WOMEN ON THE MOVE
IMMIGRATION AND HEALTH IN THE WHO AFRICAN REGION

A LITERATURE REVIEW

WORLD HEALTH ORGANIZATION
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This report Women on the move: migration and Health in the WHO African Region — A Literature Review was commissioned by the World Health Organization Regional Office for Africa. Collaborating scholars drew on current literatures to offer insights into the opportunities and benefits created by migration, and how these potentially increase the agency and capabilities of African female migrants and those left behind.

Dr Triphonie Nkurunziza, the Programme Manager, Reproductive and Women’s Health unit of the WHO regional office for Africa conceived and supervised the literature review under the leadership of the Director, Family and Reproductive Health Department, Dr Felicitas Zawaira.

The Family and Reproductive Health Department acknowledge the two independent consultants commissioned to work on the literature review, Kelly Wangui Muraya and Patricia Wawira Njuki. Using an intersectional lens on gender and focusing on female migrants in the African context, they examined current literatures concentrating specifically on migrant health, which has been and continues to be an important part of the global agenda.

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LIST OF ACRONYMS

CEDAW  Convention on the Elimination of all Forms of Discrimination Against Women
CERD  International Convention on the Elimination of All Forms of Racial Discrimination
EU  European Union
HRW  Human Rights Watch
ICCPRI  International Convention on Civil and Political Rights
ICESCR  International Covenant on Economic, Social and Cultural Rights
ILO  International Labour Organization
IOM  International Organization for Migration
MSF  Médecins Sans Frontières (Doctors Without Borders)
RMMS  Regional Mixed Migration Secretariat
UN  United Nations
UN/DESA  United Nations – Department of Economic and Social Affairs
UNFPA  United Nations Population Fund
UNHCR  United Nations High Commissioner for Refugees
WHA  World Health Assembly
WHO  World Health Organization
EXECUTIVE SUMMARY

Migration is a multifaceted phenomenon that plays a critical role in today’s world. More recently, the international importance of migration was emphasized through its inclusion on the 2030 Agenda for Sustainable Development, which recognizes the integral function of migration in achieving development goals. Furthermore, migrant health has been and continues to be an important part of the global health agenda. The numerous positive impacts of migration include increased educational and work opportunities, and its capacity to yield a positive shift or broadening of perspectives on various social issues - including gender equity — among migrants and host country communities. Nonetheless, the migratory process spawns numerous challenges that sometimes generate very adverse consequences. It is important to recognize these aspects, in order to develop appropriate and responsive migration programmes and policies, and to strengthen existing ones. There is also a growing recognition of the gendered nature of migration patterns and of the fact that female migrants, in particular, face unique and specific vulnerabilities including greater risk of exploitation, abuse and trafficking; and are more likely to lag behind in progress towards the 2030 Agenda. Statistics have shown that nearly half of all African migrants globally are women. Accordingly, it is crucial to examine their needs, vulnerabilities and capabilities, and determine how these interact with the broader global context. This report focuses specifically on the health of African female migrants, examining it through an intersectional lens which recognizes the interaction between gender and other social parameters such as age, education level, as well as marital and legal status, all of which create specific positionalities for women. Drawing on existing literature, this report presents an overview of current knowledge on women’s health throughout the migration process, describing the lived realities of African women and girls on the move, and highlighting the health issues and challenges they encounter. The report also provides insight into the opportunities and benefits created by migration, indicating how these factors can potentially increase the agency and capabilities of African female migrants and those left behind. It also discusses the potential of the law, human rights mechanisms and international agreements to improve the rights and ensure the safety of women on the move, making policy recommendations on promoting the benefits of migration and reducing its vulnerabilities and risks for migrant women and girls.
1. INTRODUCTION

Migration is a multifaceted phenomenon that plays a critical role in today’s world. More recently, the international importance of migration was emphasized through its inclusion on the 2030 Agenda for Sustainable Development (see figure 1), which recognizes the integral function of migration in achieving development goals (UN, 2015). Indeed, migration can generate numerous positive impacts through its potential to increase the opportunities for education and productive work, and can also broaden perspectives around a range of social issues for both migrants and host country communities. Nonetheless, migration has its challenges and it is crucial to examine its positive and negative aspects, in order to develop and strengthen related policies and programmes.

There is also a growing recognition of the gendered nature of migration patterns, and the interplay of gender and migration. While gender norms and expectations also influence the migration experience of men and boys, this report focuses on female migrants who face unique risks and vulnerabilities - including greater risk of exploitation, abuse and trafficking - and are more likely to lag behind in progress towards the 2030 Agenda. Furthermore, the much greater representation of female migrants in less regulated and less visible jobs such as domestic care increases their vulnerabilities. Moreover, the rapid increase in female migration - including voluntary migration of single or partnered women who emigrate unaccompanied by their families - has led to the phenomenon currently termed as “the feminization of migration”. In the African region specifically, statistics indicate that nearly half of all African migrants globally are women (Fleury, 2016, UNFPA, 2006). There is need, therefore, to specifically examine the needs, vulnerabilities, agency and capabilities of female migrants, and investigate how these aspects interact with the broader global context. However, it is important to note that the category of “female migrant” is highly heterogeneous as women migrate for a wide range of reasons, and are differently situated depending on a range of factors, such as their socioeconomic and legal status, and their context of origin (and destination) which encompasses cultural and religious norms and beliefs. All these factors have an impact on the migration experience of women and girls and require careful examination. Accordingly, a nuanced understanding of gender (and its intersection with various social aspects) and of migration is crucial to the formulation of policies and programmes that are responsive and address the diverse needs of the equally diverse range of migrant women.

Examining gender through an intersectional lens and focusing on female migrants in the African context, this report specifically targets migrant health, which has been and continues to be an important part of the global agenda. Concerns that migrant health needs have not been adequately addressed have given rise to global concerted efforts, with governments working together to improve the situation. For example, during the 61st World Health Assembly (WHA) in 2008, WHO Member States endorsed Resolution 61.17 on the Health of Migrants in recognition of the enormity of migrant health challenges and issues. In 2010, a four-pronged approach was adopted, in conjunction with International Organization for Migration (IOM) and the Government of Spain, as the blueprint for
enhancing migrant health. The approach included: improving the monitoring of migrant health; establishing policy and legal frameworks to promote equal access to health services for migrants; ensuring that health services are delivered to migrants through a culturally and linguistically sensitive approach; and ensuring cross-border and intersectoral cooperation and collaboration on migrant health (WHO, 2010).

Drawing on current literature, section two of the report sets the scene by examining the migration patterns of African women (and girls), providing an overview of what is known about their health throughout the trajectory of the migration process. This section also describes the lived realities of African women and girls on the move, highlighting their health issues and challenges, including barriers to accessing adequate health care services. It concludes with insights into the opportunities and benefits generated by migration, and how these potentially increase the agency and capabilities of African female migrants and those left behind. The third and final section discusses how the law, human rights mechanisms and international agreements can potentially improve the rights and ensure the safety of women and girls on the move. It also provides policy recommendations on promoting the benefits of migration and reducing vulnerabilities and risks for migrant women and girls. Ultimately, the report proposes an integrative and incorporative approach to respond more adequately to migration as a determinant of health; and posits that such a shift would require a nuanced understanding of how advantages and disadvantages can intersect to create unique experiences in the mobility process for the diverse range of women and girls on the move. The report also provides a list of organizations relevant to women, migration and health (Annex 1).
2. LIVED REALITIES OF WOMEN AND GIRLS ON THE MOVE AND THEIR HEALTH NEEDS

2.1 Setting the scene: African female migration patterns and trends

African migrants constitute a significant proportion of global migrants. Table 1 shows the high migration areas in African, with the predominance of a south-south migration trend, followed by an increasing trend of migration to Europe (Adepoju, 2008, Flahaux and de Haas, 2016). Migrants from Southern Africa tend to migrate to America and Oceania, while migrants from North Africa tend to emigrate to Europe, Asia and the Gulf region (Flahaux and de Haas, 2016).

<table>
<thead>
<tr>
<th>Destination</th>
<th>Africa</th>
<th>Europe</th>
<th>Asia</th>
<th>Latin America</th>
<th>Oceania</th>
<th>Other Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>% migrants</td>
<td>52.6</td>
<td>28.9</td>
<td>12.5</td>
<td>0.2</td>
<td>0.9</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Source: Ghosh (2009)
There is limited gender-disaggregated data on African migrants. Nonetheless, there is evidence of some distinct female-dominated migrant flows (Andall, 1999, Caritas, 2012). Recent estimates indicate that there are approximately 17 million African women living out of their country of origin, representing nearly 50% of the total migrant flows from Africa (Caritas, 2012, Fleury, 2016). Table 2 presents an analysis of female migration from the various subregions of Sub-Saharan Africa during the 1990-2013 period. Although, there has been a slight decrease (or constancy) in the percentage of female migrants from most of the African regions – with the exception of Southern Africa – the overall proportion still remains significant. Accordingly, it is crucial to understand the interplay of gender and migration.

**Table 2: Proportion of female migrants within the total number of international migrants**

<table>
<thead>
<tr>
<th>Region</th>
<th>1990</th>
<th>2000</th>
<th>2010</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa (total)</td>
<td>46.6</td>
<td>47.2</td>
<td>46.1</td>
<td>45.9</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>47</td>
<td>47.6</td>
<td>46.6</td>
<td>46.3</td>
</tr>
<tr>
<td>Eastern Africa</td>
<td>48.5</td>
<td>49</td>
<td>48.6</td>
<td>47.8</td>
</tr>
<tr>
<td>Middle Africa</td>
<td>49</td>
<td>48.8</td>
<td>47.1</td>
<td>46.7</td>
</tr>
<tr>
<td>Northern Africa</td>
<td>46.7</td>
<td>44.6</td>
<td>42.5</td>
<td>41.5</td>
</tr>
<tr>
<td>Southern Africa</td>
<td>38.7</td>
<td>40.9</td>
<td>42</td>
<td>42.3</td>
</tr>
<tr>
<td>Western Africa</td>
<td>46.3</td>
<td>47.4</td>
<td>46.7</td>
<td>46.7</td>
</tr>
</tbody>
</table>

Source: UN/DESA Population Division 2013 cited in Fleury 2016

African female migrants are diverse in range, encompassing: regular and irregular migrant flows; women migrating for marriage or for family reunification; women migrating for economic reasons to fill positions in both skilled and unskilled labour markets; refugees and asylum seekers; trafficked persons; persons in mixed migration flows; and traditional migrants such as nomads. Historically, global discourse on female migration has centred on women as spouses, daughters and dependents of male principal migrants. Literature, however, shows that in post-colonial Africa, women increasingly began to migrate autonomously with improved educational attainment (Adepoju, 1995), or as a result of being “pushed out” of their rural homes by poverty, land degradation, cash cropping, and lack of access to land (Tienda and Booth, 1988). High male unemployment, increased employment opportunities for women overseas particularly in the health and care sector, as well as the desire for increased educational attainment (Adepoju, 2004) have also significantly contributed to the increase of independent female migration in the African context. Furthermore, increased access to information, improved communication and close networking with prior migrants who in turn inspire others to follow suit, all act as drivers of female migration within Africa. However, in more contemporary studies of African migration, some scholars have argued that migration is driven not so much by the traditionally-cited reasons of poverty and war as by the phenomenon of rising incomes that allow only “capable” individuals to migrate (Flahaux and deHaas, 2016). Accordingly, they (2016) posit that in an era of stringent visa rules and high migration costs, only those who have already attained some level of development are able to migrate. This, in turn, implicitly
works against those who are already disadvantaged. Nevertheless, regardless of the reasons for migrating, migration can create opportunities and benefits for migrants and their families left behind, just as it can cause great challenges and generate much expense.

2.1.1 Girls on the move

As was the case for women, children and adolescents were always viewed previously as tied migrants following their migrating parents. More recently, however, there has been a growing recognition of the independent migration – both internal and external – of children and adolescents (de Regt, 2016, RMMS, 2016, Temin et al., 2013). However, scholarship in this area is still in its infancy, such that there is still a dearth of data and literature on child and adolescent migration. Consequently, there is need for more focused research in this area as well as age-disaggregated migration data. Nonetheless, available statistics imply that there is substantial migration of children and adolescents. Indeed, evidence suggests that children and youth comprise 50-60% of forced migration streams (RMMS, 2016). For example, further data from the Regional Mixed Migration Secretariat (RMMS) show that over 7000 unaccompanied children and adolescents arrived in Italy by sea from Africa in the first half of 2016. The RMMS study also estimates that over 50% of those leaving the Horn of Africa as migrants are under the age of 20 years (RMMS, 2016). Additional data show that, of the 160 000 migrants deported from Saudi Arabia to Ethiopia in 2014, 7000 were children and adolescents, implying that these categories make up a significant proportion of the migration flows to the Gulf (de Regt, 2016).

Specifically, in the African setting, the migration of adolescent girls away from their parents is not a new phenomenon. It has always existed in the context of traditions and customs such as child fostering and early marriages (Grabska, 2016). The current novelty in adolescent migration trends in Africa is the independent decision-making to migrate internally or across borders sometimes without the express permission of parents (de Regt, 2016, RMMS, 2016, Temin et al., 2013). The reasons for adolescent female migration are varied. Poverty is a key driver of the migration of adolescent girls, with many being “lured” by the hope of a better life for themselves and their families (de Regt, 2016, Temin et al., 2013). This allure is further fuelled by increased access to information and networks, mainly through social media, the internet and television; all of which may contribute to the perception of a better life elsewhere (Grabska, 2016). Another key contributor to child and adolescent migration is change in family status or circumstances, including being orphaned, parental divorce, and/or mistreatment by step-parents (de Regt, 2016, Grabska, 2016, RMMS, 2016). Escape from oppressive gender-related cultural norms and practices such as forced early marriages, female genital cutting and denial of equal access to education also contributes to adolescent migration (Grabska, 2016).

2.2 Women and girls on the move: health consequences

Women and girls encounter different opportunities and challenges during migration, as well as a range of limiting or enabling factors in both the origin and host countries. They also often work in different sectors from men (and boys) - sometimes under conditions that can be very isolating such as in domestic work and care sectors - and are therefore exposed to
different risks in the migration process compared to men. Such risks include: exploitation; higher risk of trafficking; forced sexual labour and sexual assault leading to adverse reproductive and sexual health consequences; gender-based discrimination that is sometimes exacerbated by racial and ethnic prejudices; and predisposition to a range of human rights abuses by virtue of their gender. All the above leaves an impact on their health and well-being.

Table 3 is an adaptation from a range of studies showing the vulnerability of female migrants during the various stages of the migration process as well as the attendant health risks they encounter in the four stages of migration, namely: at origin, during transit, at the destination and on returning to their countries of origin. This framework has also been used by organizations such as IOM to highlight the potentially devastating effects of migration on the physical, mental, emotional and sexual health of migrant women throughout the migratory process as well as its impact on their economic well-being. It is important to note, however, that not all migrants are necessarily of poor health or pose a health risk in the migration process. Indeed, many migrants, especially the regular ones, are selected for the process through vigorous health checks which ensure that they are likely to be in good health or even better health than the host populations. For instance, studies in Kenya show that refugees have a lower HIV/AIDS prevalence rate than the local communities in which they live (IOM, 2000).
Table 3: Women in the various stages of migration and their attendant health risks

<table>
<thead>
<tr>
<th>Type of migrant</th>
<th>Stage in the migration process</th>
<th>Characteristics</th>
<th>Health risks and implications</th>
</tr>
</thead>
</table>
| Economic migrants | Origin; pre-departure state; decision to migrate | - Women sometimes have unrealistic expectations of life in the destination countries.  
- They may lack proper information on the migration process and employment procedures, which makes them vulnerable during migration.  
- May have few resources to cover their migration expenses, which makes them vulnerable to exploitation. | - Many of these women live in situations of extreme poverty prior to migration and are thus predisposed to illnesses, poor nutrition and limited or no access to good quality health care. Consequently, migrants may have pre-existing illnesses that are exacerbated during the migration process. |
| Trafficked women | Origin or pre-departure | - Women may have limited knowledge and understanding of the migration process and possibility of trafficking.  
- Many trafficked women are in vulnerable states such as extreme poverty or having suffered family violence and abuse. | - Vulnerability to sexual violence  
- Lack or limited knowledge of STIs including HIV/AIDS  
- Psychological abuse prior to and during migration |
| Transit or travel state | | - Trafficked persons often realize that they are in a dangerous state during the transit or travel stage.  
- They are subjected to violence and exploitation, dangerous border crossings and dangerous routes that might expose them to illnesses. | - Trafficked women are exposed to physical abuse, rape and sexual violence, intimidation and psychological torture during the travel stage. |
| Destination | | - Trafficked women often end up in forced labour including sexual work and prostitution.  
- In extreme cases, victims may also be subjected to the removal of organs. | - Physical abuse, sexual abuse, forced labour, sometimes forced use of drugs and alcohol are among the health risks that trafficked women and girls face at the destination. |
| Return and reintegration stage | | - Trafficked women and girls returning to their countries of origin suffer stigmatization and discrimination and may be forced to undertake HIV tests, as well as some form of “moral reintegration”.  
- They may also return to the abuse situations they were trying to escape. | - They may experience poor physical health due to the challenges encountered when trafficked.  
- They may also experience mental health challenges such as depression, anxiety and self-stigmatization. |
| Refugees | Pre-departure | - Victims of war who may have experienced torture, trauma and sexual abuse | - They may experience physical violence, sexual assault and rape, torture and a range of mental health problems. |
| Destination | | - Prolonged stay in non-ideal situations in refugee camps where they have inadequate housing, poor nutrition and inadequate health facilities | - They live in insanitary conditions and have poor nutrition.  
- They may suffer illnesses caused by living in cramped insanitary spaces.  
- They are exposed to physical and sexual violence.  
- They experience a range of mental health problems. |
| Mixed migrants especially those in irregular situations, such as asylum seekers & urban refugees | Destination | - Irregular migrants face vulnerabilities associated with their fear of being caught by the authorities and deported, which may in turn limit their access to proper health care.  
- Other barriers to accessing health facilities include cost, language and cultural obstacles.  
- They are therefore unlikely to seek medical attention unless it is vital and miss out on preventive health initiatives such as immunization, antenatal care and safe childbirth initiatives. | - Many migrants in irregular migration streams often live in overcrowded urban slums where infectious diseases spread easily.  
- For example, a study carried out in Kenya traced outbreaks of measles in 2005, 2007 and 2009, to unvaccinated migrants. |

Furthermore, the status of both regular and irregular migrants can have a profound effect on the health status of the host community. Irregular migrants, in particular, are more vulnerable as they have limited access to quality health care due to their fear of being discovered, detained and deported. Consequently, many countries miss out on these “hidden groups” in health promotion activities such as: immunization and vaccination, family planning campaigns, antenatal and safe delivery campaigns, as well as child nutrition campaigns including breastfeeding. In Kenya, for example, a study carried out by IOM traced outbreaks of measles in 2005, 2007 and 2009 to unvaccinated migrants (IOM, 2013), highlighting the interrelatedness of migrant health and host population health.

2.3 The lived realities of African female migrants and related health implications

Drawing on the above framework, this section presents examples from the African continent to illustrate the lived realities of women and girls on the move, and the implications on their health. As earlier stated, African female migrants are a highly heterogeneous category and their movement is dynamic and diverse in terms of migration destinations, labour flows (skilled or unskilled), and the nature of migration (regular or irregular, voluntary or involuntary). The following section is an overview of some of the major trends exhibited in the migration of African women, accompanied by documented experiences.

2.3.1 African women in the global care chains

There is limited literature on African women and girls in the global care chains. In many cases, female domestic workers migrate irregularly and work in the private sphere, making it difficult to estimate the number of global female domestic workers from Africa. There is, however, evidence to suggest that the numbers could be significant. For instance, available statistics indicate that between 2009 and 2014, over 387,016 potential migrants, mostly women, signed up with the Ministry of Labour in Ethiopia to seek positions in the Middle East (Fernandez, 2011) where migrant women from the African region typically take up domestic care work. Other reports estimate that on average, every year from 2008 an estimated 35,000 regular female migrants from Ethiopia and a further 35,000 irregular female migrants moved to the Middle East and Gulf States respectively to take up work as domestic workers. Malit and Youha (2016) also cite Kenya as having significant flows of women migrating as domestic workers to the Middle East region. Additionally, there is considerable intercountry movement of female migrants within the African region for work in the domestic sphere. Literature indicates substantial migration of Sudanese, Ethiopian, Nigerian and Eritrean women to Egypt to work as domestic workers commonly referred to as “housemaids” (Ahmed, 2009; Jureidini, 2009); Ethiopian and Eritrean female migrants who move to Sudan to work as domestic workers (Bedri et al, 2015); and Basotho and Zimbabwean women who primarily migrate to South Africa to work in the domestic sphere (Griffin, 2011, Makono, 2009). Anecdotal evidence also points to flows of African domestic workers moving to countries in Europe.

Available data on African women in the global care chains indicate that the lived experiences - from a social and health perspective - of African migrant domestic workers in
their host countries, is quite often less-than-optimal. For example, Malik and Youha (2016) cite numerous cases of grave human rights abuses of Kenyan female domestic workers in the Middle East including physical, verbal and emotional abuse, and social isolation; a situation that ultimately led the Kenyan government to temporarily ban the migration of domestic workers to the Middle East.

Data from various other sources present the following adverse working conditions and related health problems of African female migrant domestic workers:

(a) Long working hours and suboptimal work environments, leading to conditions akin to indentured slavery. Women report very long working hours, being on call 24-hours a day, and sometimes working for two or three families simultaneously (HRW, 2014, 2016). Some domestic workers complain of sleep and food deprivation, living in substandard conditions and having no information on workplace safety or access to safety equipment. This results in work-related health problems such as injuries with resultant chronic conditions such as acute back pain or chemical burns resulting from inappropriate handling of cleaning materials.

(b) Physical abuse, including hitting, slapping, burning (Somnez et al, 2011, HRW, 2014, HRW, 2016).

(c) Sexual harassment and rape (Juredini, 2009, HRW, 2014, HRW, 2016).

(d) Psychological and emotional abuse including verbal abuse and insults (HRW, 2014, HRW, 2016).

(e) Loneliness and social isolation leading to a range of mental health problems including depression and anxiety. The passports of domestic migrants are often confiscated and they are denied the right to associate (Fernandez, 2011).

(f) Limited access to health care services for themselves and their dependents, sometimes due to language and cultural barriers and a lack of legal status (Dinat & Perbedy, 2007). Health care costs in most African and Middle East countries are prohibitive for domestic migrant workers, except in Kuwait which made it mandatory in 2016 for all migrants to be covered by medical insurance.

2.3.2 Migration of skilled female migrants from Africa

Much of the literature on the migration of skilled female migrants focuses on health sector migrants and centres on arguments pertaining to brain drain. The thrust of these arguments is that the migration of African nurses and doctors to the developed world has left a vacuum in their countries of origin (in addition to the millions of dollars lost in educating these highly skilled personnel). This vacuum is all the more glaring given the rising incidence of noncommunicable diseases and the growing impact of infectious diseases, including HIV/AIDS (Dovlo, 2007). Consequently, African health systems are overburdened, understaffed and incapable of offering adequate services to the local population. Indeed, there is some evidence to support the “brain drain argument”. Dovlo (2007), for instance, explains that between 1999 and 2001, 60% of the workforce in one Malawian hospital (114 nurses) emigrated to more developed countries; while the 500 nurses who left Ghana in the year 2000 represented more than double the number graduating from training schools in the country (Buchan and Sochalski, 2004). Other statistics indicate that between 1999 and
2005, the migration of nurses and midwives from sub-Saharan African countries including Botswana, Ghana, Kenya, Malawi, South Africa, Uganda, Zambia and Zimbabwe to work in the United Kingdom rose from 900 in 1999 to a high of 3800 in 2001/2002 and plateaued at an annual level of 2500 by 2004/2005 (Adepoju, 2008). Nigerian nurses were also recruited to work in Canada and the USA from as early as 1990, with 5000 nurses interviewed for that market (Adepoju 2008). Similarly, Nigerian nurses and doctors migrate to the Middle East to work in Saudi Arabia (Adepoju, 2005). As with domestic workers, there is also some level of intercountry movement of skilled migrants within the African Region.

Fewer studies have focused on the experiences of skilled African migrants once they arrive and settle in their host countries. A study by Wojczewski et al (2005) gives insight into the situation of African physicians and nurses when they migrate to middle-income countries in Africa, namely Botswana and South Africa; and to Europe, particularly in Belgium, Austria and the UK. The study shows that despite the high number of female migrants going to developed countries in the hope of career advancement and better economic prospects, their career progression is often not smooth, and in fact, many experience deskilling. According to the study (2005), a significant number of the nurses were temporarily unable to work as their skills and qualifications were not recognized in the new countries, and it was only after lengthy retraining that they were able to continue with their careers. This meant that many of them had to work in lower level jobs, sometimes as personal carers for disabled individuals and the elderly in private homes (rather than as registered nurses), as they underwent retraining. As a result, they felt a loss of professional and social status that affected their emotional well-being. Racial prejudice has also been highlighted as a serious problem by immigrant nurses from Africa. In her dissertation, Showers (2015) discusses how African nurses working in the United States of America gain ground in the labour market as they are traditionally idealized as being ‘caring and nurturing’, and enjoy a reputation for ‘working to the bone’. Nonetheless, because of their ‘thick accents’ and racial features, African nurses are often considered by patients and patients’ families as being nurses’ aides or in many cases perceived as not knowing what they are doing, while their Caucasian counterparts are viewed as ‘real nurses’.

2.3.3 Trafficked women

Africa’s human trafficking is complex and multifaceted. Trafficking is defined as the recruitment, transportation, transfer, harbouring or receipt of persons by means of threat or use of force or other forms of coercion and deception, for the purpose of exploitation (Adepoju, 2005). The major forms of trafficking identified within Africa include the trafficking of women and children for farm and domestic labour both within and outside the continent; and trafficking for sexual exploitation (Adepoju, 2005, IOM, 2006). Women and children are also trafficked for forced marriage and sex slavery, sometimes in the context of terrorist wars. In such cases, the motives go beyond simply exploitation as these women and children rather become weapons of war and a means to terrorize societies. Examples include the Lord Resistance Army in Uganda (IOM, 2006, IOM 2008), and Boko Haram in Nigeria (Zenn and Pearson, 2014) who kidnap girls and force them into marriage.

Many African countries are a source of trafficking, a transit route for trafficked persons, or a final destination country for trafficked women and children. Trafficking on the continent is
controlled not only by individual criminals (e.g. an individual who lures a relative or acquaintance into domestic or sexual labour for economic gain) but also by large international criminal syndicates (IOM, 2006, Adepoju, 2005). A review of trafficking within the African continent shows that African women are trafficked particularly to France, Germany, Italy, the Netherlands, Saudi Arabia, Spain, Sweden, Switzerland, the United Arab Emirates (UAE) and the United Kingdom for prostitution and pornography (Adepoju 2005). On the continent, they are trafficked primarily to Côte d’Ivoire and South Africa for the same purpose (Adepoju 2005). Literature also suggests that trafficking of young African girls to Europe is run primarily by international syndicates operated by wealthy businessmen, and that girls from India and parts of South Asia are also trafficked to Kenya for the local sex industry (Adepoju, 2005). Similarly, a study undertaken by IOM (2006) showed that Thai, Chinese and Eastern European women are trafficked to South Africa for debt-bonded sexual exploitation.

In addition to the significant physical, mental, sexual and reproductive health risks associated with being trafficked; victims often have very limited access to good quality health care and have minimal control (if any) over their health outcomes. In many cases, due to the forced and irregular nature of their migration, they do not have legal status within their countries of destination, which in turn limits their access to health and social services. Debt bondage and economic sabotage, where women end up keeping only very little of the money that they make, is one of the strategies used by captors to control female victims of trafficking. A study conducted among Ugandan women trafficked to Guangzhou China to take care of the ‘needs’ of the numerous African businessmen living away from their families, elucidates some of the difficulties women encounter in maintaining their health (Davis et al., 2016). According to the study, sex workers live in dire poverty due to low wages, debt bondage and the need to support families back in Uganda through remittances. Consequently, they are unable to access quality health care due to financial constraints. Another major barrier for these Ugandan women, is lack of the legal documentation required to access health services in China. In many cases, women cannot afford medicines and the lack of documentation means that they cannot get treatment for illnesses including HIV infection (Davis et al., 2016). The irregular nature of their migration makes them mistrust the system and they are discriminated against by the local population. As a result, they self-medicate with medication bought from local chemists or traditional healers, or ask friends to bring them medicines from their home country (Davis et al., 2016). All the above profoundly affects their health status, including their emotional and mental well-being.

2.3.4. Refugee women

As at the end of 2015, there were 4.4 million refugees and people of concern to UNHCR in Africa. It is estimated that about 50% of the refugees are women (UNHCR, 2015). This figure represents 26% of the global refugee population, but more importantly, a 20% increase in refugees from 2014, indicating that the conflicts on the continent continue to pose a serious threat.
Unlike voluntary migrants, refugees are forcibly displaced and have often experienced insurmountable trauma during war, including subjection to a range of human rights violations, torture, sexual and gender-based violence that directly lead to severe adverse health consequences. In many cases, the refugee camps where most of the refugees end up living for an extended period of time, are set up as temporary camps. However, experience in Africa shows that these camps long outlive the temporary emergency phases for which they are built (MSF, 1997). In the initial stages of war, conflict and crisis, the organizations tasked with refugee health often ensure that top health priorities are met. Such health priorities include: initial assessment of individuals’ health, measles immunization, satisfaction of water and sanitation needs, provision of food and nutrition services, shelter and site planning, control of communicable diseases and public health surveillance (MSF, 1997). However, the health outcomes for refugees in protracted refugee situations are often quite poor. Studies conducted in refugee camps in Africa paint a grim picture of very poor physical and mental health outcomes for female refugees, who continue to suffer rape and violence in the camps intended to be a ‘safe haven’ away from the conflict in their countries of origin (Beswick 2001).

Urban refugees have more or less similar health outcomes as their counterparts in the refugee camps. For instance, an IOM study conducted in 2011 on urban living in an ethnic enclave in Nairobi found a higher incidence of tuberculosis among urban migrants and refugees compared to the general population, owing to their living conditions. The overcrowded, dark, poorly-ventilated apartment blocks where they often reside were found to fuel the spread of the disease (IOM, 2011).

2.3.5 Mixed migration
The term ‘mixed migration’ is relatively new in migration literature, and is used for modern flows of migrants. This includes current trends whereby refugees and other migrants who are unable to reach their desired destination (through formal channels), resort to the services of smugglers and undertake highly dangerous sea and land crossings to achieve their goal. In the case of Africa, mixed migration flows are concentrated in the Mediterranean basin and the Gulf of Aden (UNHCR, 2015).
The experience of women in mixed migration flows is often traumatic with severe adverse health consequences. As with other forms of migration, such as involuntary and forced migration, women in this category experience: physical violence; sexual assault; abduction and torture; mental and psychological abuse; gender-based discrimination; detention by authorities; extortion; dangerous sea crossings for several days in overcrowded boats and vessels prone to capsizing; hazardous land crossings including across deserts where they are exposed to the elements; food and water rationing or starvation; dehydration; and loss of life (RMMS, 2014, 2012, Gerard & Pickering 2014). In Gerard and Pickering’s (2014) account of Somali women in Malta who had crossed through North Africa to reach their destination, respondents described many months of travelling fraught with danger. The women described being raped or forced to trade sexual favours in return for safe passage or to be released from detention centres (Gerard and Pickering, 2014). Similarly, a study exploring the plight of Somali and Ethiopian women moving from the Horn of Africa to Yemen details comparable experiences as they try to cross the Gulf of Aden (RMMS, 2014). Despite their exposure to such grave health risks and the adverse experiences that undoubtedly had serious negative consequences on their health, including unwanted pregnancies, unsafe abortions for fear of being left behind or denied entry, and contracting of sexually transmitted infections, women in both studies recounted having no access to any form of health care during most of the journey to their destination (Gerard and Pickering 2014, RMMS, 2014).

2.4 African women migrants’ access to health care

In light of the above detailed lived experiences of various categories of African women on the move, and the implications on their health, this next section explores access to health care for migrant women, framing it within the context of the WHO Operational Framework on Migrant Health (2010) (see figure 2). The Operational Framework (2010) underscores, as one of its key elements, the importance of developing health information systems that will provide accurate data on migrant health (including sex- and age-disaggregated data) which will be used to develop responsive and appropriate migrant health policies and systems. There is a gap in the literature on patterns of access to health care for the various categories of African female migrants - whether during transit or at their final destination — and how the governments of origin and host countries cater to the health needs of this highly...
heterogeneous group. The available data especially from Southern Africa on African migrants who have moved to other continents such as Australia, Europe and the Americas, point to underutilization of health services by African female migrants in general, due to individual or systematic barriers.

Figure 2: WHA resolution on migrant health: selected action points

The Operational Framework (2010) also highlights the need for migrant-sensitive health systems. This includes strengthening health systems to fill gaps in service delivery; as well as awareness and sensitivity training for the health workforce. Poor language skills and communication difficulties are some of the central barriers to migrants’ access to health care across the world. Where migrants cannot speak the language, they are unable to communicate with health providers in the destination countries and this limits their access and utilisation of services (Olayide, 2009, Zihindula, 2015). A study on black African migrants in the United Kingdom for example, highlights language as a major barrier to migrant access to health care (Ochieng, 2012). The (2012) study showed that even where written health information was translated to the relevant native language, low literacy levels among many of the African female migrants prevented them from understanding the information provided. Countries such as Australia, where direct translation services are available for migrants within the health care system, have been shown to have better utilization of health services by migrants (Mohammed et al. 2006). This is especially beneficial during the initial years of resettlement (Mohammed et al. 2006). Crush (2011) also explores another dimension of barriers to accessing health care, and illustrates how refusal to use a language such as English that was mutually understood by both providers and migrants, as well as refusal to use translators, were used as tactics to discriminate against Zimbabwean migrants seeking medical treatment in South Africa.

Cultural norms and practices also have a major influence on African female migrants’ access to, and use of, health care services. Olayide (2009) in her study on African women in Australia and their experiences of health-seeking, explains how certain cultural norms such as female genital cutting may make women shy away from utilizing health services for cervical cancer tests, for instance. Such examples highlight the need to raise awareness on
cultural and gender sensitivities among the health workforce as indicated in the 2010 Operational Framework on Migrant Health. In their study of African migrants in Sweden who had undergone female genital cutting, Thierfelder et al. (2005) also reiterate the importance of culturally appropriate health systems for such women, expressing the need to organize capacity-building for health workers, and to provide culturally appropriate health information so that migrants can fully benefit from available health services. Studies conducted in Lesotho and Swaziland have also indicated that external stigmatization or self-stigma, especially among migrants with sexually transmitted infections and HIV/AIDS, are a hindrance to accessing antiretroviral therapy or other health-related services (Zihindula et al., 2015). Other barriers to accessing and utilizing health services for migrants include inadequate knowledge and understanding of the host country health system. Furthermore, migrants who come from cultures where there is greater emphasis on curative services rather than preventive and promotive health care, are also less likely to utilize such services as has been observed with African female migrants in Australia (Olayide 2009). Low education levels and cultural beliefs have also been documented as hindering African female migrants in Canada from obtaining optimal health care (Davis et al., 2016).

Depending on the context, legal status of the migrant, and the ability to access public health services, the cost of medical care is often a deterrent of migrants’ access to, and use of, health care services. Many migrants (particularly irregular migrants) live in economic hardship and either cannot afford mainstream health care services or are unable to utilize free public health services due to their illegal status (IOM, 2006). In the case of intercountry migration within the African region, few African countries provide access to health services for migrants and refugees to the same extent that they provide to their own citizens. The only exceptions are Angola, which does not require any form of identification when refugees access health care services, and Botswana where health services are offered to all although refugees must be registered (Zihindula et al, 2015). Indeed, many African countries do not have adequate free public health care services even for their own citizens, and in countries where they do exist, these services are generally not extended to migrants and refugees. Hence, refugees and migrants living within the host communities generally incur out-of-pocket expenses when they utilize health services and this can hamper their use of and access to such services.

Systematic barriers to access and utilization of health services point to broader system failures in providing health services to vulnerable individuals including migrants and refugees. Weak or inadequate health systems in host countries, including insufficient number of health facilities and overburdened existing health facilities, lack of necessary medical equipment and commodities, health care staff shortages and weak health governance and financing systems, also contribute to migrants’ lack of access or utilization of health care services (IOM, 2006). Thus, as indicated in the 2010 WHO Operational Framework, it is important to strengthen local health systems and to institute migrant-sensitive health policy legal frameworks, multi-country partnerships and networks that benefit citizens and migrants alike.
Drawing on existing literature, the preceding sections set out the patterns of African female migration, highlighting the major trends and categories of African female migrants and their documented lived realities. The experiences of African female migrants in the global care chain, pertaining to skilled migration, trafficked girls and women, refugees, and women in mixed migration flows have been discussed together with the attendant health implications. Barriers to access and utilization of adequate health care services by African migrants have also been examined in the context of the 2010 WHO Operational Framework for Migrant Health. It is evident from the data presented that, regardless of status and reason for migration, African female migrants face enormous challenges throughout the migratory process of pre-migration, transit, arrival at the destination and, where applicable, re-entry and reintegration into their country of origin. These challenges necessarily have an adverse impact on their health status. All the above notwithstanding, migration is not all doom and gloom. In fact, migration has been shown, in many contexts, to create benefits and opportunities for migrant girls and women that enhance their agency and capabilities. These benefits sometimes extend to the family and communities left behind. For instance, refugee women who are forcibly displaced from their countries of origin and who may undergo harrowing experiences both in the transit period and during prolonged stays in refugee camps, may eventually resettle in their final destination country where they engage in productive work, commence or continue schooling, actively participate in their host communities as responsible citizens, and generally thrive and rebuild their lives while assisting family members left behind and generating momentum for positive social change within their communities of origin. The following section (2.5) briefly discusses some of these migration benefits and introduces the final section of the report that examines the potential of the law, human rights mechanisms and international agreements to safeguard the safety and security of women on the move and those left behind.

2.5 Opportunities and benefits of migration and resultant capabilities of women and girls on the move

As has been demonstrated in the preceding sections, the grave challenges, vulnerabilities and risks faced by migrant women and girls are a matter of concern which requires urgent action. Nonetheless, it is equally important to recognize the opportunities and benefits available to migrant women and the fact that, in many circumstances, migration can be empowering for women. It is often the case that empowerment and disempowerment operate simultaneously in the everyday realities of migrant women, producing enabling trade-offs for individual women and between varying categories of women (Ghosh 2009, O'neil et al., 2016). Accordingly, recognizing the capabilities and agency of migrant women and girls, which can be built upon to address existing challenges, can be crucial in achieving the Sustainable Development Goals.

Some of the positive impacts of migration on migrant women documented in literature include: increased autonomy; renewed self-confidence and self-esteem; greater human capital; challenging of disadvantageous traditional gender norms and roles as women gain access to education and economic opportunities; economic empowerment; escape from
oppresive cultural norms and practices such as female genital cutting and early or forced marriages; mental shifts around equitable social norms which could improve women’s rights and access to resources; and the possibility for migrant women to sustain their acquired skills and expertise even upon re-entry and reintegration in their countries of origin, which could potentially have a positive impact on their communities (Fleury, 2016, Ghosh, 2009, O’neil et al., 2016, Temin et al., 2013, UNFPA, 2006).

Migration can also have a positive impact on the women left behind. A key aspect of migration is remittances – that is, migrants sending earnings home to support family members (Fleury, 2016). In general, migrant women remit a greater percentage of their income – and are more frequent and regular in sending remittances - than male migrants, although the total amount of remittances may be lower because of lower wages (UNFPA, 2006). According to UN Women, women are also more likely to receive remittances regardless of the sex of the remitter, and although specific data from African countries is varied, women are still the majority of recipients in countries such as Lesotho (Deere et al., 2015). Remittances can increase the autonomy of the women left behind. There is sparse data from the African context specifically on the impact of remittances on female autonomy. Nevertheless, data from other regions indicate for example, that female recipients of remittances moved from depending on rain-fed subsistence farming to running small businesses, which ultimately increased their decision-making power and had a positive impact on overall family well-being (IOM, 2012, Fleury, 2016). Additionally, data clearly shows that remittances from women to other women are more likely to be utilized on: health, particularly for children including improved nutrition; children’s education including increased schooling for girls; and daily household needs for the overall well-being of the family (Fleury, 2016, Temin, 2013, UNFPA, 2006). This has an immediate positive effect on those left behind, while the investment in human capital also has a potentially sustainable positive impact on the families concerned and community at large. Meanwhile, literature shows that where men are the recipients of remittances, they are more likely to utilize it on asset accumulation (Fleury, 2016). Thus, women tend to invest remittances more in household durable needs, while men tend to invest more in consumer durables.

However, it is important to note that the notion of agency and empowerment of migrant women and girls is complex and multi-layered, and cannot be viewed from a simple unidimensional standpoint. Rather, empowerment occurs in a context where there is a range of intersecting factors including: class, social position, legal status, gendered professional demarcations, family resources, traditionally or culturally determined forms of gender discrimination, and lack of access to information and other networks (Ghosh, 2009). Empowerment is ultimately reliant on multifaceted interrelationships between the socioeconomic and public policy contexts of both the host and origin countries, which determine real outcomes. The predominant environment in the destination country and the frequently complex interactions between the host society and the migrant community, all influence the degree to which women can reap the benefits of the migration process. For example, studies have critiqued the notion that participation in paid employment directly leads to the empowerment of migrant women. This is prompted by the concurrent emergence of disempowering forces such as gender ideologies in immigrant communities,
and women’s disadvantaged position in the labour market in the host countries which entails: doing low-paid jobs with few benefits or opportunities for career advancement (even though they might sometimes have higher educational levels than migrant men), or receiving less pay than their male counterparts for the same jobs, thus reinforcing the notion of women as inferior (Ghosh, 2009, Kibria, 1993). The issue is therefore clearly complex and requires detailed understanding of the intricate relationship between gender — its intersection with other social factors — and migration. Nonetheless, it is still essential to recognize the potential (and real) benefits and opportunities associated with migration, and draw on these to improve the situation of migrant women.

3. LAW, HUMAN RIGHTS MECHANISMS AND INTERNATIONAL AGREEMENTS IN ENSURING SAFETY AND SECURITY OF WOMEN ON THE MOVE

3.1 Overview of international agreements and regional frameworks and their role in protecting the rights of migrants

The complex and unprecedented levels of migration flows require concrete policies and legal frameworks both within and across countries to ensure that migration is organized, protective and enabling for all concern. As discussed in section two, in recognition of the unique health needs of migrants, the 61st World Health Assembly adopted a resolution that encouraged States to develop migrant-sensitive health policies and practices, resulting in the 2010 WHO Operational Framework on Migrant Health. Policymaking for migrant health is generally viewed from a human rights perspective that recognizes migrant vulnerabilities to: interpersonal and occupational hazards; social exclusion; discrimination; and the importance of universal access and culturally competent health care services (Zimmerman et al., 2011). Human rights are expressed and guaranteed by law in national constitutions and legislation, as well as in international agreements and mechanisms.

Over the years, there have been several international covenants and conventions specifically affirming health as a fundamental human right for all, including migrants. One of the key international instruments recognizing this right and that can specifically be related to migrant health is the International Covenant on Economic, Social and Cultural Rights (ICESCR). As of 2015, the covenant had been signed and ratified by 164 countries including most African States, except Botswana, Mozambique, Sudan and Western Sahara. The ICESCR grants every individual the right to the best attainable state of physical and mental health, based on individuals’ cultural and social rights. Accordingly, the ICESCR views the right to health, not as an isolated principle, but in conjunction with other broader social factors that are crucial to the overall well-being of individuals. These include: the right to work under just and favourable conditions, including balancing work and family life; the protection of children; the provision of social insurance and social security; adequate standards of living, including adequate food, clothing and housing; provision and availability of high quality education; and participation in social and cultural life (IOM, 2013). The IOM (2013) report on international migration, health and human rights further explains that both host and origin country governments have a responsibility to ensure the availability and
accessibility of adequate health care facilities and services to all without any form of discrimination or prejudice; and particularly targets the most vulnerable and marginalized populations, which would include migrants and refugees. Furthermore, the report states that health services should be of high quality and ‘acceptable’, noting that they must be gender-sensitive, culturally appropriate and compliant with the high standards of medical ethical practice.

Another international instrument that covers migrants and migrant health is the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. This agreement has been ratified by 20 countries and it entered into force in 2003. Most of the countries that have signed or ratified this treaty are in West and North Africa; with Uganda being the only East African country to have signed the treaty, and Mozambique and Lesotho being the only Southern African countries to do so. The Convention provides for equal treatment of all regular migrants and their families with respect to access to social and health services. There are, however, concerns that although the Convention recognizes the right to emergency medical treatment for regular migrants and their families, it fails to guarantee access to preventive medical treatment such as early diagnosis and screening, medical follow-up, as well as palliative health services (IOM, 2009); services which, if included, would better serve the migrant communities.

The 1979 Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) is one of the international treaties that focuses specifically on the rights of women. It pays special attention to female migrant workers, especially in light of their sex and gender-based human rights concerns. Women have different and unique health needs from men, and thus require special attention. For example, in the context of migration, women may suffer discrimination if found to be pregnant, which may lead to their deportation, coerced abortion, or denial of entry into their destination (IOM, 2009). Accordingly, States are urged to offer affordable gender-sensitive and rights-based health services, as well as legal rights and protection for female migrants including those who are undocumented (IOM, 2009). CEDAW has been signed, acceded to or ratified by most countries globally. In Africa, only Sudan and Somalia have not ratified the Convention. There are other international treaties that highlight specific categories of women on the move. Refugees are protected under the 1951 Convention of Refugees and its 1967 protocol, whereas the rights of those who have been trafficked or smuggled are protected under the 2002 Protocol against the smuggling of migrants by land, sea and air and the 2000 Protocol to prevent, suppress or punish trafficking in persons especially women and children. The latter two protocols supplement the 2000 United Nations Convention against Transnational Organized Crime. These and other protocols have been put in place mainly to protect the rights of women on the move. Table 4 summarizes additional current international treaties that protect migrants.
### Table 4: Summary of international treaties and conventions for the protection of migrants

<table>
<thead>
<tr>
<th>General international instruments</th>
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</thead>
<tbody>
<tr>
<td>• Universal Declaration of Human Rights (1948)</td>
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<tr>
<td>• International Convention on Civil and Political Rights (ICCPR); and the</td>
</tr>
<tr>
<td>• International Convention on the Elimination of All Forms of Racial Discrimination (CERD)</td>
</tr>
<tr>
<td>Both conventions prohibit discrimination based on race, colour, sex, language, religion, political views or opinions, national or social origin, property, birth or other status</td>
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</tbody>
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<table>
<thead>
<tr>
<th>International Labour Organization (ILO) - instruments on the protection of migrant workers</th>
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<tbody>
<tr>
<td>• Convention No. 97 concerning Migration for Employment (1949)</td>
</tr>
<tr>
<td>• Recommendation No. 86 concerning migration for employment (1949)</td>
</tr>
<tr>
<td>• Convention No. 143 concerning Migration in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers (1975)</td>
</tr>
<tr>
<td>• Recommendation No. 151 concerning Migrant Workers (1975)</td>
</tr>
</tbody>
</table>

Source: IOM, 2009

In addition to the international frameworks, the African Union has also prepared legal and policy instruments that impact on migrants. These include the Abuja Treaty that came into effect in 1994, with a vision of African economic integration, and has been ratified by 48 African States. The Treaty prioritizes migration as it advances the notion of “...necessary measures to achieve progressively, the free movement of persons and to ensure the enjoyment of the right to residence and the right to establishment by nationals within the African Economic Community...” (Landau and Achiume, 2015). Additionally, the Treaty calls on countries to protect the human rights of all migrants and offers guidelines on how to combat discrimination and xenophobia. The African Union’s position on migration is documented in two policies, namely the African Common Position on Migration and Development, and the Migration Policy Framework for Africa, both of which were adopted in 2006 by the Executive Council of the African Union. The Migration Policy Framework for Africa is the more comprehensive of the two documents, giving explicit guidelines on: labour migration; border management; irregular migration; forced displacement; human rights of migrants; internal migration; collection and use of migration data; migration and development; and interstate cooperation and partnerships (Landau and Achiume, 2006).

In addition to the legal and policy frameworks, it is important to note that there are other factors that impact on policy and practice around the protection of African migrants. Carling (2015) in his report on smuggling in West and Central Africa reported that in 2014, almost 60 000 sub-Saharan Africans were apprehended as undocumented entrants at Europe’s external borders. Most of these were from the Horn of Africa, and a significant proportion were from West and Central Africa. In the same year, 73 000 West and Central Africans applied for asylum in Europe. These significant movements between Europe and Africa have necessitated increased cooperation between African and European states to manage the unprecedented levels of migration flows between the two regions. Consequently, the EU-Africa Action Plan on Migration and Mobility is the current three-year strategy to provide comprehensive responses to migration between the two regions. The goals of the action plan include: addressing the root causes of migration and refugee flows; ensuring fair
treatment of all migrants under applicable international law; finding concrete solutions to problems posed by irregular flows and trafficking of human beings; as well as ensuring that migration and mobility work for development. The cooperation is accompanied by funding to operationalize some of the programmatic and protection opportunities to manage the flow of migrants to Europe. Some of the listed funding priorities include: funding legal migration, for example, by offering scholarships to Europe for African students and academics; providing protection and economic opportunities to displaced persons from the Horn of Africa and North Africa; and stepping up cooperation to stem illegal migration and people trafficking. Meanwhile, African countries are urged to assist Europe in the repatriation of failed asylum seekers.

3.2 Challenges to the adoption of international and regional frameworks by African states

Although these legal international and regional treaties have drawn almost universal support from African countries, evidenced by the high levels of ratification, their adoption in practice is still far from optimal. The reality in many settings is that African migrants are still largely exposed to numerous risks and threats with severe adverse consequences to their health; and face significant barriers in accessing health care as discussed in section two of this report. The main impediments that prevent African governments from implementing the legal and policy frameworks and providing health services as prescribed include: financial and human resource constraints, particularly where countries are struggling to provide basic adequate quality health care services even to their own citizens; and the concerns harboured by some countries that offering minimum standards of health care to all migrants will act as an immigration magnet, resulting in an influx of migrants seeking health services – consequently these countries withhold such services as a means of population control (IOM, 2009). For example, a study in Kenya found that one of the major challenges to migrants accessing health care services was the poor quality and lack of health facilities in border towns (IOM, 2006). In Malawi, while there are no legal impediments to migrants accessing health care, the lack of necessary medications and other commodities within hospitals hampers migrants’ access to health care (Zinhindula et al, 2009). However, there is need for further research to explore the relationship between offering adequate migrant health services without prejudice and discrimination, and overall healthier societies (IOM, 2009). Political considerations are another impediment to operationalizing international and regional policy and legal frameworks. Landau and Achiume (2015), for example, explain that the free movement of persons, which was a key aspirational pillar of the *Abuja Treaty*, together with increased trade and information exchange, is being accompanied by ‘politics of closure’ with regards to immigration. As such, there must be a balance between safeguarding national security and opening up borders to immigration flows, if African states are to achieve their regional integration agenda.

Despite these challenges, the legal and policy frameworks developed and outlined under the above-mentioned international and regional treaties, have high human rights ideals. If adequately implemented, they will have a huge potential to protect women and girls on the move, safeguard their human rights and ultimately ensure that African female migrants, as
well as those who are left behind, fully benefit from the migration process and associated opportunities.

4. CONCLUSIONS AND POLICY RECOMMENDATIONS

Women migrate as much as men, and statistics indicate that the global proportions of male and female migration are almost equal. Men and women experience migration differently, and gender – and its intersections with other social aspects – has a complex interaction with migration, producing varying positionalities for migrant women. Migration can be enabling, offering new prospects for women and girls, just as it can expose them to new or heightened risks. Hence, to ensure that they benefit fully from migration, legal frameworks and policies must be instituted to empower them; promote economic opportunities arising from their mobility; and safeguard their health, human rights and security. This is particularly crucial for the most vulnerable categories, including forcibly-displaced persons like refugees, trafficked persons or female workers with low skills working in highly unregulated markets.

Female migrants are also a highly diverse and heterogeneous group with individuals migrating for varying reasons and situated differently based on their socioeconomic and legal status, and other social factors such as age, (dis)ability, race, ethnicity, educational level, religious and cultural beliefs. As such, migration-related policies and frameworks will augment the enabling effects of migration and alleviate increased risks and vulnerabilities, only if they consider the specific needs of various categories of female migrants. This also requires a nuanced understanding of the various contexts and programmes tailored to accommodate the differently positioned female migrants.

Literature suggests that migration is most likely to empower women and girls if it follows regular channels that enable them to make informed choices and decisions and to have access to legal protection services and social networks in both the origin and host countries. This would require concerted efforts and action at various levels, from the grassroots community to the global level, and collaboration within and across sectors, including international organizations, government agencies, the private sector and civil society. Furthermore, countries have vastly differing political contexts, including political willpower and leadership on gender and migration issues. All these factors need to be considered when formulating strategies that are most beneficial to female migrants. Ultimately, addressing the needs and challenges of female migrants while maximizing the potential opportunities and benefits available to them, requires an integrative and incorporative approach that also recognizes migration as a determinant of health. Such an approach would perforce require a transformational shift in thinking that recognizes the nexus of empowerment and disempowerment for migrant women, and how this creates unique experiences in the mobility process for the diverse range of women on the move.
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## ANNEX: LIST OF ORGANIZATIONS RELEVANT TO WOMEN, MIGRATION AND HEALTH

<table>
<thead>
<tr>
<th>Organization</th>
<th>Area of expertise</th>
<th>Country/areas of operation</th>
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</table>
| International Committee of the Red Cross (ICRC)   | • General health  
• Health in conflicts and crisis  
• Water and habitat  
• Addressing sexual violence  
• Enabling people with disabilities                  | Lake Chad, Somalia, South Sudan and Sudan                                                    |
| Medecins San Frontiers (MSF) – Doctors Without Borders | • Humanitarian medical assistance to victims of conflict, natural disasters, epidemics or health care exclusion  
• Basic healthcare including: performing surgeries, managing epidemics, rehabilitating and running hospitals and clinics, operating nutrition centres, conducting vaccination campaigns and providing mental health care  
• Migrant and refugee health programs including rescue at sea | Burundi, Central African Republic, Cameroon, Chad, Côte d’Ivoire, Egypt, Ethiopia, Guinea, Guinea-Bissau, Kenya, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Sierra Leone, South Africa, South Sudan, Sudan, Swaziland, United Republic of Tanzania, Uganda and Zimbabwe |
| International Medical Corps                        | • Emergency response and preparedness  
• Health services support  
• Family and community health  
• Women and children’s health  
• Mental health and psychosocial support            | Burundi, Cameroon, Central African Republic (CAR), Chad, Darfur, Democratic Republic of Congo (DRC), Ethiopia, Guinea, Guinea-Bissau, Kenya, Liberia, Libya, Mali, Nigeria, Sierra Leone, Somalia, South Sudan and Zimbabwe |
| CARE                                              | • Maternal health  
• Reproductive health and family planning  
• Child health and survival  
• Water and sanitation  
• HIV /AIDS                                           | Angola, Benin, Burundi, Cameroon, Chad, Côte d’Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mali, Morocco, Mozambique, Niger, Rwanda, Sierra Leone, Somalia, South Sudan, Sudan, United Republic of Tanzania, Togo, Uganda, Zambia, Zimbabwe |
| International Organization for Migration          | • Monitoring migrant health  
• Enabling conducive policy and legal frameworks on migrant health  
• Strengthening migrant-friendly health systems  
• Facilitating partnerships, networks and multi-country frameworks on migrant health  
Programs include:  
• Migration health assessments  
• Health promotion for migrants  
• Health of migrants in crisis | Global                                                                                      |
<table>
<thead>
<tr>
<th>Organization</th>
<th>Area of expertise</th>
<th>Country/areas of operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Save the Children</td>
<td>• Universal health coverage</td>
<td>Burkina Faso, Democratic Republic of Congo, Ethiopia, Guinea, Ivory Coast, Kenya, Liberia,</td>
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<tr>
<td></td>
<td>• Vaccines</td>
<td>Libya, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Somalia, South</td>
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<td></td>
<td>• Emergencies</td>
<td>Africa, South Sudan, United Republic of Tanzania, Uganda, Zimbabwe</td>
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<td>• Nutrition programs</td>
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<td></td>
<td>• Upgrading hospitals</td>
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<td>Oxfam</td>
<td>• Humanitarian crisis care</td>
<td>Ethiopia, Somalia, South Sudan, Sudan, Malawi, Mozambique, South Africa, Zambia, Zimbabwe,</td>
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<tr>
<td></td>
<td>• Public health</td>
<td>Benin, Burkina Faso, Central African Republic, Chad, Ghana, Senegal, Liberia, Mali, Niger,</td>
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<td></td>
<td>• Water and sanitation</td>
<td>Nigeria, Burundi, Democratic Republic of Congo, Kenya, Rwanda, United Republic of Tanzania,</td>
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<td></td>
<td></td>
<td>Uganda</td>
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<tr>
<td>Relief International</td>
<td>• Food security</td>
<td>Ghana, Guinea, Niger, Senegal, Somalia, South Sudan, Sudan</td>
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<td>• Water and sanitation</td>
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<tr>
<td></td>
<td>• Maternal and child health and nutrition</td>
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<tr>
<td></td>
<td>• Strengthening local health care systems</td>
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<tr>
<td>International Rescue</td>
<td>• Primary and reproductive health care</td>
<td>Burundi, Cameroon, Central Africa Republic, Chad, Democratic Republic of Congo, Ethiopia,</td>
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<tr>
<td>Committee</td>
<td>• Water and sanitation</td>
<td>Ivory Coast, Kenya, Mali, Niger, Nigeria, Sierra Leone, Somalia, United Republic of Tanzania,</td>
</tr>
<tr>
<td></td>
<td>• Vaccinations</td>
<td>Uganda and Zimbabwe</td>
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