Contribution of net international migration to population growth or decrease (1995 – 2000)[7]

Major area	Net migration rate (per 1000)	Rate of natural increase (per 1000)	Population growth rate (per 1000)
More developed regions	2.2	1.2	3.4
Less developed regions	- 0.6	16.7	16.1
Africa	- 0.5	24	23.5
Asia	- 0.4	14.5	14.1
Latin America and the Caribbean	- 1.2	16.8	15.6
Northern America	4.6	6.1	10.7
Europe	1.4	- 1.2	0.2
Oceania	3.0	11.1	14.1

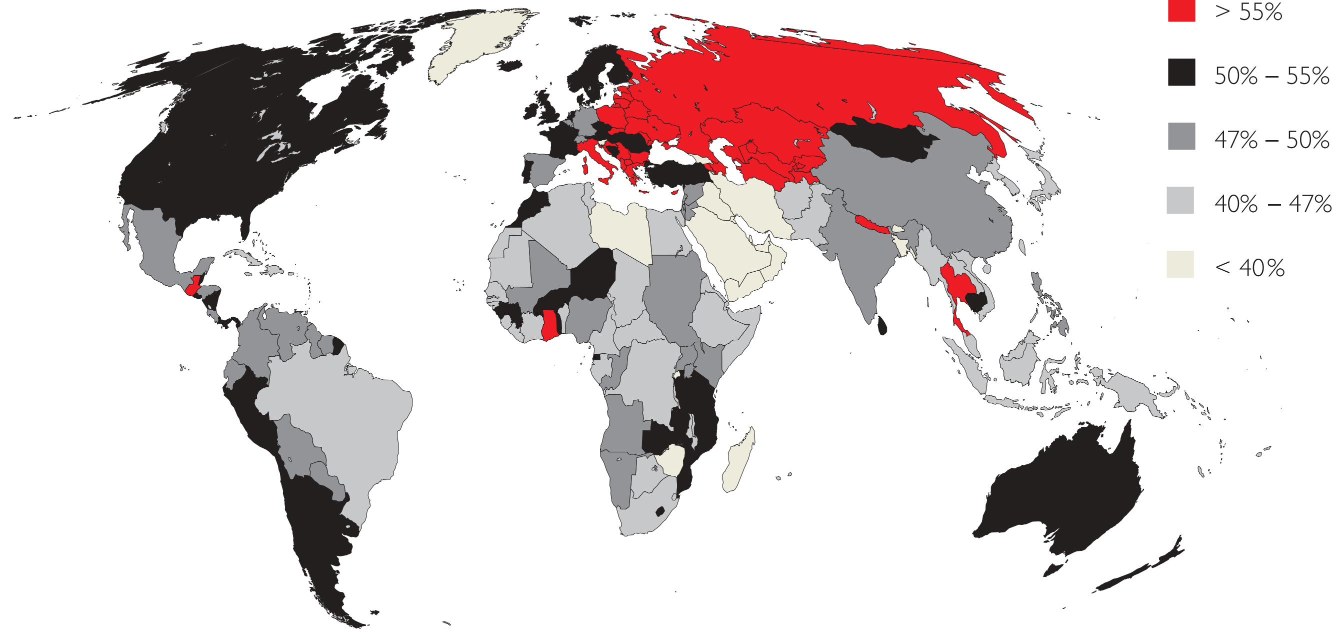
Top ten countries hosting the largest number of international migrants (2000)[7]

Country	Migrant stock (in millions)	Percentage of the world's migrant stock
US	35	20
Russian Federation	13.3	7.6
Germany	7.3	4.2
Ukraine	6.9	4.0
France	6.3	3.6
India	6.3	3.6
Canada	5.8	3.3
Saudi Arabia	5.3	3.0
Australia	4.7	2.7

Foreign population % of total population[8]

	2003	1993		2003	1993
Austria	9.4	9.1	Luxembourg	38.6	5.1
Belgium	8.3	0.8	Netherlands	4.3	3.8
Czech Republic	2.4	3.6	Norway	4.5	-
Denmark	5.0	1.1	Poland	0.1	1.3
Finland	2.0	6.3	Portugal	4.2	0.2
France	5.6	8.5	Slovak Republic	0.5	1.1
Germany	8.9	-	Spain	3.9	5.8
Greece	7.0	1.3	Sweden	5.1	18.1
Hungary	1.3	2.7	Switzerland	20.0	2.0
Ireland	5.6	1.7	Turkey	1.9	3.5
Italy	3.8	31.8	United Kingdom	4.8	-

International Migration of Women (2005)[9]



Percentage of female migrants (1960 – 2000)[10]

Region	1960	1980	2000
World	46.6	47.4	48.8
Europe	48.5	48.5	52.4
Northern America	49.8	52.6	51.0
Oceania	44.4	47.9	50.5
Northern Africa	49.5	45.8	42.8
Sub-Saharan Africa	40.6	43.8	47.2
Southern Asia	46.3	45.9	44.4
Eastern and South-eastern Asia	46.1	47.0	50.1
Western Asia	45.2	47.2	48.3
Caribbean	45.3	46.5	48.9
Latin America	44.7	48.4	50.5

Facts[5, 11, 12]

- Migrants: 174 – 178 million worldwide, 3% of the world population; 86% are migrant workers, 30% live in Europe
- Refugees: 12.7 million worldwide; in the OECD countries, the number of asylum applicants has decreased by 35% since 2000
- IDPs (internally displaced persons): 25 million worldwide; are expelled from their home countries because of civil wars and natural disasters
- Remittances: 167 million US $ per year; 15% of household incomes in the Philippines derive from remittance services; a 10% rise in remittances would reduce the number of people living in poverty by 1.7%
- Knowledge transfer: per year, 20.000 trained doctors and nurses leave Africa in order to work in a Western country
- HIV/AIDS: in 2003, 69% of all persons diagnosed with HIV/AIDS in France were migrants, 65% of which were women
- FGM: per year, approximately 2 million women/ girls become victims of FGM; worldwide, more than 150 million women/ girls are victims of FGM
- Slave work: 19.000 of the more than 1 million women working in Saudi Arabian households have fled their employers
- Trafficking in human beings: 1.2 million persons per year; in the 1990s, the Ukraine lost over 400.000 women through trafficking in women
- Mail-order brides: 300.000 women (50% of the foreign population) came to Taiwan as mail-order brides; up to 15.000 marriages between Russian women and foreign men are arranged by marriage agencies per year
- Honour killings/ dowry deaths: 5.000 victims per year; Pakistan tops the list with 1.200 honour killings or dowry deaths per year
- Son preference: due to selective abortions and the neglect of female children, 60 million women are lacking worldwide

International Human Rights and Conference Documents

- International Human Rights; www.ohchr.org/english/law/
- Organisation of African Unity (OAU) Refugee Convention Governing the Specific Aspects of Refugee Rights in Africa (1974) www.achpr.org/english/_info/refugee_en.html
- European Convention on Human Rights (1950) www.hri.org/docs/ECHR50.html#Convention
- EU Charter of Fundamental Rights(2000) www.europa.eu/scadplus/leg/de/s20000.htm
- ICPD (International Conference on Population and Development, 1994) Programme of Action (PoA); www.unfpa.org/icpd/icpd_poa.htm
- ICPD+5 (Key Actions, 1999); www.unfpa.org/icpd/icpd5.htm
- ICPD+10 (Official Outcomes, 2004) www.unfpa.org/publications/detail.cfm?ID=226
- Beijing Declaration and Platform for Action (Outcome document of the Forth World Women Conference, 1995) www.un.org/womenwatch/daw/beijing/platform/index.html
- Beijing+5 (Further actions, 2000) www.un.org/womenwatch/daw/followup/reports.htm
- Beijing+10 (Declaration, 2005) www.un.org/womenwatch/daw/followup/reports.htm
- United Nations Millenium Declaration (2000) www.unfpa.org/publications/detail.cfm?ID=273&filterListType=5
- World Summit Outcome (2005); www.unfpa.org/icpd/docs.htm
- Declaration of Commitment on HIV/AIDS (2001) www.unaids.org/en/Goals/UNGASS/default.asp
- Political Declaration on HIV/AIDS (2006) www.unaids.org/en/AIDSreview2006/AIDSReview2006/default.asp

migration and women

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migration and women

Migration: in the past – in the present – in the future

Before people decided to settle down, they used to live as nomads, and their usual concept of living consisted of constantly migrating from one place to another. Today, migration has many different faces. Migration is often a conscious choice or decision, it is desired by the target country, can be enforced by the country of origin, is very often a problem for transit countries, occurs within a country or reaches beyond borders and continents, and is a profound decision for all those who leave their home country – whether voluntarily or involuntarily.

In the past, up to the 1950s, Europeans emigrated to the USA, Canada and Australia in hope of a better life. During the economic wonder years of the 1950s and 1960s, European governments recruited urgently needed migrant workers from the Mediterranean countries.

Today, migration pressure increases globally due to armed conflicts, impoverishment and natural disasters in the developing world. Currently, 60 percent of migrants live in industrial countries and 40 percent in countries of the developing world. Europe, the frequently desired residence for people from Eastern Europe, Africa, Asia and Latin America, responds to the rising number of immigrants with increasingly restrictive asylum laws and immigration quotas. Only desired migrant workers (such as IT-experts, medicinal personnel, and seasonal workers) are granted entry. Nowadays, family reunification is the main source of regular immigration.

In the future, apart from encouraging the rise of birth rates, controlling migration will be one of the principal possibilities to counteract the lack of workers. At present, 75 percent of the population growth in the developing world results from migration. According to estimates[1], the number of migrants will increase from currently 187 million to 230 million in 2050.

Photos

Cover: Injured girl from Mostar, Bosnia-Herzegowina, being flown out to Great Britain;
Regina Boucault; IOM 1993

Indochinese refugees in a refugee camp in the north of Thailand;
Karl Zirbs; IOM 1979

Mother with baby, survivors of the 2005 tsunami, receiving health care in a hospital in Madras, India;
© 2005 Galia Barkai, Photoshare

Father with child in a refugee camp in Grozny, Chechnya;
Cemil Alyanak; IOM 1995

Mother with baby, returning to the refugee camp in Kissidougou, Guinea, after having received food;
© 2003 Nell Kussian; Photoshare

Afghan women and children on their way to a refugee camp in Pakistan;
© 2002 Jonathan Frerichs/Lutheran World Relief; Photoshare

Santa Elena in the north of Guatemala is the destination of many Guatemalan people searching for cheap land;
© 2002 Aimee Centivany; Photoshare

Woman in a refugee transport, taking her to Burkina Faso;
Jean-Philippe Chauzy; IOM 2003

The pros and cons: Migration and development[2]

Migration influences development in the following fields:

Knowledge transfer (brain drain/ waste/ gain circulation): through the recruitment of workers in the home country
Advantages: relieves the labour market, facilitates the transfer of skills and knowledge, creates access to a global network, allows the flow of venture capital and gains savings at its backflow
Disadvantages: leads to the loss of qualified workers urgently needed in the countries of origin (especially in the health sector) without compensation of educational costs, causes qualified migrants to perform unskilled work in the target countries

Remittances to family members living in the home countries; are generally twice as high as state development aid
Advantages: reduce poverty, secure school attendance, provide vocational training and guarantee health care services, contribute to the establishment of small enterprises, finance infrastructure projects through expatriates
Disadvantages: increase the difference between poor and rich, create dependencies and reduce individual initiative, and reduce the sums of money transferred through high bank expenses

Expatriate communities form bridges to the home country
Advantages: give impetus as far as the change of values is concerned, are a source of information and support for newcomers, promote the empowerment of women through better education and own incomes, provide information about sexual and reproductive health, and facilitate access to counselling services
Disadvantages: favour the development of parallel societies through the lack of integration as well as of individual and vocational perspectives; render women increasingly dependent on their husbands; limit access to social networks and the labour market through lacking language skills, domestic violence or other forms of violece; provide only little information on health care services.

Sources

[1] United Nations Population Fund (UNFPA): Meeting the Challenges of Migration, 2004
[2] Global Commission on International Migration (GCIM): Migration in an Interconnected World: New Directions for Action, 2005
[3] ÖGF: Informiert handeln, 2005
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[8] Organization for Economic Co-operation and Development (OECD): OECD in Figures – 2005 edition, Demography
[9] Hania Zlotnik: International Migration of Women, UN Population Division, 2006
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[11] World Bank: World Development Indicators, 2005
[12] UNHCR: Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons, 2003

Sexual and reproductive health and rights[3]

On the occasion of the International Conference on Population and Development (ICPD) held in Cairo in 1994, a concept of sexual and reproductive health based on rights was adopted and confirmed and was further developed by the Fourth World Conference on Women (1995) and the ICPD conferences of 1999 and 2004. The action programme adopted by 179 countries contains statements on both internal and international migration. The important aspects of the concept based on rights include the following: the equal status of women and men as well as gender equality, sexual and reproductive rights and patient-focused health care.

Sexual health: the integration of physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love.

Sexual rights: rights of couples and individuals to decide freely, responsibly, without discrimination, coercion or violence on all aspects of their sexuality (including the protection and promotion of sexual and reproductive health as well as the right to make autonomous decisions about one's sex life)

Reproductive health: a state of general and complete physical, mental and social well-being, and not merely the absence of disease or infirmity of the reproductive system, or of its functions and processes.

Reproductive rights: the right of couples and individuals to decide freely and responsibly the number, timing and spacing of their children, as well as the right to have the information, education and means necessary to do so.

Traditional violence against women[4]

Due to their origin, female migrants are very often at risk of becoming victims of human rights violations. Many European states have adopted explicit laws rendering traditional violence a punishable crime. Apart from the training of mediators, women and girls affected by traditional violence are in need of care and support provided by specifically trained personnel, and they need safe accommodation, information on the right of residence as well as help and support in finding new life perspectives. It is also important to hold awareness campaigns about how traffickers work in the women's countries of origin.

Traditional violence includes:

Son preference: Daughters are often neglected, very often not allowed to attend school and killed through selective abortions

Arranged marriages/forced marriages/mail-order marriages: In Europe, arranged marriages are very common within the extended families of migrant workers and among Eastern European and Asian women who get married to Western European husbands via marriage agencies

Dowry deaths: Brides are killed by the groom or the groom's family when the demanded payment of dowry is not made

Violence against women in the name of honour: Male members of (extended) families punish women in order to avenge violations of rules and norms (such as, for example, extramarital sexual relations, rapes, marrying without the family's consent, leaving the husbands they were forced to marry, etc.)

FGM: The external female genitals are partly or wholly removed for cultural reasons, a practice leading to serious health problems in many cases.

Trafficking in women/slavery: Criminal job/marriage brokers offer especially young girls/women job or marriage opportunities which end in working slavery or prostitution.

Sexual and reproductive health services[5]

should be holistic, affordable and easily accessible for the patients, and should comprise the following components:

- *Information, education and counselling on sexual and reproductive health and rights*
- *Prevention and treatment of infertility*
- *Prenatal, postnatal and birth care*
- *Health care for infants*
- *Prevention and treatment of sexually transmitted infections and HIV/AIDS (STI) and other infections of the reproductive system*
- *Safe performance of abortions and treatment of abortion-related complications*
- *Information on family planning counselling centres*

Patient-focused care comprises free and well-informed decision making and respect for the patients' rights through providing integrative health institutions which correspond to the patients' demands, which involve the patients in the conception and evaluation of the programmes offered, and which dispose of qualified personnel as well as of modern and adequate medical equipment.

Sexual and reproductive health problems of women:

During their childhood (0 – 9 years):
selective abortions, female genital mutilation (FGM), discrimination of girls as a far as nutrition, health care and education are concerned

During their adolescence (10 – 19 years):
premature and unplanned pregnancies, pregnancy and delivery complications, premature births, dangerous abortions, FGM, STI

During their reproductive years (15 – 49 years):
unplanned pregnancies, dangerous abortions, pregnancy and delivery complications, FGM, STI

During their post-reproductive years (45+):
gynaecological cancer (cervical cancer), osteoporosis

During their whole life: gender-related violence

Health Care[6]

The health of female migrants is influenced by:
Little knowledge (about their own body), misdiagnoses and false information (language barriers and false shame), late consultation of health care providers (fear of costs) as well as the migration situation itself (increased amount of stress, depression and violence)

Consequences for the sexual and reproductive health are:
Lack of prenatal care, delivery complications, miscarriages, premature deliveries, lower birth weights and higher child mortality; Lower use of modern contraceptive methods and higher abortion numbers, higher risk of STI and HIV/AIDS, higher infertility risk through non-treatment of STI, lack of cancer prevention programmes.

Migrants need comprehensible information which takes their cultural background and their social situation into account. Apart from counselling in their native language, migrants need bilingual information brochures on the following topics:

The health system and health services, the human body, birth preparation, contraceptive methods, sterilisation and abortion, the desire for children, menopause, protection against STI and HIV/AIDS, as well as sexual and reproductive rights.

The competences and health potentials of female migrants are to be recognised and systematically included in health care services.