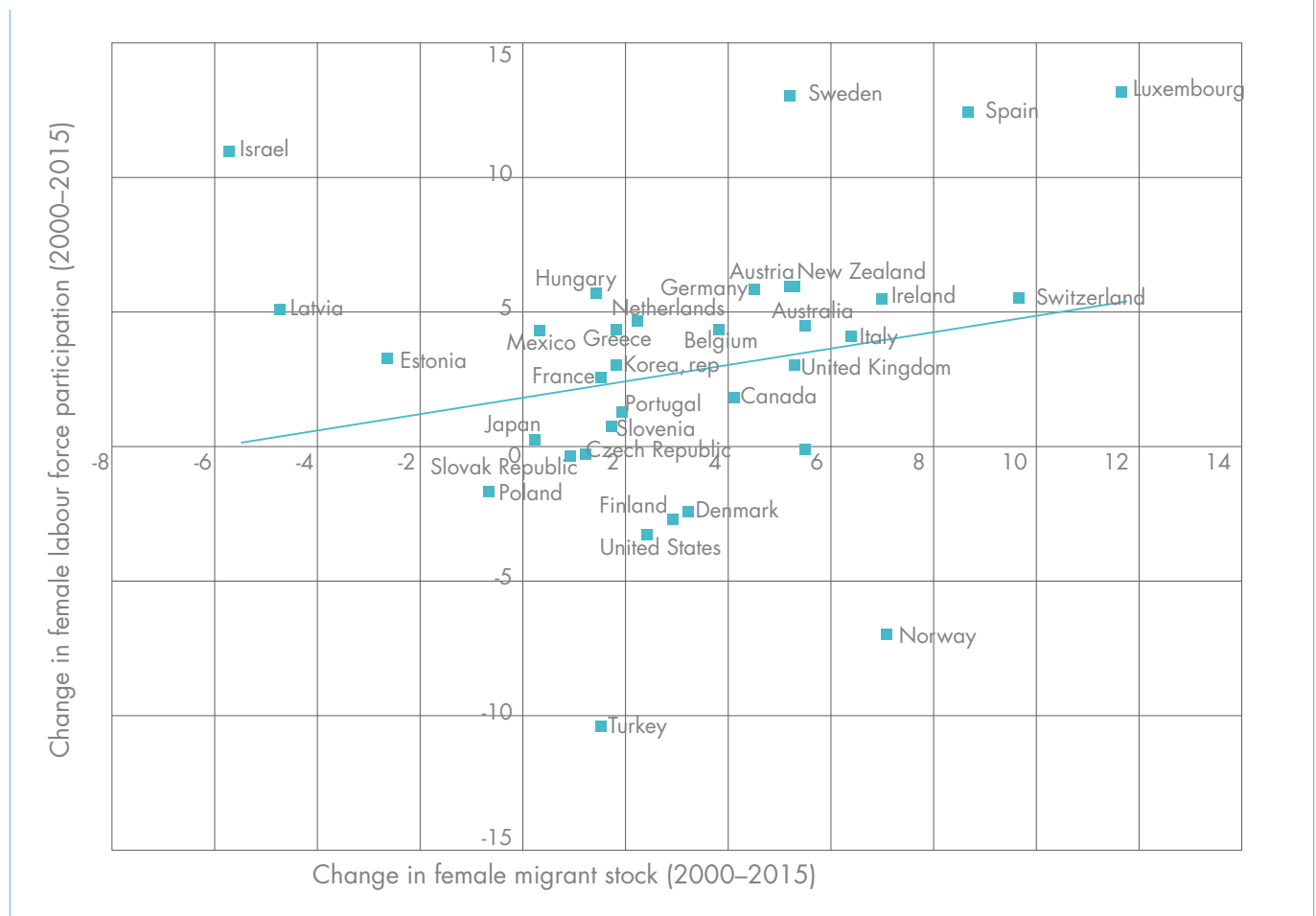
- 370 Levitt P, 2017. See Reference 139.
- 371 MacLaren B. Securing health services in Guatemala for the families of migrant workers. *FocalPoint*. 2008;7(5):10-1. (http://www.focal.ca/pdf/focalpoint_june2008.pdf, accessed 5 September 2017).
- 372 Guinto RL et al., 2015. See Reference 138.
- 373 Guinto RL et al., 2015. See Reference 372.
- 374 Hennebry J et al., 2016: (77). See Reference 48.
- 375 Republic of Ireland. National Intercultural Health Strategy 2007–2012. Dublin: Health Service Executive; 2008 (https://www.hse.ie/eng/services/Publications/SocialInclusion/National_Intercultural_Health_Strategy_2007_-_2012.pdf, accessed 4 September 2017).
- 376 Ambrosini M. Irregular migration and invisible welfare. Basingstoke: Palgrave Macmillan; 2013.
- 377 Summary report on the MIPEX Health Strand and country reports. IOM Migration Research Series, No.52. Geneva: International Organization for Migration; 2016 (https://publications.iom.int/system/files/mrs_52.pdf, accessed 4 September 2017).
- 378 Lu Y, Wang F. From general discrimination to segmented inequality: migration and inequality in urban China. *Soc Sci Res*. 2013;42(6):1443–56. doi:10.1016/j.ssresearch.2013.
- 379 Resources for CALD carers [website]. Canberra: Carers Australia; 2016 (<http://www.carersaustralia.com.au/about-carers/culturally-and-linguistically-diverse-carers/resources-for-cald-carers/>, accessed 4 September 2017).
- 380 van Ginneken W. Social protection for migrant workers: national and international policy challenges. *European Journal of Social Security*. 2013;15(2):209–21. doi: <https://doi.org/10.1177/138826271301500206>.
- 381 Migrants in an irregular situation: access to healthcare in 10 European Union Member States. Vienna: European Union Agency for Fundamental Rights; 2011.
- 382 Meghania Z, 2016. See Reference 120.
- 383 Jayaweera H, Shlala EH, 2015. See Reference 76.
- 384 Christensen K, Guldvik I, 2013. See Reference 21.
- 385 European Union Agency for Fundamental Rights, 2011. See Reference 381.
- 386 United Nations Commission on Information and Accountability for women and children's health. May 2011.
- 387 High Level Panel on Women's Economic Empowerment, 2017. See Reference 23.
- 388 International Covenant on Economic, Cultural and Social Rights, 1996. See Reference 69.
- 389 Catalania C, Minkler M. PhotoVoice: a review of the literature in health and public health. *Health Educ Behav*. 2010;37(3):424–51.
- 390 Anderson B, 2012. See Reference 342.
- 391 Pearse R, Connell R. Gender norms and the economy: insights from social research. *Fem Econ*. 2015;2(1). doi:10.1080/13545701.2015.1078485.
- 392 Anthias F. Transnational mobilities, migration research and intersectionality. Towards a translocational frame. *Nordic Journal of Migration Research*. 2012;2(2):102–10. doi:10.2478/v10202-011-0032-y.
- 393 Bastia T. Intersectionality, migration and development. *Progress in Development Studies*. 2012;14(3):237–48.
- 394 Burkner H-J. Intersectionality: how gender studies might inspire the analysis of social inequality among migrants. *Popul Space Place*. 2012;18:181–95. doi:10.1002/psp.664.
- 395 Mahler S, Chaudhuri M, Patil V. Scaling intersectionality: advancing feminist analysis of transnational families. *Sex Roles*. 2015; 73(3-4):100–12.
- 396 Hankivsky O, 2014. See Reference 24.
- 397 Poverty, social exclusion and health systems in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2010.
- 398 Viruell V, Miranda P, Abdulrahim S. More than culture: structural racism, intersectionality theory and immigrant health. *Soc Sci Med*. 2012;75:2099–106.
- 399 Spitzer D, 2016. See Reference 173.
- 400 Gideon J, editor. Introduction. In: Gideon J, editor. *Handbook on gender and health*. Cheltenham: Edward Elgar Publishing; 2016:1–35
- 401 Cartwright E, Manderson L. Diagnosing the structure: immigrant vulnerabilities in global perspective. *Journal of Medical Anthropology* 2011;30(5):451–53.
- 402 Quesada J, Hart LK, Bourgois P. Structural vulnerability and health: Latino migrant labourers in the United States. *Med Anthropol*. 2011;30(4):339–62.
- 403 Spitzer D, 2016. See Reference 173.
- 404 De Jong S, 2015. See Reference 26.
- 405 Woodward D, Smith RD, 2003. See Reference 215.
- 406 Smith RD, MacKellar L. 2006. See Reference 46.

- 407 Stenberg K, Hanssen O, Edejer TT, Bertram M, Brindley C, Meshrekey A, et al. Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *Lancet Glob Health*. 2017;5(9): e875–87. [http://dx.doi.org/10.1016/S2214-109X\(17\)30263-2](http://dx.doi.org/10.1016/S2214-109X(17)30263-2).
- 408 International Task Force on Global Public Goods. Final report: meeting global challenges: international cooperation in the national interest. Stockholm: Ministry of Foreign Affairs; 2006.
- 409 Hennebry J et al., 2016. See Reference 49.
- 410 Migration Governance Framework [website]. Geneva: International Organization for Migration (https://www.iom.int/sites/default/files/about-iom/migof_brochure_a4_en.pdf, accessed 4 September 2017).
- 411 Castañeda X and Rodriguez-Lainz, 2014. See Reference 123.
- 412 Wu J, Zhang J. The effect of parental absence on child development in rural China. *Asian Economic Policy Review*. 2017;12(1):117–34.
- 413 WHO Consultative Group on Equity and Universal Health Coverage, 2014. See Reference 51.
- 414 Pan American Health Organization, 2014. See Reference 52.
- 415 WHO, forthcoming. See Reference 53.
- 416 Khan S, Pedersen A. Black Africa immigrants to Australia: prejudice and the function of attitudes. *J Pac Rim Psychol*. 2010;4(2):116–29.
- 417 WHO Regional Office for Europe, 2010. See Reference 397.
- 418 Langer A, Meleis A, Knaul FM, Atun R, Aran M, Arreola-Ornelas H et al., 2015. Women and Health: the key for sustainable development. *Lancet*. 2015; 386:1165–210. [http://dx.doi.org/10.1016/S0140-6736\(15\)60497-4](http://dx.doi.org/10.1016/S0140-6736(15)60497-4).
- 419 Langer A et al., 2015. See Reference 418.

Annexes

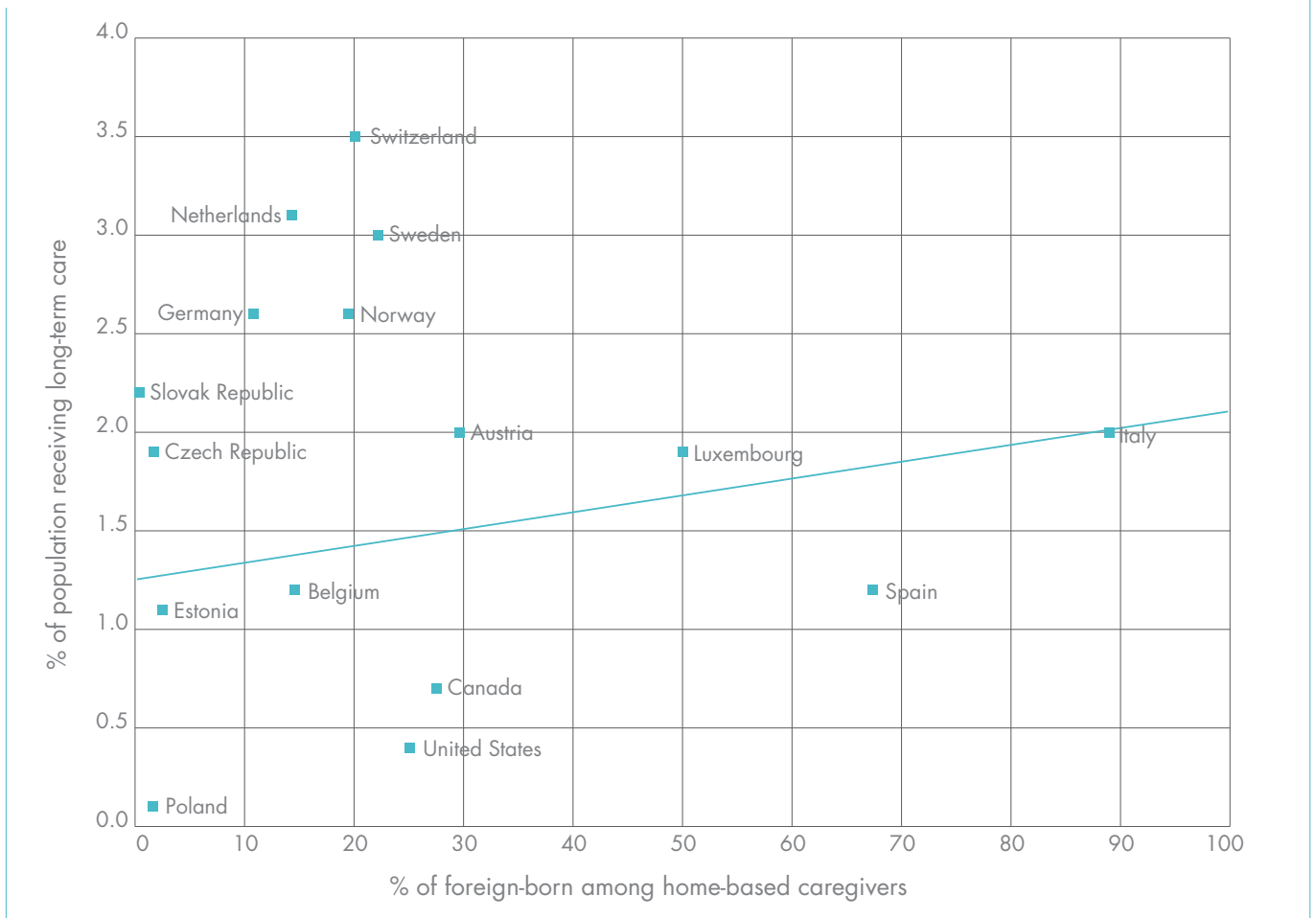
Annex 1

1.1. Change in female labour force participation and change in female migrant stock (OECD)



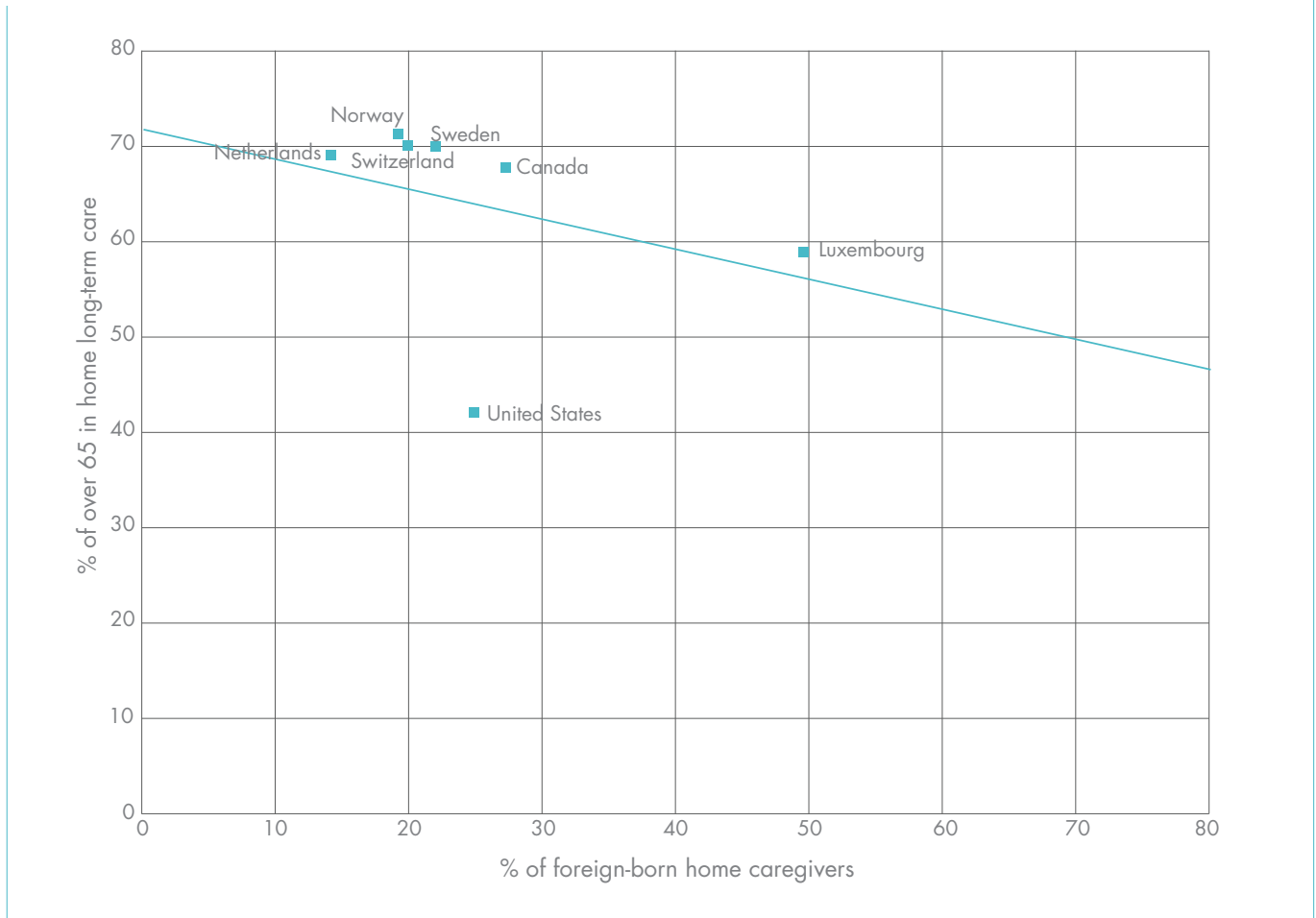
Source: Data on the stocks and flows of migrants are from UNDESA, <http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates15.shtml>
 Change in labour force participation data are from the World Development Indicators, World Bank, <https://data.worldbank.org/data-catalog/world-development-indicators>

1.2. Proportion of population receiving long-term care and % of female-born caregivers



Source: Data on the stocks and flows of migrants are from UNDESA, <http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates15.shtml>
 Change in labour force participation data are from the World Development Indicators, World Bank, <https://data.worldbank.org/data-catalog/world-development-indicators>

1.3. % total over 65 long-term care recipients receiving care at home and % of foreign-born home caregivers



Source: OECD Health at a Glance 2015

http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2015/recipients-of-long-term-care_health_glance-2015-75-en

Notes: Percentage of over 65 years old receiving long-term care at home

Annex 2

Model of Care for Carers

The Carers Compass (Modes of Care for Carers) was first developed by the Kings Fund UK in 1998, it is now being applied in health services in South East Sydney and other parts of New South Wales, Australia. It aims to recognise the challenges of caring and meet the needs of carers. It focuses primarily on unpaid carers but is also relevant for paid carers. Although it does not address migrant care workers directly some of the aspects of the program could be adapted to support migrant carers.

*The aim of the **Model of Care for Carers** is to recognise and build on the existing knowledge, skills and experience of LHD services and staff who already have a strong focus on carers. It will assist not only clinical streams and acute care facilities but also support units such as corporate services and human resources to further develop and improve their capacity to consistently meet the needs of carers through their identification, inclusion and empowerment. It provides a framework/model to identify and address gaps in the provision of a family and care friendly service.*

*The **Model of Care for Carers** was developed to assist services identify gaps or areas of weakness in the assistance and support provided to carers. The Carers Compass names 8 key outcomes that carers have identified as being important to them. This includes questions about full information about caring, recognition of their own health needs and wellbeing, the right to a life of their own and quality services for the carer and the person being cared for, time off from caring, emotional support, training and support to care, financial security and a voice in care needs and policies. It has been used as an audit and performance management tool for National Health Services and local Authority commissions to improve support to carers in the United Kingdom (Kings Fund, UK 1998). The compass relates well to the priorities for action identified in the National Carer Strategy and the NSW Carer Action Plan. It also supports the 13 principles for working with Carers outlined in the carers Charter (NSW Carers Recognition Act 2010. Lastly, the Model can be used to address the National Safety and Quality Health Service Standards both National Standards (especially no. 2) and the ACHS EQUIP 5 criteria relating to carers. This will assist services and facilities to meet accreditation standards.*

Adapted from: http://www.seslhd.health.nsw.gov.au/Carer_Support_Program/Model_of_Care_for_Carers.asp



World Health
Organization

ISBN 978-92-4-151314-2



9 789241 513142