A Policy Paper on the Health Implications of Labor Migration from the Philippines

JORGE V. TIGNO

Abstract

Globalization and the consequent increase in international migration impact on the health and well-being of migrants and the populations of both the sending and receiving countries. Health care delivery systems may also be affected either positively or negatively. International labor migration is a highly complex process with different dimensions that affect health in different ways. Migration health is the nexus between disease and other threats to physical well-being, on one hand, and human mobility on the other. Migration health can also refer to the well-being of communities that either send or receive migrants. The Philippine government must play a key role in upholding the right to health of Filipino migrants even as it must work for counterpart programs on the part of the receiving country. The role of civil society cannot be over emphasized.

Keywords: globalization, migration health, labor migration, Filipino migrants

Introduction

Globalization is broadly understood as the intensification and/or proliferation of cross-border flows and transnational networks. Altogether it is made up of a multiplicity of interactions, factors, and mechanisms "that lead to the establishment

of transnational structures and the global integration of cultural, economic, environmental, political and social processes on global, supranational, national, regional and local levels" (Rennen and Martens 2003 as cited by Huynen, et al. 2005, 2). Table 1 lists the hallmark features of globalization as identified by Huynen, et al. (2005). The emergence of global markets; increased cross-cultural interactions;

Table 1. Features of Globalization

New global governance structure	Globalization influences the interdependence among nations as well as the nation-state's sovereignty leading to (a need for) new global governance structures.
Global markets	Globalization is characterized by worldwide changes in economic infrastructures and the emergence of global markets and a global trading system.
Global communication and diffusion of information	Globalization makes the sharing of information and the exchange of experiences around common problems possible.
Global mobility	Global mobility is characterized by a major increase in the extensity, intensity and velocity of movement and by a wide variety in types of mobility.
Cross-cultural interaction	Globalizing cultural flows result in interactions between global and local cultural elements.
Global environment changes	Global environment threats to ecosystems include global climate changes, loss of bio-diversity, global ozone depletion and the global decline in natural areas

Source: Table 2, Huynen, Maud, Pim Martens, and Henk BM Hilderink (2005), "The Health Impacts of Globalization: A Conceptual Framework," in *Globalization and Health*, accessed at http://www.globalizationandhealth.com/content/1/1/14 in October 2005, p.5.

as well as the advent of advanced information, communication, and transportation infrastructures are promotive of migratory flows and resettlements. These factors and linkages have become the driving forces for transnational migration.

International migration is a phenomenon that affects a growing number of countries. It has reached proportions that inevitably generated serious implications for polities, societies, and economies. There are approximately 175 million people

living outside their country of birth – almost 3 percent of the world population, roughly equivalent to 40 percent of the entire European Union (around 454 million) and almost double the total population of the Philippines. It is even larger than the population of Japan (almost 128 million). It is said that around 700 million people (including visitors on business or personal/family trips) cross nation-state boundaries (See Saker, et al. 2004 and Lee and Dodgson 2003) and one million per week move from less developed countries to the highly developed areas (See Garrett 2001). Many of these migrants come from or can be found in Asia (around 50 million) and almost half (48 percent) are said to be women. (Bach 2003, 2)

Global developments particularly in the fields of information/ communication and transportation technologies have allowed migration flows to flourish both at the domestic and international levels. Rapid improvements in transportation technologies have given more people (especially in developing countries like the Philippines) the opportunity to avail of cheaper transport and freight fares. Relatively faster and safer ways to travel by land, sea, and air have allowed more people to travel over greater distances in shorter periods of time. Moving one's place of residence and employment across borders is easily done now and can be compared roughly with simply moving from one city to another. Moreover, technology now allows for migrants to maintain their ties with families and friends at the country of origin thus minimizing the anxiety and pain associated with classical separation.

Rapid and extensive access to information via the Internet and the transnational media, among others, provide a growing number of people with an idea (at times untrue and exaggerated) of conditions in other societies and areas halfway around the world. People have become more aware of what they can expect in different economic, social, and political environments.

With rapid and extensive integration across economies and societies particularly between developed, highly industrialized and developing countries, migration can be expected to increase and intensify further. Linkages across borders will compel multinational corporations to hire workers in areas where they have investments as well as train them in the home office. At the same time, barriers to less skilled workers will be raised and border patrols intensified as a consequence of globalization.

The 1997-1998 Asian regional financial crisis illustrates the degree to which countries respond to perceived and real immigration and emigration flows. Newly industrialized countries in Southeast Asia such as Singapore and Malaysia have established more stringent barriers to immigration in their respective areas. Most affected are migrants coming from political strife-ridden Indonesia and crisis-plagued Philippines as well as the less developed countries of South Asia (e.g., India, Pakistan, and Bangladesh).

From the increased border crossings of knowledge, capital, goods, and most of all persons, a number of issues have emerged that radically affect both the sending and receiving areas.

Population pressures, social and political uncertainties, as well as growing relative poverty have become the primary motivation for hundreds of thousands of Filipinos to leave the country in search of better opportunities elsewhere. As more and more people move (aided in no small way by global forces and structures), a number of migration-related issues have now become more magnified and to some extent become acute. The health situation of migrants or migration health is one such issue that deserves serious consideration not only by the governments of destination areas but also by the countries of origin.

This paper will focus specifically on the impact and implications of global mobility, a distinctive feature of globalization, on health concerns obtaining in the Philippines. This paper is about the implications derived from the large-scale out-migration of labor from the Philippines on health and well-being of migrants, their families, as well as that of the populations in both the sending and receiving countries. This paper underscores the health risks faced by migrants leaving the Philippines for overseas employment. It also provides a backdrop for understanding the health concerns facing authority-holders in both sending and receiving countries.

More specifically, this paper will (a) provide a brief review of the relevant literature on migration health so as to provide clarity of analysis in the context of Philippine experience; (b) trace or outline the key issues and concerns pertinent to the subject of migration health currently obtaining in the Philippines; and (c) recommend the most likely alternatives and policy options to address these issues and concerns. The presentation begins with the dynamics of international labor

migration and the extent to which such movement has been made even more complex and transnationalized by global forces.[1] This is followed by a discussion of the implications of labor migration on health, as well as the health care issues and concerns of Filipino migrant workers. And, finally, a number of policy options are suggested for consideration both by authority-holders and by civil society groups.

International Labor Migration

For purposes of this paper, a migrant worker is one who seeks, is employed or has been actually employed overseas on a contractual or temporary basis, which can be conceptually differentiated from a permanent migrant (immigrant) or refugee or tourist although the distinctions are not mutually exclusive. A tourist or refugee can first become a migrant worker and ultimately become a permanent immigrant or settler. The term migrant worker will be used throughout the paper although the popular literature in the Philippines (particularly in the mass media) would often refer to them as overseas contract workers (OCWs) which is often used interchangeably with Filipino migrant workers (FMWs) or Filipino overseas workers (FOWs).

Human migration is a complex process. In order to develop a simple and coherent framework, a distinction must be made between regular or documented migration and irregular or undocumented migration.[2] The World Health Organization (WHO) identifies regular migrants, on the one hand, to be those "people whose entry, residence and, where relevant, employment in a host or transit country has been recognized and authorized by official State authorities" (WHO 2003, 9). On the other hand, irregular or undocumented migrants are those "people who have entered a host country without legal authorization and/or overstay authorized entry as, for example, visitors, tourists, foreign students or temporary contract workers" (WHO 2003, 9). Human smuggling falls under irregular migration. It is contended that labor migration can involve both regular and irregular procedures.

In addition to the distinction between regular and irregular migration, there is also the distinction between forced and voluntary migration. Voluntary migration

Migration health has many dimensions. In immediate terms, migration health can refer to the state of "physical, mental, and social well being and not merely the absence of disease or infirmity" of migrants.[4] Migration health can also refer to the well-being of communities that both send and receive migrants (including the families of migrants).

involves the movement of "people who have decided to migrate of their own accord (although there may also be strong economic and other pressures on them to move)" (WHO 2003, 9). Involuntary or forced migration refers to the movement or displacement of persons due to war, environmental disaster, famine or state development projects (See WHO 2003). Also included under forced migration are situations that allow for deception or coercion of the person to move such as the trafficking in human beings.[3] Voluntary migration generally involves labor migration although it is possible for a migrant to move voluntarily initially and later on to be forced by circumstances beyond the person's control to continue to stay and work (albeit under inhuman working conditions).

In any case, it is argued that the extent of the impact on and implications to the health of migrants is affected by the type of migration that takes place (i.e., whether it is forced or voluntary, or whether it is documented or undocumented). The nature of the health problem to be experienced by the migrant will depend principally on the person's status (e.g., documented or undocumented) and also on the motivation to move (e.g., willful or deceived or forced).

What is migration health?

Health refers to a state of physical as well as mental well-being of a person. It also involves security from epidemiological threats such as diseases that constitute the primary threats to one's well-being and wellness.

Wheras most studies on migration emphasize the goal and process of maintaining the integrity and security of borders from unauthorized crossings and intrusions, migration health is where epidemiology meets demography. It is the nexus between disease and other threats to physical well-being, on the one hand, and human mobility, on the other. It is one that takes into account the state of well-being of people who have moved as well as those people indirectly affected by the movement. Migration health has many dimensions. In immediate terms, migration health can refer to the state of "physical, mental, and social well being and not merely the absence of disease or infirmity" of migrants.[4] Migration health can also refer to the well-being of communities that both send and receive migrants (including the families of migrants).

The Migration Health Department of the International Organization for Migration (IOM) is tasked to respond "to the needs of individual migrants as well as the public health needs of host communities through policies and practices appropriate to address the challenges facing mobile populations today" (See IOM website at http://www.iom.int). Moreover, the concerns of this IOM Department "covers infectious disease control, emergency interventions, chronic diseases, mental health, particular cultural and health concerns, human rights issues, migration health management and many other issues that affect the health of migrants and the communities they live in or transit."

For all the quantitative and qualitative significance of transnational migration as a whole, not much emphasis is given neither to acknowledging nor to acting upon migration health issues and concerns. There are several reasons . Carballo and Mboupa (2005) suggests these reasons to be the following:

> The first and most important may be the fact that the pace of contemporary migration has outstripped the capacity of countries not only to respond but indeed to even keep pace with and acknowledge the growing scope and

> nature of cross-border migration. The second is that to acknowledge the health needs and problems of migrants is to some extent to recognize liability and responsibility. This, in an international context where the cost of health care is becoming a universal problem, may well be an important reason why countries have been reluctant to confront the issue of migration and the health care of migrants. A third reason is that surrounding the phenomenon of migration is the myth that all migration is ultimately successful and that in the final analysis everyone stands to benefit. While this may be true from a structural-functionalist perspective, the reality is that migration is (and probably always has been), characterized by relatively massive human wastage in terms of avoidable illness, injury, neglect and mortality. (Carballo and Mboup 2005, 13)

Health Implications of Human Mobility

Globalization has made it possible for "people and microorganisms" to mix at "an unprecedented scale" (Glasgow and Pirages 2001, 196 as cited by Koehn 2006). The increased and large-scale mobility of people across borders has either reintroduced old infections or introduced new strains of old diseases in destination areas. Some of the more recent examples are the rapid transcontinental transmission of Severe Acute Respiratory Syndrome (SARS) and the Acquired Immune Deficiency Syndrome (AIDS) caused by HIV as well as the impending pandemic threat of the avian influenza (H5N1 virus). Such public health issues can have serious consequences both for the migrant as well as the non-migrant populations.

In this regard, Director Antonio Amparo of the Bureau of Quarantine states that –

> Infectious microbes can travel quickly from one country to another – in people and in commercial products – within hours, and new diseases like SARS, Marburg and Ebola, West Nile and new forms of old diseases, like drug-resistant malaria and Tuberculosis and influenza [including the present avian influenza], can emerge in one region and spread throughout the world... As travel and trade (including tourism) become increasingly global, new infectious diseases are also increasingly able to spread and make a

> worldwide impact [and the] ... migration of humans has been the pathway for disseminating infectious diseases.[5]

Certainly, globalization is seen to be an important context and driving force behind the persistent and prevailing health issues and concerns confronting many countries today (see Huynen, et al. 2005). The impacts of globalization on transnational labor migration are essential to understanding the persistent as well as emerging trends and concerns in regard to the health and well-being of migrants.

The literature is consistent in identifying the different health dimensions of mobility, i.e., the existing medical condition during pre-departure; the health problems during migration; the health issues arising after arrival; and the health consequences of return travel (Gushulak and MacPherson 2006 and 2000, 68; and see alPHa 2003, 9; McKay, et al. 2003; and Bhugra and Jones 2001, 216). Thus, the migrants' health conditions are affected by their (a) preexisting health situation or their health status at the point of origin; and (b) acquired health problems that result from the actual journey and arrival and adjustment in their new environment (See Carballo and Mboupa 2005).

Favorable outcomes can materialize when a migrant moves to an area where preventive health services are more accessible or widespread than in their country of origin. At the same time, such positive effects can also be felt by the receiving country especially when the migrant is a skilled (or more so if he/she is a health care) professional.

Adverse health outcomes among migrants arise out of situations in which persons are made vulnerable to contracting diseases in the course of the journey or upon their arrival such as exposure to unsafe working conditions, harmful occupational practices (such as unprotected sex or under-aged sex). (See Simonet 2004; Loutan 2002; Gushulak and MacPherson 2000; Carballo, et al. 1998; Diallo 2004; and Bach 2003)

In addition, other factors that can affect the state of migration health are: (a) legal status; (b) the job category of the migrant; and (c) the package of policies being implemented by the government in the receiving country.[6] The extent and nature of the health problems and risks can vary depending on whether the migrant

is undocumented or legal and whether the work involved is labor-intensive or sexual, in nature. The impact and implications of migration health can also be both negative and positive depending on the policies in both the sending and receiving areas. By and large, the policies that have been observed and applied (especially in receiving countries) is one that can be considered restrictive, complicated, difficult, and unattractive which may eventually produce unintended consequences that are detrimental to the health and well-being of the overall population (See Carballo and Mboupa 2005). Furthermore, Carballo and Mboupa (2005) state that –

> The type of work people are expected to perform once they arrive, the physical and housing conditions available to them, the access (perceived or real) they have to health and social services ... and the extent to which they are able to remain in contact with family are important determinants of health and well being. Language skills and familiarity with the culture of the host community also play an important role in determining health outcomes (Carballo and Mboupa 2005, 4).

The Extent of Labor Out-migration from the Philippines

The level of labor out-migration from the Philippines is as extensive as a large-scale sending country. Indeed, it is not impossible to imagine the Philippines ranking third after China and India, with the largest migrant population worldwide. Stock estimates (i.e., the estimated number of actual Filipinos abroad) compiled by the Commission on Filipinos Overseas (CFO) as of December 2003 indicate that there can be as much as 7.9 million Filipinos living abroad with roughly 3.38 million being migrant workers as indicated in Table 2 . What is significant to note in the estimates is that the number of irregular or undocumented migrants is said to be around half the size of the regular or temporary migrants. The largest number of temporary migrants is currently located in West Asia or the Middle East (e.g., Saudi Arabia, Kuwait, etc.) followed by East Asia (e.g., Hong Kong, Singapore, Japan, South Korea, and Taiwan).

If the above estimates were accurate, the total stock population of migrant workers would be roughly equivalent to four percent of the country's total population.

However, based on the 2000 Census of Population and Housing by the National Statistics Office (NSO), the number of overseas workers is at 992,397 or roughly equivalent to 1.3 percent of the national population (Ericta, et al. 2003, 2). The discrepancy may be due to the inability or unwillingness of those asked in the census to expose their relatives working abroad for various reasons. Still the census figures are substantial.

Table 2: Stock Estimates of Overseas Filipinos By World Region
As of December 2003

REGION / COUNTRY	PERMANENT	TEMPORARY	IRREGULAR	TOTAL
WORLD TOTAL	3,074,429	3,385,717	1,515,688	7,975,834
AFRICA	318	53,706	16,955	70,979
ASIA, East & South	85,570	944,129	503,173	1,532,872
ASIA, West	2,290	1,361,409	108,150	1,471,849
EUROPE	165,030	459,042	143,810	767,882
AMERICAS /	2,386,036	286,103	709,676	3,381,815
OCEANIA	226,168	55,814	31,001	312,983
AUSTRALIA	209,017	716	2,923	212,656
Regions Unspecified		8,767		8,767
SEABASED WORKERS		216,031		216,031

Prepared by the Commission on Filipinos Overseas from CFO, DFA, POEA and other sources covering 192 countries / territories.

Legend:
Permanent - Immigrants or legal permanent residents abroad whose stay do not depend on work contracts.
Temporary - Persons whose stay overseas is employment related, and who are expected to return at the end of their work contracts.
Irregular - Those not properly documented or without valid residence or work permits, or who are overstaying in a foreign country.

As with global trends, more recent figures indicate that a significant number of Filipino migrant workers are women. Table 3 shows the male-female ratio for newly hired migrant workers to be 1 to 2. Meanwhile, the NSO data on overseas employment by sex reveals that the ratio is almost even with the males (50.27 percent for males and 49.73 percent for females) (Ericta, et al. 2003, 2). There is

an indication that the number of women migrants is increasing at a faster rate than that of the men.

Table 3. Deployment of Newly Hired Migrant Workers by Gender (2002)

Gender	Female	Male	F/M Ratio	Total
TOTAL	199,423	88,732	2	288,155
Percentage	69%	31%		

Source: Philippine Overseas Employment Administration Statistics accessed at: http://www.poea.gov.ph docs/Deployed% 20New%20Hires%20by%20Skill%20and%20Sex.xls in July 2005.

Migration involves a highly selective process. Filipinos who work abroad tend to comprise the highly productive and highly educated portion of the local workforce and overall population. About four in five Filipino migrant workers have completed high school education while 50 percent have had some years of college education prior to going abroad. In contrast, only 20 percent of locally employed Filipinos have actually completed high school (See Carino 1992). Around 50 percent of these Filipino migrants are in their early 20s and 30s while this age-group comprises only 25 percent of the total local population (See Stahl 1986).

Moreover, quite a number of these Filipino migrant workers have had at least two years of local work experience prior to overseas employment. Many are married while most (if not all) have sought overseas employment in order to support a family or some family members back in the Philippines. Many are employed doing construction-related and production (i.e., manufacturing) work while a substantially growing number are involved in services (e.g., domestic work, entertainment, health, etc.).

The significance of labor migration from the Philippines is underscored by the fact that billions of dollars from the incomes of migrant workers overseas are sent back to the country from all over the globe. In 1982, remittances from migrants overseas totaled more than US$ 810 million. Ten years later, these remittances

reached more than US$ 2 billion. By 2000, remittance inflows to the Philippines reached more than US$ 5 billion annually as seen in Table 4.

Table 4: OVERSEAS FILIPINO WORKERS FOREIGN EXCHANGE REMITTANCES (1984 – 2000 In US$Millions)

YEAR	LANDBASED	GROWTH RATE
1982	642.34	67.43
1983	660.08	2.76
1984	472.58	-28.41
1985	597.89	26.52
1986	571.75	-4.37
1987	671.43	17.43
1988	683.31	1.77
1989	755.19	10.52
1990	893.4	18.3
1991	1,125.06	25.93
1992	1,757.36	56.2
1993	1,840.30	4.72
1994	2,560.92	39.16
1995	4,667.00	82.24
1996	4,055.40	-13.1
1997	5,484.22	35.23
1998	4,651.44	-15.19
1999	5,948.34	27.88
2000	5,123.77	-13.86
Q1 2001	1,081.66	-21.82

* Source : Bangko Sentral ng Pilipinas (BSP). May not add up to totals due to rounding off.

Current Data on the Health Problems of Filipino Migrant Workers

The body of literature on Philippine migration is certainly quite extensive in the areas of examining the socio-economic impacts of transnational population movements; the family; women migration; and migration policy discourses. (See Asis 1995; Battistella and Paganoni 1992; CIIR 1987; and Gonzalez 1998). However, there appears to be limited attention given to migrant health concerns.

Despite several glaring realities (e.g., the feminization of Philippine migration; the high degree of population mobility brought about by developments in information, communication, and transportation technologies), there continue to be gaps between what is known and unknown in current Philippine migration health studies. This may be due in part to the estimated large number of undocumented migrants which can adversely affect any estimate of the actual population.

At the same time, actual interventions at the official / governmental level are not yet extensively tuned to the impacts and implications of migration health. In a forum on global health issues and international labor migration held in September 2001, the Overseas Workers Welfare Administration (OWWA) data on migration health was limited to health or medical problems experienced by migrant workers and their dependents who filed claims or requests for financial assistance. There has not been any systematic attempt to generate large-scale data on migration health in the Philippines much less their implications on the rest of society. At best, there are anecdotal evidences but not really enough to identify the state of migration health in the country.

Health concerns associated with labor migration from the Philippines

This paper takes off from the framework used by Gushulak and MacPherson to describe the impact of different environments and the phases of human mobility on health.

Filipino migrant workers are vulnerable to health risks. The extent and nature of the health problems and risks that migrant workers are exposed to are quite extensive. In general, the two major dimensions of physical health are those that are communicable and non-communicable. Communicable diseases include tuberculosis (TB); hepatitis B and C; schistosomiasis; malaria; sexually transmitted diseases (STDs) such as syphilis and HIV/AIDS. Of particular concern to countries that both send and receive migrants is the alarming spread of AIDS/HIV as well as the avian influenza and SARS.

Non-communicable diseases can be classified into organic disorders (e.g., asthma, cardiovascular problems, pulmonary dysfunction, hypertension, stroke, diabetes, oral or dental health, reproductive health problems; cancers; etc.); substance abuse (migrants may be coerced by the trafficker to assist in the illicit drug trade; isolation and family separation may lead to increased risk of substance abuse); occupational illnesses (due to unsafe and dangerous working conditions including risk of exposure to occupational injuries or toxic materials); sexual abuse (especially among commercial sex workers which can lead to sexually transmitted diseases); and psychosocial or mental illnesses that can lead to schizophrenia, depression, or even suicide) (See Gushulak and MacPherson 2000; Simonet 2004; and Carballo, et al. 1998).

Another dimension of migration health involves the (inward or outward) migration of health professionals. Losing a part of the health workforce can "result in either an absence of some services or in professionals' having to adapt their roles to deliver services commonly outside their scope of practice" (Stilwell, et al., 2003). A related dimension to this would be migrants' access to health care services. The extent of access to health care services can have an effect on the early detection of certain illnesses whether they are communicable or not.

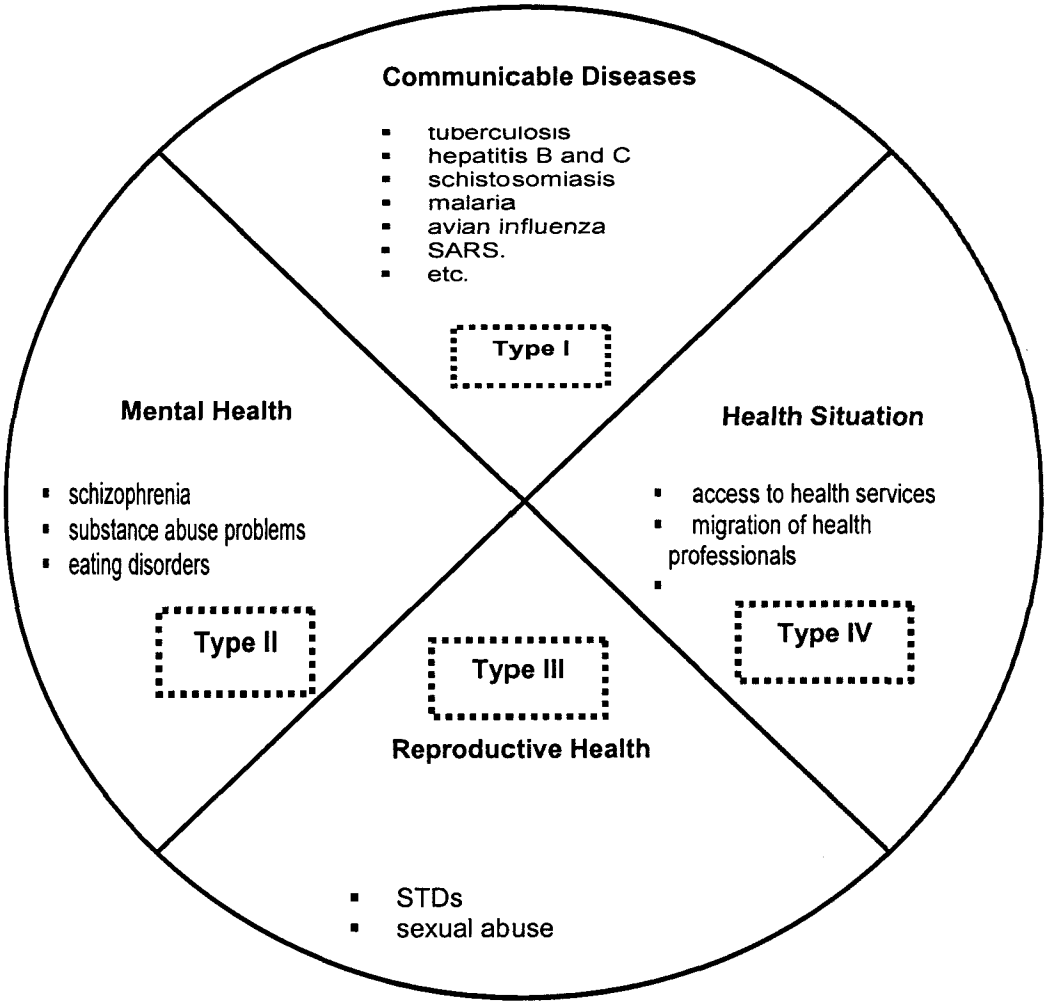
The implications of migration health cannot be underestimated. For instance, the migration of female migrants can cause the emergence of reproductive health issues including sexually transmitted diseases (STDs). The clandestine migration of workers can lead to problems with regard to occupational health and access to health care services in the country of destination. Another critical health concern is the mental stability of migrants as well as the children left behind. Migrants can be

exposed to numerous health risks that can lead to serious implications later on for the Philippines in general as well as for their relatives left behind in particular. By and large, the movement has made migrants more susceptible or vulnerable to health risks that could very well be prevented given alternative circumstances and responses from the authorities concerned.

At the same time, income remittances from professional migrants (especially those belonging to the health care sector) may compensate for the sending country's economic imbalance temporarily. However, the long-term effect is that (unless they are properly reinvested in health care human capital formation) countries that continue to send their health professionals abroad more than what they are able to receive or train locally "will end up with a net loss of human capital in the health system... and [which] could have serious implications for coverage of and access to services in developing countries." (Stilwell, et al. 2003)

For purposes of descriptive simplification, health concerns may be classified into four types. Communicable diseases are classified as Type I health concerns while the non-communicable diseases are Type II concerns. Type II concerns largely refer to mental health problems. However, this does not disregard the importance of other related migration health areas of concern including occupational health problems and substance abuse problems which are considered as life-style and work-related concerns. The paper presumes that the issues of occupation health and substance abuse can be the causes and effects of mental health disorders among migrants. Type III concerns are those involving reproductive health issues which can be communicable (e.g., STDs) and non-communicable problems (e.g., sexual abuse). Type IV concerns would be those that have to do with the health care delivery system including (a) the migration of health care professionals and (b) migrants' access to health care services particularly in the country of destination. This typology (Figure 1) is certainly not exhaustive but only serves to highlight some of the key concerns pertaining to migration health from the Philippines.

Figure 1: Typologies of Migration Health Concerns



Type I Migration Health Concerns – Communicable Diseases

Infectious diseases constitute a serious area of concern not only in terms of maintaining migration health but also in bringing about the well-being of the overall population. According to Director Antonio Amparo of the Bureau of Quarantine "every hour, infectious diseases take more than 2000 lives."[7] As discussed above, the advent of contagious diseases is affected by (a) the conditions within which the migrant lived prior to the journey and (b) the conditions in the country of destination. In general, migrants move from poor health (as well as socio-economic) conditions to better health situations. Such a movement can have an effect upon the country of destination especially so if the migrant has been exposed to communicable or contagious diseases in the country of origin.

However, the situation may not be simple as it appears. Conditions within the receiving country (including the government's policies) may aggravate the weak health conditions of migrants and the surrounding population. Where overcrowding is common and the living as well as working conditions are poor or inadequate, infectious diseases such as TB may arise and spread. Nevertheless, microbes and other biological organisms do not stop at the border. These organisms accompany the billions of people that cross borders each year. Director Amparo asserts that "organisms that survive primarily or entirely in the human host that are spread either through sexual contact, droplet nuclei and close physical contact can be readily carried to any part of the world in hours." Tubercolosis, for instance, is one contagious disease that has the potential to affect many travelers. Director Amparo states that –

> International travelers today need to be aware of TB because travel may increase the risk of contracting TB for two reasons: they are more likely to visit countries where TB is prevalent; their mode of transportation is frequently a confined area (such as an airplane), where they potentially share air space with someone

> who has TB. Although health officials stress that TB is more commonly transmitted from repeated daily exposure, documented cases of transmission while in the aircraft has been reported.[8]

Two emerging and also serious contagious diseases are the severe acute respiratory syndrome (SARS) and the avian or bird influenza virus that has appeared in China, Vietnam, and Thailand. Countries like the Philippines continue to seriously look out for the entry or emergence of these two diseases and to prevent them from entering the country. However, given the number of migrant workers (including tourists and other travelers) that enter and leave the country each day, it is a difficult task to continue monitoring migrants and travelers for symptoms of SARS and avian influenza.

The prevalence of young migrant women from the Philippines strongly underscores the importance of reproductive health concerns. In this paper, these types of concerns have to do with pregnancy-related issues as well as problems associated with STDs especially among women. It also relates to satisfying and safe sex and the capability to reproduce as well as the freedom to decide on when and which contraceptive method to use.

Irregular migrants arrive via irregular or illegal channels. As such, they have not gone through the typically highly selective process of immigration screening and "more likely to have those characteristics associated with the risk factors for greater disease potential" including the risk of acquiring and spreading contagious diseases (Gushulak and MacPherson 2000, 69).

Type II Migration Health Concerns – Non-Communicable Diseases

The World Health Organization (WHO) has argued that the mental health of immigrants and refugees are serious areas of concern. Although not much is known about the exact mental health conditions of migrant populations, there is some evidence to suggest that severe psychological stress may be due to uprooting, disruption of family life and a hostile social environment typical in the life of the migrant. Moreover, a significant proportion of migrants have little or no access to mental health care, either because they are excluded from existing service arrangements or because such services do not exist in many countries. (See UNDESA 2005 and Loutan 2002)

The labor migration process is one that is highly selective in the sense that it greatly favors either men or women but not both and certainly not with their families. It has been increasingly observed in the Philippines that children are typically left behind with either friends or relatives or grandparents. This development can have serious implications for all concerned – the migrants, the surrogate parents, and especially the children – as far as mental health is concerned. Carballo and Mboupa (2005) have observed that even when family reunification occurs it is rarely easy for the partners or the children to be reconciled (Carballo and Mboupa 2005, 5).

Due to the complicated and selective nature of the migration process, certain psychiatric or mental conditions can be highlighted in dealing with the issue of migration health. These include schizophrenia and other common mental disorders such as the likelihood to entertain suicidal thoughts and initiate self-harm; alcoholism; insomnia; eating disorders; and post-traumatic stress disorder. (See Bhugra and Jones 2001; McKay, et al. 2003; and Carballo, et al., 1998)

The factors that might mitigate such mental conditions in migrants include the absence or presence of social support networks; proximity with other members of the same ethnic group; and early detection and diagnosis. (See Bhugra and Jones 2001 and Carballo, et al., 1998). The mental stress and psycho-social problems are magnified as a result of the other compounding elements in the migration process itself. The decision to move is usually accompanied by a certain fear of what is still largely unknown in the area of destination (despite the attractiveness as well as the

economic and material opportunities it may eventually bring about). This fear is made even worse by the status of the migrant upon arrival. The clandestinity associated with the attempt to circumvent established legal procedures and mechanisms including payment for the complicity of corrupt government officials and organized crime groups adds to the overall feeling of uncertainty that can have serious effects on the mental well-being of the person concerned.

Ms. Andrea Anolin of the Batis Center for Women acknowledges that "there is a gap in research concerning the prevalence of mental health problems among women migrant workers" and because of these gaps, existing policy responses may be insufficient or inappropriate.[9] The case of Filipino women migrant workers is a serious area of consideration as far as Type II migration health is concerned. In particular, these are the women migrants who work as (a) domestic helpers in Hong Kong, Singapore, Malaysia, Saudi Arabia, Kuwait, among other countries of destination and (b) entertainment workers primarily in Japan. Ms. Anolin states that 90 percent of the Filipino women migrants to Japan are entertainment workers while a few are married to Japanese men and where the marriage is seen largely as an economic transaction.

Ms. Anolin also observed that women migrants are exposed to a number of abusive living and working conditions that eventually lead to some degree of psychological instabilities. During the process of resettlement, migrant women experience difficulty in adjusting to the culture and language of the country of destination. Loneliness and homesickness are common.

These social difficulties are aggravated by work-related problems. Ms. Anolin asserts that "in Japan employment contracts are honored more in the breach than in compliance"; the women are not properly informed about the nature of the work they will perform as well as their compensation and benefits (all too frequently a certain portion is deducted from the salaries of the women); employers are abusive and cruel; and there is competition from other entertainment workers.[10] In addition, women who are trafficked are likely to be prostituted against their will. The migrant women are also sexually harassed and abused (at times raped). For those married to Japanese men, reports of domestic violence are not uncommon.

As a result, it is not surprising to find migrant women who are depressed, have an acute sense of persecution, incoherent, and sometimes they hallucinate. These problems manifest themselves in a number of ways including suicidal tendencies, eating disorders, substance abuse, and extremes of emotions.[11] Not only are the migrants themselves at risk with respect to mental health disorders but so are the families left behind, including the children of the migrants.

Type III Migration Health Concerns – Reproductive Health

The prevalence of young migrant women from the Philippines strongly underscores the importance of reproductive health concerns. In this paper, these types of concerns have to do with pregnancy-related issues as well as problems associated with STDs especially among women. It also relates to satisfying and safe sex and the capability to reproduce as well as the freedom to decide on when and which contraceptive method to apply.

The increasing demand for women to migrate forms much of the context for the reproductive health dimension of migration health. The types of jobs taken by migrant women from the Philippines also impact on reproductive health. Many are employed in the entertainment sector which is prone to prostitution. In a survey by Unlad Kabayan, about one-third of the migrant women respondents said that they had experienced reproductive health problems abroad.[12] The common problems experienced are: dysmenorrhea, irregular menstrual period, abnormal vaginal discharge, painful urination, painful intercourse, dizziness, vomiting, and/or weight gain after missed menstruation, high blood pressure during pregnancy, ectopic pregnancy, and spontaneous abortion.[13]

Several reasons were cited by the respondents in the Unlad Kabayan survey for why they do not seek reproductive health care services. These include problems with language communication; the desire to engage in self medication with medicines sent from the Philippines; the fear of being caught and deported for undocumented migrants; the objection of employers; and the desire to continue sending money back to the Philippines. Almost all are aware of the dangers of STDs including HIV/AIDS. However, not that many take the necessary precautions to prevent the

contraction and spread of STDs. Only one in five migrant women are said to use contraceptives. The stigma attached to STDs and HIV/AIDS can also be a problem in so far as dealing with such diseases upon return are concerned. Families may wish to hide their migrant members or choose not to report such cases to the authorities. As a result, many such cases tend to go unreported and can even aggravate the health situation of the country upon the return of the migrants.

Type IV Migration Health Concerns – Health Care Services and Professionals

Access to Health Care. Health care services refers to the set of services and methods that contribute to the overall well-being and health maintenance of the overall population in general and the migrants in particular. This includes preventive care and health services related to the detection and treatment of illnesses. The absence or lack of viable health care services in the Philippines can be an inducement for Filipinos to migrate. It is not uncommon for Filipinos to migrate in order to generate enough income to pay for the health care needs of a loved one.

There is evidence to suggest that "migrants may sometimes be reluctant to assert their rights and stop short of availing themselves of the health services they are entitled to for reasons that are not totally clear but may range from language problems and lack of information to cultural gaps and various forms of discrimination." (UNDESA 2005)

Migrants (whether legal or irregular) continue to have "limited access to health services due to a number of cultural, linguistic, and structural reasons [which] ... may affect the recognition and treatment of illness." (Gushulak and MacPherson 2000, 69; and see Simonet 2004) In not a few cases, undocumented migrants are also prevented from availing themselves of government services by their own employers. Access to adequate health care on the part of migrants is "compounded by more limited access to health information, health promotion, health services and health insurance." (UNDESA 2005)

The policies and practices of governments particularly in receiving areas effectively make the migrants' lives "more insecure and risky from a health

perspective" (Carballo and Mboup 2005, 13). The denial or limited access (whether intentionally or unintentionally) on the part of government health care services to migrants "have also contributed to a worsening of the health of migrants and the larger public health of the countries concerned" (Carballo and Mboup 2005, 13). Availing of health care abroad is also seen as too expensive particularly among those undocumented or irregular migrants who are not likely to carry health insurance.

Trafficked persons are often afraid of interacting with official systems that provide basic social services even if such services are made available without cost for fear that they will be reported to immigration authorities. (Gushulak and MacPherson 2000, 72) In all of this, state policy is significant. Toyota (2003) argues that –

> ... the state can be an obstacle to rather than the provider of public health services in the case of the 'floating population,' or 'un-authorized' migrants. It is entitlement and/or empowerment which determine access (or non-access) to economic, social, and political resources that avert vulnerability. (2)

The irregular status of the migrants may not allow them to readily seek and obtain medical care. Their precarious financial and legal situation can preempt their ability to pay for health care. This in

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a sense will force them to seek medical care by other means which may not be as reliable and are in fact dangerous (Gushulak and MacPherson 2000, 72).

Migration of Health Professionals. Migration health is also affected by the nature of the migration process that takes place such as the outflow or inflow of health professionals. The categories of health care workers affected by migration are diverse and can include "physicians, specialists, nurses, paramedics, midwives, technicians [e.g., X-ray technicians, laboratory technicians], consultants, trainers, health management personnel, [dental hygienists, physiotherapists, medical rehabilitation workers], and other professionals." (Chanda 2002, 159) Accompanying the significant rise in transnational migration is "the increase in skilled labour migration" many of whom are "health-care professionals in search of better pay and enhanced career opportunities to work in other countries." (Bach 2003, 2 and see Chanda 2002)

The migration of health care professionals from the Philippines is not a new phenomenon. During the mid-1970s, a total of 13,480 physicians were working in the Philippines compared to 10,410 Philippines-trained physicians who were employed in the United States. (Goldfard, et al. 1984, 1-2 as cited by Bach 2003, 4) The out-migration of health professionals from the Philippines is due mainly to the low wages for such professionals combined with the growing demand abroad. According to Dr. Rodel Nodora of the Planning and Standards Division of the Health Human Resource Development Bureau (HHRDB), the Department of Health (DOH), roughly eight percent of the country's labor force is comprised of health human resources. According to the National Statistical Coordination Board (NSCB) and the Commission on Higher Education (CHED), the country currently has some 350 nursing colleges, around 30 medical schools, 129 midwifery schools, 31 dental schools, 35 pharmacy colleges, 95 colleges for physical and occupational therapists (OT/PTs).[14] These training and education institutions turn out tens of thousands of medical and health professionals each year.

The Philippines has certainly become a major source of health-care professionals worldwide. More than 70 percent of the 7,000 nursing graduates each year leave the country despite the existence of an estimated 30,000 unfilled nursing positions in the Philippines (Corcega, et al. 2002, 3; Adversario 2003; and OECD 2002, 75

in the Philippines (Corcega, et al. 2002, 3; Adversario 2003; and OECD 2002, 75 as cited by Bach 2003, 4). Table 6 provides a list of the number of health care professionals trained in the Philippines and how they are currently deployed as of 1998. A significant portion of nurses (more than 39,000) are actually practicing abroad. The country is presently one of the largest source markets for nurses, occupation and physical therapists (OT/PTs), and medical technicians.

Table 7 illustrates the extent to which the number of health care professionals working abroad has been growing rapidly over the last 10 years. As of 2003, there were almost 9,000 nurses and almost 5,000 OT/PTs working abroad. The leading countries of destination for Filipino nurses are Saudi Arabia, the US, and the United Kingdom together making up almost 85 percent of the total deployments for theperiod as seen in Table 8. This outflow of health human resources from the country seriously hampers the capacity to provide for adequate local health care. This health outflow is aggravated by the inequitable distribution of health care professionals who are concentrated in the urban areas.

Table 6. Stock Distribution of Health Workers Produced in the Philippines as of 1998

	Government	Abroad	Private	Others	Total
Nurses	9778	39174	nd	214959	263911
Dentists	1963	242	10513	18320	31038
Doctors	7671	495	18425	38546	65137
Pharmacists	229	302	nd	28324	28855
Midwives	15893	1196	nd	103412	120501
MedTech	1560	2090	nd	27396	31046
OT/PT	76	3300	nd	2602	5978

Source: Table 1 of the Presentation of Dr. Rodel Nodora of the Planning and Standards Division of the Health Human Resource Development Bureau (HHRDB) under the Department of Health (DOH) during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman

Ultimately, the migration of health workers contributes to the problems faced by health care systems in sending countries including the Philippines. Although it

Table 7: Filipino Health Human Resources Working Abroad (1992-2003)

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Doctors	86	91	57	69	47	82	63	59	27	61	129	112	883
Dentists	27	22	38	48	36	52	19	56	33	57	62	40	490
Nurses	5788	6739	6853	7597	4698	4282	3217	5413	7683	13536	11867	8968	86641
Pharmacists	52	32	32	54	57	42	33	55	30	64	57	74	582
Medtechs	312	329	302	270	247	343	287	nd	nd	nd	nd	nd	2090
Midwives	246	295	126	161	142	113	113	66	55	190	312	276	2095
Ot/Pt	542	608	645	581	426	289	209	147	235	330	517	371	4900
Year ToTal	7053	8116	8053	8780	5653	5203	3941	5796	8063	14238	12944	9841	97681

Source: Table 2 of the Presentation of Dr. Rodel Nodora of the Planning and Standards Division of the Health Human Resource Development Bureau (HHRDB) under the Department of Health (DOH) during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman.

does contribute positively in terms of addressing shortfalls or shortages in health personnel in receiving countries (and hence contribute to the further improvement of their respective health care systems), the brain drain that underpins this kind of migration has had an adverse impact on many sending countries. Although the number of migrating health professionals is a small proportion of the total of highly skilled migrants nationwide, the loss of such "health human resources" for less developed countries can significantly and adversely affect the capacities of their respective systems to deliver adequate and equitable health care for all. (See Bach 2003; Stilwell, et al., 2003; Diallo 2004; and Scott, et al. 2004)

Table 8. Leading Countries of Destinations for Filipino Nurses
(Percentage Distribution from 1992-2003)

Country of Destination	Percentage (%)
Saudi Arabia	57.58
United States	13.87
United Kingdom	12.42
Libya	3.58
United Arab Emirates	3.34
Ireland	3.33
Singapore	2.70
Kuwait	2.30
Qatar	0.80
Brunei	0.08
TOTAL	**100.00**

Source: Table 9 of the Presentation of Dr. Rodel Nodora of the Planning and Standards Division of the Health I Development Bureau (HHRDB) under the Department of Health (DOH) during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman

Policy Recommendations

Migrants are highly vulnerable to health problems for a variety of reasons. Gushulak and MacPherson (2006) have put forward several proposals for consideration by national authorities in order to preempt the serious consequences

consequences of these health problems. Among their proposals is a mechanism for immigration medical screening and the inclusion of mobility as a determining factor for health outcomes.

In turn, the following actions are recommended in the light of insights gained from data gathered in preparing this paper and are directed to Philippine government authorities and civil societies. Some advocacy issues are also included for consideration of the governments of destination countries. The findings and observations made in the paper using the typologies of migration health concerns are summarized in the matrices of Table 10.

Table 10. Migrant Status

		Job Type	Health Risks	Policy Dimension
Migrant Status	Documented	All categories	Undergo screening procedures – Perceived health risks likely to be low	Less restrictive, complicated, and unattractive
	Undocumented	Usually menial labor and sex work	Do not undergo screening procedures – Perceived health risks likely to be high	More restrictive, complicated, and unattractive; criminalizes the migrants

A primary recommendation is for the Philippine government to see to it that the process of migrant worker recruitment is competently regulated without criminalizing the migrants.

The Philippine government must integrate health concerns in its program for migrant workers, e.g., a mandatory health insurance for all migrants regardless of status. It needs to craft and implement proper intervention mechanisms that can promote awareness of the health risks faced by migrants including provision of relevant information on health and reproductive rights during the pre-departure stage as well as upon return and to initiate programs for health evaluation of returning

migrant workers. It must establish a sensitive HIV/AIDS and STI prevention, detection, and treatment program for migrant men and women. Additionally, the Philippine government must monitor compliance of foreign employers to fair labor practices and health standards.

There is a need to address the looming crisis in human health resource because of migration. Human health resource development must be rationalized in the light of demand for health services in other countries and our national needs. One option to limit the outflow of health care professionals is by way of a quota system. Training programs must be designed so that the role of other health professionals can be expanded to substitute for doctors in underserved areas. There may be a need to upgrade the training of barangay and community health workers to provide basic preventive and curative services. At the international level, the Philippine government must engage destination countries in a serious bilateral or multilateral dialogue to reach an agreement regarding recruitment of health professionals toward a win-win situation.

Because of its extensive experience in advocacy and organization work, the civil society can be harnessed to assist government in designing appropriate and alternative intervention mechanisms that can promote awareness of the health risks faced by migrants. Its networking capabilities should also contribute in the provision of support information for migrants of their health and reproductive rights.

Ultimately, it will be the government of the destination countries that will be largely instrumental in protecting the health and rights of Filipino migrant workers. There are two important issues that foreign governments must acknowledge: (a) the gravity of human trafficking and smuggling and the need to address their root causes including the need to punish organized criminal syndicates involved in such activities; and (b) the seriousness of the problem of migration health and the need to provide Filipino migrants better access to health care. This may include the provision of mandatory insurance for comprehensive health care coverage for all migrants regardless of status and reproductive health and mental health services for migrant women. For example, HIV/AIDS and sexually transmitted infection prevention, detection, and treatment program for migrant men, women, as well as the clients of sex workers should be put in place. They need to craft and implement

proper intervention mechanisms that can promote awareness of the health risks faced by migrants and surveillance mechanisms to monitor, detect, and perhaps anticipate health problems among migrant population groups. In order to sustain these efforts, there is a need to monitor the compliance of employers to fair labor practices. Indeed, being proactive is certainly more cost-effective over the long-term. As Gay and Edmunds (1998) pointed out:

> Investing in improving health in poor countries is not a question of altruism but of long-term self-interest. For example, it has been shown by mathematical modeling for hepatitis B that the resources needed to prevent one carrier in the United Kingdom could prevent 4,000 carriers in Bangladesh of whom, statistically, four might be expected to migrate to the UK. Thus, it would be four times more cost-effective for the UK to sponsor a vaccination programme against hepatitis B in Bangladesh than to introduce its own universal vaccination programme (Gay and Edmunds 1998, 1457 as cited in WHO 2003, 8).

Notes

1 Transnationalism is that process or phenomenon that allows for people and communities to forge and sustain multi-stranded social relations. As it applies to population movements, transnational migration allows for a connection or link to be established among migrants and non-migrants alike in both societies of origin and settlement. Migration used to be seen as a "one-way" process. Leaving your place of origin or place of birth was thought to be permanent. Being cut off from your birth place was seen as absolute. Today, migrants have a tendency to open up or create transnational spaces both in the points of origin and destination. For further details, see Parnwell (2005).

2 There are many other ways of classifying migrants and the migration process. For details, see Parnwell (1993).

3 For information on what constitutes human trafficking and how it is different from smuggling in the Philippine context, see RA 9208 or the Anti-Trafficking in Persons Act of 2003.

4 From the presentation by Ellene Sana of the Center for Migrant Advocacy Philippines during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman.

[5] Paper presented by Director Antonio Amparo of the Bureau of Quarantine entitled "Migration and Contagious Diseases: Emerging Issues for the Philippines" during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman, p. 2.

[6] From the presentation by Ellene Sana of the Center for Migrant Advocacy Philippines during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman.

[7] Paper presented by Director Antonio Amparo of the Bureau of Quarantine entitled "Migration and Contagious Diseases: Emerging Issues for the Philippines" during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman, p. 3.

[8] Paper presented by Director Antonio Amparo of the Bureau of Quarantine entitled "Migration and Contagious Diseases: Emerging Issues for the Philippines" during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman, p. 4.

[9] Presentation of Ms. Andrea Anolin of the Batis Center for Women during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman.

[10] Presentation of Ms. Andrea Anolin of the Batis Center for Women during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman.

[11] Presentation of Ms. Andrea Anolin of the Batis Center for Women during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman.

[12] Presentation of Ms. Maria Lorena Macabuag of UNLAD-Kabayan during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman.

[13] Presentation of Ms. Maria Lorena Macabuag of UNLAD-Kabayan during the "Second Global Health Forum on International Labor Migration From the Philippines," 18 October 2005, Foundation for Integrative and Development Studies (FIDS), World Health Organization (WHO), and the Department of Health (DOH), ISSI Bldg., UP Diliman.

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