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Abstract:

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Worldwide, women's equality remains elusive in the social, political, civil, economic and cultural spheres. Such reality presents a challenge in the movement of persons across state borders because, globally, the world is experiencing a feminization of migration. In turn, the feminization of migration effects threats to the health and safety of migrant women, whose well-being is in peril at all stages of the migration journey – from the country of origin, to the transit states, to the receiving state – from smugglers and official actors alike. Because the globalization discourses exclude the movement of persons and focus on the movement of goods and services, migrants become invisible. This work suggests a paradigmatic shift in the way institutions engage migration – from a system that treats migrants as disposable people and focuses on legality of presence to a human rights-inspired one that centers on migrants' well-being and dignitary interests. In support of this shift, this essay employs the overarching frameworks of glocalization and of marginableness to fill the existent void in the current conversations on migration. Three premises are foundational in the discussion: one, woman is not a monolithic category and its meaning is culturally dependent so it is imperative not to exclude any "woman;" two, there is no monolithic migrant woman and some, such as LGBT migrants, face mutidimensional challenges; and, three, the human rights system utilized is not the existent one but rather one reimagined without it being tethered to its western, heteronormative, patriarchal, colonialist, racialized, sexist origins. Such a reimagined human rights paradigm provides the foundation for migrants' protections in their perilous journeys.

I. INTRODUCTION

Global Justice for Women: Advancing Equality is a hugely significant theme, because no matter where we search, or what corner of the world we scrutinize, equality for women remains elusive in the social, political, civil, economic and cultural spheres. This condition of women's inequality is also a

reality in the area of migration. The disparities are noteworthy because the world is experiencing a feminization of migration.

The foundational premise of this essay is that because migration, work, and labor—interconnected spheres in which health and human well-being are central concerns—are human rights issues, they are properly located within the human rights[1] paradigm. Significantly, this work suggests a paradigmatic shift in the way governments, health care and related institutions, and civil society evaluate and engage migration. It urges that, rather than continue with the current version that treats fragile persons as disposable people, we embrace a worldwide model of migration analysis that pursues a human rights vision centering on human well-being.

The proposed paradigmatic shift utilizes critical theoretical interrogations[2] to reframe the debate and shift the focus from legality of presence—a focus that unveils the injustice of a politically driven, often xenophobic analysis—to human dignitary interests. Such understanding permits the crafting of a well-being/human thriving-based approach to migration. It embraces the analysis of the migration phenomenon that promotes human flourishing and centers on people,[3] not politics. In doing so, it also shows how legality of status is but a meme—a culturally transmitted pattern of behavior, as those who are legally present—be they with documents or even citizens—but disempowered share the plight of the migrant.

In support of the proposed paradigmatic shift, this essay utilizes the overarching frameworks of glocalization and of marginableness. Glocalization is an idea that brings to the forefront the reality that the global and the local are inextricably intertwined. This is particularly true with respect to issues of migration. The migratory move itself is one in which the local moves through the global—indeed one or more localities—to arrive at another local space in the global marketplace. While globalization is recognized in the context of markets—the ubiquity of blue jeans around the world or the presence of flute music from various cultures in South America in farmers' markets around the U.S.—talk of this phenomenon is largely absent in the conversations about migration. Such silence can be attributed to

1. This work uses the language of rights. However, this author is conscious of and in agreement with much of the literature on the critique of rights. *See, e.g.,* DUNCAN KENNEDY, A CRITIQUE OF ADJUDICATION (1997); Frances Olsen, *Statutory Rape: A Feminist Critique of Rights Analysis*, 63 TEX. L. REV. 387 (1984); Cass Sunstein, *Rights and Their Critics*, 70 NOTRE DAME L. REV. 727 (1995). A key component of the critique is the injustice of the existing system particularly in its protection and perpetuation of the status quo of the existing distributions and practices, which are themselves bound by inequality. As such, any goal of equality and justice in the human "rights" field has to acknowledge the financial biases inherent in any articulation of rights, which ultimately is intertwined with the power to articulate such rights and consequently reflects the interests of those engaged in the articulations. These are not novel thoughts, but they are significant ones if one is suggesting any type of paradigmatic shift.
2. *See generally, e.g.,* critical race, third world, and queer theories, respectively, challenging the law as white, male, and hetero-normative. CHRISTIE LAUNIUS & HOLLY HASSEL, THRESHOLD CONCEPTS IN WOMEN'S AND GENDER STUDIES: WAYS OF SEEING, THINKING AND KNOWING (2015); A QUEER WORLD: THE CENTER FOR LESBIAN AND GAY STUDIES READER (Martin Duberman ed., 1997); CRITICAL RACE THEORY: THE CUTTING EDGE (Richard Delgado ed., 1995).
3. This suggested approach is akin to Amartya Sen's focus on human capabilities rather than human capital. *See* AMARTYA SEN, DEVELOPMENT AS FREEDOM (1999).

the reality that the movement of people is invisible in the globalization conversations because of its narrow deployment, as simply what happens in the marketplace.

The traditional focus of globalization is the movement of goods, capital, and information across national borders. Such a concept, which expressly excludes the movement of persons, is ill founded. It is the movement of persons that truly serves to influence local norms, traditions, processes of learning, the exchange of information, and lifestyles. Ironically, the invisibility of people in globalization discourse, allows the powerful to commodify humans, that is, treat people as goods without acknowledging that they are doing so. To bring migrants out of the shadows, this project incorporates persons in the idea of globalization.

Marginableness, on the other hand, fills a linguistic void existing in the current conversations about migrants, among others, who are both vulnerable and marginalized. To be sure, all migrants, and in particular migrant women and their children, are vulnerable because they are subject to discrimination and are not part of the privileged in society.[4] However, they are also marginalized; they are subjected to processes that relegate them to secondary status in society and life and have the consequence of excluding them from full participation.[5] Such marginalization is a structural manifestation of social hierarchies that are based on social distinctions—a type of caste system. The entrenched system results in the exclusion of persons from enjoying rights, opportunities, resources, or protections simply because of who they are. Marginalization, like vulnerability, can exist because of race, color, class, ethnicity, education, language, religion, sexuality, or any other trait or combination of traits, over which persons have no control but that nevertheless serves to "other" them from the perceived accepted normative.

Thus, to describe migrant women as vulnerable or marginalized would be underinclusive. This group is both vulnerable and marginalized, not only because of being women who are migrants, but also because they are often poor and often racial, ethnic, linguistic and/or religious minorities in their destination country. Thus, marginable more holistically captures the migrant woman's reality.

Within this framework, in Part II the essay presents the human rights structure that can be utilized to protect migrants. Part III considers migration: its geography and demographics—who the migrants are, where they come from, where they go, as well as what they do—and its feminization. Part IV shifts the gaze to the gendered risks of the migration journey. In Part V the essay examines glocal reproductive realities: the risks for migrant women in their journey, migration for giving birth, and the disparate

4. Martha A. Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1 (2008) (defining vulnerability as follows: "Vulnerability is and should be understood to be universal and constant, inherent in the human condition. The vulnerability approach is an alternative to traditional equal protection analysis; it represents a post-identity inquiry in that it is not focused only on discrimination against defined groups, but concerned with privilege and favor conferred on limited segments of the population by the state and broader society through their institutions. As such, vulnerability analysis concentrates on the institutions and structures our society has and will establish to manage our common vulnerabilities. This approach has the potential to move us beyond the stifling confines of current discrimination-based models toward a more substantive vision of equality.").

5. *See Marginalization*, Int'l Encyc. of the Soc. Sci. 2008, ENCYCLOPEDIA.COM, http://www.encyclopedia.com/doc/1G2-3045301449.html (last visited May 19, 2016).

health outcomes in the U.S. of marginable pregnant women, regardless of migration status. This piece concludes that a human rights framework will enable a paradigmatic shift that will better position migrant as well as local women in their journeys to enjoy a path towards human thriving and full personhood.

However, before engaging the essence of this work, it is first appropriate to provide both context and clarity on three realities. First, the focus of this essay, is on Global Justice for Women. Thus before proceeding to the substantive analysis, it is imperative to problematize the term "woman." There is no monolithic woman. Women are multidimensional beings with varied sexual, gender, ethnic, religious, class, race, ability, and economic identities – identities all of which are performed within cultural frameworks.[6] Moreover, who is perceived to make up the category "woman" can be different people in different cultures and contexts and it is imperative that all who may constitute that category be included in the analysis.[7]

Similarly, there is no monolithic migrant woman. And while the migration experience is demanding and debilitating and may even be humiliating for everyone, it has distinct health and safety challenges for LGBT migrants.[8] The particularized challenges for LGBT migrants include navigating where transgendered persons are detained, where they go to the bathroom, and where they sleep;[9] facing a much higher likelihood of being sexually assaulted;[10] and lacking access to treatment—be it for HIV or hormones—to name a few.[11] Moreover, LGBT migrants face the additional burdens of rejection by

6. *See*, Kimberlé W. Crenshaw, *Close Encounters of Three Kinds: On Teaching Dominance Feminism and* Intersectionality, 46 TULSA L. REV. 151 (2010); Berta Esperanza Hernández-Truyol, *The Gender Bend: Culture, Sex, and Sexuality—A Latcritical Human Rights Map of Latina/o Border Crossings,* 83 IND. L.J. 1283 (2008); Berta Esperanza Hernández-Truyol, *Las Olvidadas—Gendered in Justice/Gendered Injustice: Latinas, Fronteras and the Law*, 1 J. GENDER RACE & JUST. 353 (1998); Berta Esperanza Hernández-Truyol, *Borders (En)Gendered: Normativities, Latinas, and a Latcrit Paradigm*, 72 N.Y.U. L. REV. 882 (1997); Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581 (1990).

7. Berta Esperanza Hernández-Truyol, *Unsex CEDAW? No! Super-Sex it!,* 20 COLUM. J. GENDER & L. 195 (2011) [hereinafter *Super-Sex*]; Berta Esperanza Hernàndez-Truyol (2011) *On Que(e)rying Feminism: Reclaiming the F Word*, Issues in Legal Scholarship, Vol. 9, Iss. 2 (Article), Article 4 (noting that "[w]hether or not the category "woman" is valid, the data indicates the people who are perceived to make up that category (and that can be different people in different cultures and contexts) are less likely to enjoy the trappings of full personhood.").

8. The Queer Undocumented Immigrant Project, *5 Things You Should Know About Trans & Queers in Detention*, UNITED WE DREAM, http://unitedwedream.org/blog/5-things-know-trans-queers-detention/ (last visited on May 20, 2016).

9. *Id*. (explaining that "The protocol to consider housing for detainees is not decided on self-assessed gender, but instead on physical anatomy or legal documentation. This causes for our Transgender community to be at risk of physical and psychological abuse when placed in all male or female facilities that do not reflect their gender identity nor choice and do not respect the individual's preferred gender pronoun.").

10. *Id*. (noting that "LGBTQ detainees are 15 times more likely to be sexually assaulted than their heterosexual, not-transgender counterparts. Most incidents of sexual assault against LGBT detainees are by fellow detainees and by guards employed by detention facilities.").

11. *Id*. (noting that "LGBTQ and HIV+ individuals are particularly at risk of lacking access to treatment. On multiple occasions, the denial of hormone treatment for transgender individuals has been documented as well as care for HIV+ individuals has caused deaths in detention centers.").

their families of origin (which might be the reason for/causes of the migration journey), the migrant community, and possibly the society in which they may be seeking refuge because of their sexuality.[12]

Indeed, there are 74 states around the world where homosexual acts are criminalized—45 include lesbians, and in 13 of these, the death penalty can be imposed.[13] These circumstances render LGBT migrants "others" within an already othered community, underscoring their marginableness. Moreover, LGBT migrants are often invisible or erased from the migration discourse altogether. Thus, they, too, must come out of the shadows and be counted.

Last, the human rights system from which this essay draws rights, often honored in the breach with respect to migrants, is not perfect. It has western, heteronormative, patriarchal, colonialist, racialized, sexist foundations which must be eschewed.[14] These flawed structures have subjected the system to Asian,[15] southern,[16] feminist,[17] 3rd World/anti-colonialist[18] critiques. This work embraces a reimagined human rights system that is both egalitarian and equitable—an inclusive system that adopts an intersectionality/multidimensionality[19] approach and is multidisciplinary—it considers not only law but also sociology, psychology, economics, science—in the ultimate pursuit of human-flourishing. Such system serves all human beings well, particularly the marginable. This paradigm can provide context for an analysis of the health and safety of migrants, workers, and women in labor.

As the next section will show, such a reimagined human rights system provides the foundation for a plethora of protections for migrants. The indivisibility and interdependence paradigm of the human rights system, which recognizes that all types of rights, regardless of categorization, are necessary for

12. Necesidades Migrantes LGBT, *available at* https://www.google.com/search?q=necesidades+migrantes+LGBT&espv=2&biw=1050&bih=1619&source=lnms&tbm=isch&sa=X&ved=0ahUKEwjr5d6twOnMAhVJkh4KHRmYDAkQ_AUIBygC&dpr=1#imgrc=Xz10q63D5IJj1M%3A (last visited May 20, 2016) (noting that LGBT migrants need psychological counseling because of community rejection). *See also The Gender Bend: Culture, Sex and Sexuality, supra* note 6.
13. Aengus Carroll, *State Sponsored Homophobia 2016: A World Survey of Sexual Orientation Laws: Criminalization, Protection and Recognition,* INTERNATIONAL LESBIAN, GAY, BISEXUAL, TRANS, AND INTERSEX ASSOCIATION (ILGA), *available at* http://ilga.org/downloads/02_ILGA_State_Sponsored_Homophobia_2016_ENG_WEB_150516.pdf.
14. I have suggested reformations to remedy the biases and it is with that reformed model in mind that I offer this principle as an organizing principle for the feminist project. *See generally* Berta E. Hernández-Truyol, *Human Rights, Globalization, and Culture—Centering Personhood in International Narrative,* in MORAL IMPERIALISM – A CRITICAL ANTHOLOGY (Berta E. Hernández-Truyol, ed., 2002).
15. *See generally* WM. THEODORE DE BARY, ASIAN VALUES AND HUMAN RIGHTS: A CONFUCIAN COMMUNITARIAN PERSPECTIVE (1998).
16. *See generally* BALAKRISHNAN RAJAGOPAL, INTERNATIONAL LAW FROM BELOW: DEVELOPMENT, SOCIAL MOVEMENTS AND THIRD WORLD RESISTANCE (2003).
17. *See generally* INTERNATIONAL LAW: MODERN FEMINIST APPROACHES (Doris Buss & Ambreena Manji, eds., 2005); *see also* GLOBAL CRITICAL RACE FEMINISM: AN INTERNATIONAL READER (Adrien Katherine Wing, ed., 2000).
18. *See generally* ANTONY ANGHIE, IMPERIALISM, SOVEREIGNTY AND THE MAKING OF INTERNATIONAL LAW (2004).
19. *See generally supra* note 6. For a concise definition of intersectionality, see LAUNIUS & HASSEL, *supra* note 2, at 194 (noting that intersectionality refers to "[t]he ways multiple forms of oppression and identity interact to create someone's experience of and access to social influence and individual institutional power"). Multidimensionality, on the other hand, is the concept that every person is comprised of myriad layers of identity including race, sex, ethnicity, sexuality, language, religion, etc. *See* Berta E. Hernàndez-Truyol, *Building Bridges – Latinas and Latinos at the Crossroads: Realities, Rhetoric and Replacement*, 25 COLOM. HUM. RTS. L. REV. 369 (1994).

the fulfillment of the human spirit and the attainment of full personhood, is hugely valuable for the marginable who endure privation at all levels of life: civil and political as well as social, cultural and economic.

II. THE LEGAL PROTECTION OF HUMAN RIGHTS[20]

International human rights are those rights vital to individuals' existence—they are fundamental, inviolable, interdependent, indivisible, and inalienable rights predicate to life as human beings.[21] Human rights are moral, social, religious, legal, and political prerogatives that concern the respect and dignity associated with personhood, with a human being's identity.[22] Human rights' origins are traced to religion, "natural law [and] contemporary moral values."[23] The concept of human rights is a relatively recent idea that some suggest is universally applicable, at least in principle.[24]

Even before the formal birth of the human rights discipline, early writers recognized the importance of individuals to the Law of Nations. Because it is natural persons who comprise "the personal basis of every State,"[25] international law needs to "provide certain rules regarding individuals."[26] However, in the early days of the discipline individuals were deemed to be objects, not subjects, of International Law.[27] Thus, international laws, while applicable to individuals, could not be enforced by or against individuals; individuals were considered to lack standing to enforce infractions.

Oppenheim, an early philosopher of international law, identified certain "rights of mankind" that, pursuant to the Law of Nations, should be guaranteed to all individuals regardless of nationality. Specifically he identified the "right of existence, the right to protection of honor, life, health, liberty, and property, the right of practicing any religion one likes, the right of emigration and the like" as "rights of mankind."[28] It is significant, as will be seen below, that contemporary human rights documents recognize each and every right Oppenheim listed. Of particular importance to this essay's thesis, however,

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20. Parts of this section are derived from Berta Esperanza Hernández-Truyol, *On Disposable People and Human Well-Being: Health, Money and Power*, 13 U.C. DAVIS L. REV. 101 (2006).
21. *See generally* Berta E. Hernández-Truyol, *Human Rights Through a Gendered Lens: Emergence, Evolution, Revolution, in* WOMEN AND INTERNATIONAL HUMAN RIGHTS LAW (Kelly Askin & Dorean Koenig eds., 1999) [hereinafter Hernández-Truyol, *Gendered Lens*]; *see also* International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171, *entered into force* March 23, 1976 [hereinafter ICCPR] (noting that these rights derive from the inherent dignity of the human person); REBECCA M. WALLACE, INTERNATIONAL LAW 175 (1986) ("Human Rights . . . are regarded as those fundamental and inalienable rights which are essential for life as a human being."). Portions of this section are taken from Hernández-Truyol, *Gendered Lens*, *supra* note 21.
22. *See generally* Hernández-Truyol, *Gendered Lens, supra* note 21.
23. RESTATEMENT (THIRD) OF THE FOREIGN RELATIONS LAW OF THE UNITED STATES § 701 cmt. b (1987).
24. *See* Berta E. Hernández-Truyol, *Women's Rights as Human Rights—Rules, Realities and the Role of Culture: A Formula for Reform*, 21 BROOK. J. INT'L L. 605 (1996) [hereinafter Hernández-Truyol, *Women's Rights as Human Rights*]. For a discussion of the universality versus relativity debate, *see id.*, at nn.168–73 and accompanying text.
25. I.L. OPPENHEIM, INTERNATIONAL LAW: TREATISE 362-69, § 288 (2d ed., 1912) *reprinted in* LOUIS B. SOHN & THOMAS BUERGENTHAL, INTERNATIONAL PROTECTION OF HUMAN RIGHTS 1 (1973).
26. *Id.*
27. *Id.* at § 290, *reprinted in* SOHN & BUERGENTHAL, *supra* note 25, at 3.
28. *Id.* at § 292, *reprinted in* SOHN & BUERGENTHAL, *supra* note 25, at 4.

is the fact that, even before human rights had evolved as a discipline, Oppenheim recognized the rights to life, health, and emigration—all central to the migration discourse—as a rights of humankind. Since the birth of the discipline, the literature has acknowledged and embraced the centrality of these rights to human well-being.

While recognizing that individuals could not be subjects of international law because of its statist focus, Oppenheim philosophized about and acknowledged the ostensibly supra-sovereign nature of what he called "rights of mankind" that today we describe as "human rights":

> [T]here is no doubt that, should a State venture to treat its own subjects or a part thereof with such cruelty as would stagger humanity, public opinion of the rest of the world would call upon the Powers to exercise intervention for the purpose of compelling such State to establish a legal order of things within its boundaries sufficient to guarantee to its citizens an existence more adequate to the ideas of modern civilization.[29]

Confirming that Oppenheim was a true visionary in evaluating the importance of basic human rights to human existence, when the human rights field became structured, formal instruments guaranteed all persons such rights, including an adequate standard of living and "the highest attainable standard of physical and mental health."[30] Article 25 of the Universal Declaration on Human Rights, an aspirational, non-binding document, first articulated this right and did so quite broadly:

> (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
>
> (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.[31]

It is noteworthy that Article 25 realistically contextualizes the goal of human well-being within an amalgam of rights, all of which are necessary for healthy human thriving. It connects a range of social, economic, and cultural rights such as work, housing, nutrition, and medical care as well as other civil and political rights including equality and nondiscrimination all of which are of critical significance to migrant's safety. Thus, Article 25's holistic approach reflects the indivisibility paradigm, which was then embraced by the legally binding International Covenants on Economic, Social and Cultural Rights, andCivil and Political Rights.[32]

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29. *Id.* The evolution of the role of the individual in international law can clearly be seen in Lauterpacht's revision of Oppenheim's work. *See* I.L. OPPENHEIM, INTERNATIONAL LAW: A TREATISE 632–42 (8th ed. 1955) *reprinted in* SOHN & BUERGENTHAL, *supra* note 25. For example, in revising § 289, Lauterpacht concluded that "[s]tates may, and occasionally do, confer upon individuals . . . international rights *stricto sensu,* i.e., rights which they acquire without the intervention of municipal legislation and which they can enforce in their own name before international tribunals." *Id.* at § 289, *reprinted in* SOHN & BUERGENTHAL, *supra* note 25, at 5.
30. International Covenant on Economic, Social and Cultural Rights, arts. 11(1), 12(1), Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].
31. Universal Declaration of Human Rights, art. 25, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948).
32. *Id.* International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR] (noting that these rights derive from the inherent dignity of the human person), Preamble (recognizing that "the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only

Focusing on health, it is indisputable that there are multiple linkages between health and human rights violations. The World Health Organization states in its Constitution that

> health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.[33]

This language evidences the drafters' recognition of the indivisibility of health from other human rights. It renders clear that enjoyment of health is crucial to all facets of a person's life and to her/his enjoyment of other human rights. This approach recognizes the complexity of human well-being and suggests the myriad interlocked locations that must be protected in order to attain human thriving. It also denotes the importance of the indivisibility approach to the marginable, specifically here migrant women, whose lives are precarious along all of the human rights axes.

Other human rights documents substantially protect the specific fundamental right to health, as well as other rights that are indivisible from and interdependent with that right and that, as will be shown in the following section, have a huge impact on migrant women. The ICCPR[34] protects so-called civil and political rights, which include the rights to non-discrimination (Articles 2, 26); life (Article 6); bodily integrity/safety (Article 7); freedom from slavery (Article 8); movement (Article 12); privacy (Article 17); and to seek, receive, and impart information (Article 19). The ICESCR,[35] on the other hand, protects so-called social, economic and cultural rights which expressly include nondiscrimination (Article 2); work (Article 6); a just and healthy work environment (Article 7); an adequate standard of living—including food, clothing and housing (Article 11); rights to physical and mental health (Article 12); and education (Article 13).

Among the international human rights treaties, the Convention on the Elimination of All Forms of Discrimination against Women[36] (Women's Convention or CEDAW) holds a significant place in the body of human rights law as it makes the female half of humanity the focus of human rights concerns[37] and thus, is invaluable in the quest for justice for the marginable.[38] The Women's Convention creates an important and broad legal norm prohibiting sex-based discrimination with the central aim of promoting women's equality. The comprehensive definition of prohibited discrimination includes:

> any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose

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be achieved if conditions are created where everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights").

33. Constitution of the World Health Organization, *available at* http://www.who.int/governance/eb/who_constitution_en.pdf (last visited May 24, 2016).
34. *See* ICCPR, *supra* note 32.
35. *See* ICESCR, *supra* note 30.
36. Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180, U.N. Doc A/RES/34/180 (Dec. 18, 1979) [hereinafter CEDAW].
37. *See id. at* Preamble (noting that notwithstanding nondiscrimination mandates in international conventions, discrimination against women persists forming the impetus behind the Women's Convention to eradicate discrimination against women in all its forms and locations ranging from government to family, from traditional roles to economic locations).
38. *See* Hernández-Truyol, *Super-Sex*, *supra* note 7.

> of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[39]

The Convention emphasizes that such discrimination "violates the principles of equality of rights and respect for human dignity."[40] Significant for this work, the Convention includes "express and comprehensive" provisions on women's health including specifically protection of the family and reproduction. Indeed, the Convention's protection of reproductive health and health services is a means to attainment of equality between men and women.[41]

The plain language of CEDAW's Article 1—which protects fundamental freedoms ranging from political to economic, from civil to cultural—shows that the Women's Convention, like the Universal Declaration, embraces the indivisibility of rights paradigm. The Convention's objective is to effect equality between women and men; it achieves this goal by establishing normative standards that ensure women's equal access to, and equal opportunities in, political and public life—including the right to vote and to stand for election, as well as rights to education, health, and employment. Indeed, recognizing the universality/relativism discourse,[42] and that culture is often used as a pretext to subordinate women, the Convention targets culture and tradition as influential forces shaping gender roles and family relations, and seeks to eliminate oppressive gender roles and problematic gender stereotyping.

Specifically with respect to health, the Women's Convention is the only human rights treaty that affirms and protects the reproductive rights of women. Article 12 directly addresses health beyond the broad prohibition against sex discrimination in health care articulated in Paragraph 1. Paragraph 2 provides that "States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[43]

Another significant document with respect to the right to human well-being and migration, is the Convention on the Rights of the Child (CRC).[44] Like Article 12 of the Women's Convention, Article 24 of the CRC provides for comprehensive health protections. Beyond a mandate that there be broad access to health care, the article also seeks to have states adopt practices that will reduce infant and child mortality. Similarly, in the quest for enabling children's health, the document recognizes the possible negative impact of cultural practices. To address this concern, Article 24 provides that, "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices preju-

39. CEDAW, *supra* note 36, at art. 1.
40. *Id*. at Preamble.
41. *Id.* at art. 12(1) ("States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.").
42. *See* Hernández-Truyol, *Women's Rights as Human Rights, supra* note 24.
43. CEDAW, *supra* note 36, at art. 12(2).
44. Convention on the Rights of the Child, Sept. 2, 1990, 1577 U.N.T.S. 3.

dicial to the health of children." Lastly, consistent with the desire to eradicate harmful cultural practices, Article 2 of the CRC includes a right to non-discrimination on the bases of the child's, the parent's, or the legal guardian's, "race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status."

The U.S. has not ratified the convention, although it has ratified two Optional Protocols from May 2000, which entered into force in 2002, on Involvement of Children in Armed Conflict,[45] and on The Sale of Children, Child Prostitution and Child Pornography.[46] The latter is significant in the context of migrant children as, at Articles 1-3, it explicitly forbids the sale of children, sexual exploitation of the child, or engaging the child in forced labor.

Finally, the Convention on the Elimination of All Forms of Racial Discrimination (CERD)[47] also provides for "[t]he right to public health, medical care, social security and social services."[48] Interestingly, especially in light of the multidimensionality and indivisibility approach, although CERD deploys the lens of race, it is silent on gender just like CEDAW is silent on race.

There are additional protections that are found in the specialized conventions on the specific rights of migrant workers and their families, as well as in the rights of refugees. The 1951 Convention relating to the Status of Refugees and the 1967 Protocol Relating to the Status of Refugees[49] enshrined the age-old concept of non-refoulement. This concept prohibits signatories from returning victims of persecution who are seeking refuge from their persecutors. The provision includes protections of those seeking asylum because they are being persecuted on the basis of membership in a social group, which includes race, gender, sexual orientation, etc.[50]

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45. Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict Feb. 12, 2002, 2173 U.N.T.S. 222.
46. Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, Jan. 18, 2002, 2171 U.N.T.S. 227.
47. Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), U.N. Doc. A/RES/2106 (Jan. 4, 1969), *available at* http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx.
48. *Id*. at art. 5.
49. Convention and Protocol Relating to the Status of Refugees, G.A. Res. 2198 (XXI), U.N. Doc. A/RES/2198 (Dec. 2010), *available at* http://www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf.
50. *Id*. at art. 33. The Convention provides, in pertinent part, as follows:

> "1. No Contracting State shall expel or return ("refouler") a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.
>
> 2. The benefit of the present provision may not, however, be claimed by a refugee whom there are reasonable grounds for regarding as a danger to the security of the country in which he is, or who, having been convicted by a final judgment of a particularly serious crime, constitutes a danger to the community of that country."
>
> Interestingly, the Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment, G.A. Res. 39/46, U.N. Doc. A/RES/39/46 (Dec. 10, 1984) *as modified* 24 I.L.M. 535 (1985), 1465 U.N.T.S. 85 (1984), at art. 3, has a non-refoulement provision: "1. No State Party shall expel, return or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture."

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families[51] underscores the relationship between migration and human rights. It provides that migrants, regardless of status, should be afforded a minimum of protection equal to that given to nationals of the host state. Significantly, Article 7 includes a non-discrimination clause that provides that migrant workers and their families have rights without regard to, "sex, race, colour, language, religion or conviction, political or other opinion, national, ethnic or social origin, nationality, age, economic position, property, marital status, birth, or other status." In addition, Article 16 expressly provides for migrant workers' and their families' right to security of the person and entitles them to "effective protection by the State against violence, physical injury, threats and intimidation, whether by public officials or by private individuals, groups or institutions."

Finally, it is appropriate to mention the Yogyakarta Principles.[52] These apply international human rights law principles in relation to sexual orientation and gender identity including, e.g., the rights to universal enjoyment of human rights, (Principle 1), life (Principle 4), equality (Principle 2), personhood (Principle 3), security (Principle 5), privacy (Principle 6), work (Principle 12), education (Principle 16), health (Principle 17), family (Principle 24), freedom of movement (Principle 22), and culture (Principle 26), among other matters. The Principles are significant because the concerns this essay raises apply to lesbian, transgender, and gender non-conforming women although disaggregated data for these populations are non-existent. These Principles confirm that the LGBT migrant, who is at higher risks of violence and health concerns, is protected by law.

In summary, existing international[53] human rights law specifically protects myriad rights denied to migrants. Significantly, this approach embraces the right to health and health care, includes reproductive health and autonomy in the existing mix of rights, and maps health and health care in the broad geography of human thriving. In addition, other rights that affect migrants, such as the right to security, an education, information, food and nutrition, also receive protection.

III. GEOGRAPHY AND DEMOGRAPHY: THE FEMINIZATION OF MIGRATION

Every continent sends or receives migrants, be it for labor or refuge. Migration affects hundreds of millions every year. In 2015, the number of international migrants reached 244 million, which was an

51. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, G.A. Res. 45/158, U.N. Doc. A/RES/45/158 (Dec. 18, 1990), *available at* http://www.ohchr.org/EN/ProfessionalInterest/Pages/CMW.aspx.

52. THE YOGYAKARTA PRINCIPLES, The Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity, http://www.yogyakartaprinciples.org/principles_en.htm (last visited May 24, 2016).

53. It should be noted that regional human rights systems also include protections of these rights. *See*, *e.g.,* European Convention on Human Rights, *available at* http://www.echr.coe.int/Documents/Convention_ENG.pdf (last visited May 24, 2016); American Convention on Human Rights, *available at* http://www.cidh.org/basicos/english/Basic3.American%20Convention.htm (last visited May 24, 2016); African Charter on Human and Peoples' Rights, *available at* http://www.achpr.org/instruments/achpr/ (last visited May 24, 2016).

increase of 71 million in 15 years,[54] but also an increase of 12 million in just 2 years.[55] Some of the largest outgoing numbers originate in Asia and Europe, but these continents also receive the majority of migrants. In fact, two thirds of international migrants live in these two continents.[56] 76 million international migrants live in Europe, while 62 million such migrants come from Europe.[57] Similarly, 75 million migrants live in Asia, while 104 million migrants come from Asia.[58]

As of 2015, there were 54 million migrants living in North America while North America was responsible only for 4 million migrants moving elsewhere.[59] By contrast, in the same timeframe, Latin America has acted mostly as a sending region. There are 37 million migrants who come from Latin America and the Caribbean while only 9 million international migrants live there.[60] Similarly, 34 million migrants come from Africa while 21 million migrants live there.[61] What we find in these trends is that populations in the less developed nations seek work and opportunity in their richer neighbors.[62]

One interesting trend is the feminization of migration, with women comprising an increasing number of the migrant population.[63] In 2015 almost half – 48%—of the migrants were women,[64] a figure that has been fairly stable since it reached 47% in 1960.[65] By contrast, in the 19th century men comprised the vast majority of migrants.[66] The uptick in the number of female migrants is linked to "the feminization of poverty and the feminization of work."[67]

Data on migrant workers also is pertinent with respect to the feminization of migration. In 2013, when there were 232 million migrants, 207 million of whom were older than 15 years of age, 150 million were migrant workers. Of the 150 million migrant workers, 44% were women. Like with the general migration trends, the migrant workers' trends reflect a desire to move to more developed lo-

54. U.N. Department of Economics and Social Affairs, Population Division, *International Migration Stock: The 2015 Revision,* (2015), www.unmigration.org (last visited 24, 2016) [hereinafter The 2015 Revision].
55. *ILO Global Estimates on Migrant Workers: Results and Methodology - Special Focus on Migrant Domestic Workers* (2015), INTERNATIONAL LABOR ORGANIZATION, http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_436343.pdf (last visited May 25, 2016) [hereinafter *ILO Migrant Workers*].
56. *The 2015 Revision*, *supra* note 54.
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.*
62. *The 2015 Revision*, *supra* note 54.
63. CARITAS INTERNATIONAL, *The Female Face of Migration-Background Paper*, http://www.caritas.org/includes/pdf/backgroundmigration.pdf (last visited May 26, 2016) [hereinafter Caritas].
64. *The 2015 Revision, supra* note 54. Also noteworthy is that the median age of migrants was 39, and that 15% were below the age of 20.
65. U.N. Development Programme, *Human Development Report 2009*, p. 25, http://hdr.undp.org/sites/default/files/reports/269/hdr_2009_en_complete.pdf (last visited May 26, 2016) [hereinafter *Human Development Report 2009*].
66. *Id.*
67. Caritas, *supra* note 63. *See also infra* note 73 and accompanying text for the notion of the feminization of work.

cations where there exist more work opportunities. In 2013, of the total 150.3 million migrant workers, approximately 75% were in high-income countries, with almost 12% in upper-middle income states, 11% in lower-middle income states and only 2.4% in low-income states.[68]

Studies have shown that migrant workers are concentrated in certain economic sectors. The vast majority of migrant workers, 71.1%, are involved in services with 7.7% being in domestic services. 17.8% are involved in industry, mostly manufacturing and construction, and 11.1% are involved in agriculture.[69]

Not surprisingly, the trends in women's employment track the feminization of work meme. In receiving states, women are mostly relegated to service fields, including not only domestic work, but also in caregiving, such as nursing home-care, and waitressing.[70] Even within the subset of skilled workers, women and men have different tracks. While men concentrate in information technology and science, women concentrate in the care and welfare professions including health, education and social areas.[71]

Significantly, in 2013, when women comprised 44% of the migrant workers, of the 11.5 million migrant workers who were working as domestic workers, a huge majority, 73.4%, were women.[72] The general migrant worker trend shows that 79.2% of migrant domestic workers are in high-income countries, while only 10.3% are in upper-middle income countries and only 6.2% and 4.2 % are in lower-middle income countries and low-income countries respectively.[73] Those figures when disaggregated by sex, make the reality starker for women who comprise 82% of the domestic workers in high-income countries, 11.6% in upper-middle income countries, 3.6% in lower-middle income countries, and 2.8% in low-income countries.[74] It is interesting to note that migrant workers in general, and in particular migrant women, have higher labor participation rates than their non-migrant counterparts: 72.7% to 63.9% and 67% to 50.8% respectively.[75]

As these figures suggest, for many women migration offers a chance to access new economic opportunities for employment and development, to escape political or domestic instability, to enjoy more egalitarian social conditions, and to avoid discrimination, as well as to provide better living conditions and support for their children,[76] although most of the world's migration occurs within countries in similar levels of development.[77] Migration can be a source of empowerment when it "provid[es]

68. *ILO Migrant Workers*, *supra* note 55.
69. *Id.*
70. Caritas, *supra* note 63.
71. *Id.*
72. *ILO Migrant Workers*, *supra* note 55.
73. *Id.*
74. *Id.*
75. *Id.*
76. Caritas, *supra* note 63. *See also supra* note 3 and accompanying text.
77. *Human Development Report 2009*, *supra* note 65, at 21. Development of a state is often linked to its economic status, including GDP, GNP, per capita income, industrialization levels, infrastructure, and standard of living, to name a few basic indicators. However, there is also the notion of human development, which is broader and focuses on "the richness of human lives rather than narrowly on the richness of economics." *See* U.N. Development Programme, *Human Development Report 2015,* Foreword, at iii, http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf (last visited June 9, 2016).

women migrants with income and status, autonomy, freedom, and the self-esteem that comes with employment."[78]

IV. THE MIGRATION JOURNEY: GENDERED RISKS

While for women, migration may open doors in society, work, and family, it also comes with risks. For many women migrants, the risks far outweigh the oftentimes questionable benefits that they manage to gain. Migrant women, especially, lack safety nets to protect them from abuses. They are the more likely targets of violence, often sexual, and of more oppressive work.[79] Women migrants experience difficult working conditions, low pay, illegal withholding of wages, and sexual abuses that include sexual slavery.[80] They are also more likely to continue working in unsafe conditions, as many women are working to support their families and children. Migrant women frequently do not have access to social services or legal safeguards.[81] While these are travesties in and of themselves, women face extra health risks that stem from these abuses.

Migration alone presents dangers for women. The ongoing migration crisis in Europe has vividly shown the world how women experience violence in transit. In fact, this migration seems to have triggered an increase of violence against women that includes domestic violence, sex trafficking and even forced marriages.[82]

Research reveals "that women and girl refugees face violence, assault, exploitation and sexual harassment at every stage of their journey."[83] Amnesty International's interview of 40 women and girls found that they all, without exception, felt threatened and unsafe; they faced not only physical violence but also financial exploitation.[84] One woman put it bluntly: "Everybody knows there are two ways of paying the smugglers. With money or with your body."[85]

78. Caritas, *supra* note 63, at 6.
79. *Id.* (noting that "women from poor environments who have experienced lack of opportunities and violence are likely to become easy targets for traffickers, who promise them a richer economic and social future abroad whilst luring them into forced labour, in most cases forced prostitution, sweat-shops and inhumane domestic work conditions.").
80. Ruchika Bahl, *UN Women Rolls Out a Three-Year Project to Improve Working Conditions of Women Migrant Domestic Workers in South Asia*, (Sept. 17, 2015), http://asiapacific.unwomen.org/en/news-and-events/stories/2015/09/un-women-rolls-out-a-three-year-project (last visited May 25, 2016).
81. Bahl, *supra* note 80. *See also* Shalini Bhargava Ray, *Optimal Asylum,* 46 VAND. J. TRANSNAT'L L. 1215 (showing linkages between asylum – seeking and irregular migration).
82. Katrin Benhold, *On Perilous Migrant Trail, Women Often Become Prey to Sexual Abuse*, N.Y. TIMES (Jan. 2, 2016), http://www.nytimes.com/2016/01/03/world/europe/on-perilous-migrant-trail-women-often-become-prey-to-sexual-abuse.html.
83. *Female Refugees Face Physical Assault, Exploitation and Sexual Harassment on their Journey Through Europe*, AMNESTY INTERNATIONAL (Jan. 18, 2016, 4:41 PM), https://www.amnesty.org/en/latest/news/2016/01/female-refugees-face-physical-assault-exploitation-and-sexual-harassment-on-their-journey-through-europe/ [hereinafter *Female Refugees*].
84. *Id.*
85. Benhold, *supra* note 82.

Women traveling alone or with children,[86] small boys traveling alone, "pregnant and lactating women, adolescent girls, unaccompanied children and early married children"[87] are particularly susceptible to violence and sexual exploitation.[88] Smugglers, prey on women in many ways. For example, if women do not have the financial resources to pay for the journey, smugglers may try to force them to have sex as a method of payment. Smugglers, and others who work with them, may also offer discounted prices or abbreviated waiting times in exchange for sex.[89] Smugglers may even threaten stranding the victim mid-journey if they refuse sexual access.[90] Married women traveling with their families have been solicited and pressured for sexual favors to which they at times must succumb for the sake of helping their families. Sometimes, when the family runs out of money, a husband will offer to pay the smuggler with his wife.[91]

But smugglers are not the only sexual predators. Security staff, as well as other refugees, also threaten women migrants. For example, sometimes women are pressured to perform sex in order to pay for the travel documents necessary for the journey.[92]

Women are vulnerable even in government-run camps and shelters, especially in those where there are no sex-segregated sleeping, bathroom, or shower facilities and in which none of the facilities can be locked from the inside.[93] Centers are overcrowded and the facilities often lack the most basic trappings that are necessary to ensure sanitary conditions for health and safety.

For example, at the refugee shelter in Bonn, Germany, women are held with men, and dozens share a single toilet that does not lock. Sleeping areas also lack locks and leave women and children open to assault.[94] Women reported being watched by men as they went to the bathroom. Some even reported not eating or drinking for extended periods of time if they felt unsafe going to use the sanitary facilities. Pregnant women reported lack of food and absence of any healthcare.[95] Beyond the physical threats, likely psychosocial consequences suffered by the women and children are exacerbated by cultural, religious, and social factors that render women and children disinclined to report or talk about the abusive experiences.[96]

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86. *Female Refugees, supra* note 83.
87. Lisa Schlein, *Refugee Women Seeking Safety in Europe Risk Sexual Abuse, Violence*, VOICE OF AMERICA (Jan. 21, 2016, 10:39 AM), http://www.voanews.com/content/refugee-women-seeking-safety-in-europe-risk-sexual-abuse-and-violence/3156025.html.
88. For a thorough, insightful and comprehensive look at why unaccompanied minors are particularly vulnerable, susceptible to violence and sexual exploitation see Shani M. King, *Alone and Unrepresented: A Call To Congress to Provide Counsel to Unaccompanied Minors,* 50 HARV. J. ON LEGIS. 331 (2013).
89. *Female Refugees*, *supra* note 83.
90. Schlein, *supra* note 87.
91. Benhold, *supra* note 82. One woman reported being raped almost daily for three months "to earn her family's onward journey." *See Female Refugees, supra* note 83.
92. Schlein, *supra* note 87.
93. Manasi Gopalakrishnan Bonn, *No 'Safe' Asylum for Female Refugees in Europe*, DW (Oct. 11, 2015), http://www.dw.com/en/no-safe-asylum-for-female-refugees-in-europe/a-18775017.
94. *Id*.
95. *Female refugees, supra* note 83.
96. Gopalakrishnan Bonn, *supra* note 93.

At the same time, shelters segregated by sex create difficulties. They may cause harms and raise fears when the segregation results in families becoming separated. As noted earlier, such single sex shelters also create challenges for transgendered migrants who may, and often do, get placed based upon their biological sex rather than their own gender identity. Such policies force already vulnerable persons into hostile environments. Similarly, in both segregated and non-segregated facilities LGBT persons may be subject to psychological and physical harms as a result of derision and social rejection not only by officials but also by the migrant community.

Abuse of migrants, however, is by no means isolated to the European crisis; it is ubiquitous. The locales may be different, but the narratives—frequently horror stories—the migrants, especially migrant women, share are the same. In the western hemisphere, and right in the United States' own backyard, it is common knowledge that the journey to Mexican border towns, often to seek employment in the factories, is hazardous.

Like in the European scenario presented above, Central American migrants leave their homes seeking to escape poverty, governmental insecurity, gang violence, lack of opportunity, as well as social, cultural and economic factors that make them desire a better life.[97] Their journeys are fraught with danger, violence, and abuses.

In the Central American scenario, many seek to escape by riding on top of cargo trains, like the one nicknamed the *la Bestia*—the Beast-–which travels from Guatemala through the length of Mexico.[98] Alternatively, they hire smugglers, or otherwise risk their lives by hiding in trucks or traveling on foot over the more than 1,000-mile journey.[99] The train ride itself is precarious. But beyond physical challenges of the trip itself, migrants face discrimination, xenophobia, ill treatment, kidnapping and abduction by criminal gangs; they are robbed, assaulted, disappeared, and killed.[100]

The U.S. has been involved in trying to stem the flow of Central American migrants and, as part of this plan, the U.S. has pressured the Mexican government to tighten its southern border. *Plan Frontera Sur* (Plan Southern Border), as Mexican authorities call it, is a U.S.-sponsored policy that, in order to protect the U.S. borders, effectively shifts border enforcement from the U.S.'s southern border to Mexico's southern border. At Mexico's *Frontera Sur*, the first locale where the weeding out of migrants headed to the U.S. takes place, arrests of Central American migrants have at least doubled and deportation numbers have increased dramatically. The enhanced enforcement at *Frontera Sur* has reduced the use of train passage to cross Mexico's southern border resulting in more trips on foot, with smugglers leading the way.[101]

97. *Invisible Victims: Migrants on the Move in Mexico,* AMNESTY INTERNATIONAL (Apr. 8, 2010), http://www.amnestyusa.org/sites/default/files/amr410142010eng.pdf.
98. *Taming the Beast: The Mexican Authorities Block an Infamous Route North*, THE ECONOMIST (Sept. 20, 2014), http://www.economist.com/news/americas/21618786-mexican-authorities-block-infamous-route-north-taming-beast.
99. Azam Ahmed, *Step by Step on a Desperate Trek by Migrants Through Mexico*, N.Y. TIMES (Feb. 8, 2016), http://www.nytimes.com/2016/02/08/world/americas/mexico-migrants-central-america.html?_r=1.
100. *Invisible Victims*, *supra* note 97.
101. Ahmed, *supra* note 99.

As with the European story, the Central American migration journey is particularly precarious for women and children. These more vulnerable migrants face the dangers all migrants face, but are at heightened risk of trafficking and sexual assault not only by criminals but also by fellow migrants or even government officials.[102] One 2014 report provides that migrant shelter directors estimate "[a] staggering 80%of Central American girls and women crossing Mexico en route to the United States are raped along the way."[103] That number is up from an estimated 60% in a 2010 Amnesty International report.[104]

Similar to their European migrant counterparts, those women who are physically violated also have to deal with the psychosocial consequences. For one, they face the stigma linked with sexual violence. Additionally, they have to be concerned about reporting the violation, lest they be deported or for fear that seeking treatment might interfere with reaching their desired destination.[105]

Yet the migration journeys continue. Patently, these women are so desperate to leave their often lamentable and excruciating situations—social, political, economic, and cultural—that they knowingly take the safety risks associated with migration. Indeed, given the probability of sexual assault and violence, the women, in a new trend, seek to mitigate the health risks. In one "hot spot for assault" in the migrant path, *La Arrocera*, a prosecutor reports that some women take contraceptives to avoid pregnancy when the inevitable rape occurs.[106]

A lawyer who works with migrant women who are trafficked into prostitution notes that the women "know the price to pay for getting to the United States … is being sexually violated" by coyotes, migrants, gangs, or government officials.[107] Sex, like in the European scenario, acts as a form of currency for those who lack material resources. In fact, one chief in a migrant protection unit in Chiapas notes that some women, who lack resources but are desperate, have been known to "offer their bodies in exchange for being able to cross over."[108]

It even has been documented that in transnational routes, houses of prostitution are set up, utilizing migrant and often trafficked women, to service migrant men's sexual desires.[109] There are hundreds of brothels along Mexico's southern border at which the workers are migrant women who have been "tricked" into prostitution.[110] This reality standing alone is bad enough. But oftentimes the women are required to pass time drinking with patrons, which then leads to using the "back rooms,"

102. *Invisible Victims*, *supra* note 97.
103. Erin Siegal McIntyre & Deborah Bonello, *Is Rape the Price to Pay for Migrant Women Chasing the American Dream?* FUSION (Sept. 10, 2014 9:51 PM), http://fusion.net/story/17321/is-rape-the-price-to-pay-for-migrant-women-chasing-the-american-dream/.
104. *See Invisible Victims*, *supra* note 97.
105. *Id.*
106. McIntyre & Bonello, *supra* note 103.
107. *Id.*
108. *Id.*
109. BERTA ESPERÁNZA HERNANDEZ-TRUYOL & STEPHEN JOSEPH POWELL, JUST TRADE: A NEW COVENANT LINKING TRADE AND HUMAN RIGHTS, 182-83 (N.Y.U. Press 2009).
110. McIntyre & Bonello, *supra* note 103.

which, in turn, leads to debts for "room, board, alcohol and even food" that need to be paid off to the brothel owner in bondage work.[111]

The migration journey is replete with challenges to health and safety. Beyond the violations of physical integrity in the sexual assaults, even taking contraceptives to avoid pregnancy does not solve the danger of contracting STDs. It also does not resolve the failure of contraceptives.

V. JOURNEY'S END – GLOCALIZING LABOR

For many women, migration is not just an issue of movement or work, but also a matter of safety, health, and labor. For millions of women these factors intersect to make them the most marginable of populations, who risk smugglers and natural dangers to seek safety and work outside their home countries, only to face new perils on the other side of the border.

Even once migrants arrive at their desired destination, the migration journey never ends. Persons may establish a new place to live, but women continue to face disproportionate safety concerns. For one, women who arrive at a new locale without papers, live in constant fear of deportation with its own possibly unsafe and violent consequences. Moreover, as was detailed in Part III, migrant women are pigeonholed into low-paying "traditional" work sectors.

In addition, some work sectors serve to isolate the migrant worker. Nannies and domestic workers, for example, most of whom are women, face some of the worst abuses.[112] The nature of their domestic work often finds them isolated and locked up at homes in which they work. Their employers usually deny them contact with anyone beyond the household—the employers and their families. Often stripped of their documents the moment they arrive at the employers' homes, these domestic workers are denied the basic necessities of and for life—such as food, privacy, and even some time to rest.[113] Sometimes they can be in debt bondage and the conditions and hours of work can be slave-like.[114] They can also be subject to verbal and sexual abuse by their employers.[115] But alone and isolated in a foreign country, and often dispossessed of their documents — if they happen to have them, they have few avenues of recourse. They are, almost literally, invisible.[116]

These violations of rights do not only take place abroad—in Europe or in Central America or in the Middle East. They take place worldwide. Indeed, much happens in the U.S., where domestic workers can come in legally with special visas to work as live-in migrant domestic workers. Notwithstanding

111. *Id*.
112. *Immigrant Domestic Workers Face Tough Challenges in a Push for Better Conditions,* PUBLIC RADIO INTERNATIONAL (May 16, 2013), http://www.pri.org/stories/2013-05-16/immigrant-domestic-workers-face-tough-challenges-push-better-conditions [hereinafter *Immigrant Domestic Workers*].
113. *Hidden in the Home: Abuse of Domestic Workers with Special Visas in the United States* (Vol. 13, No. 2 (G)), HUMAN RIGHTS WATCH (June 2001), https://www.hrw.org/reports/2001/usadom/usadom0501.pdf.
114. *Domestic Workers: Modern Enslavement of Migrant Domestic Workers by Foreign Diplomats in the United States*, AMERICAN CIVIL LIBERTIES UNION, https://www.aclu.org/domestic-workers.
115. *Immigrant Domestic Workers*, *supra* note 112; *see also* Gloria Moreno-Fontes Chammartin, *Domestic Workers: Little Protection for the Underpaid*, MIGRATION POLICY INSTITUTE (Apr. 1, 2005), http://www.migrationpolicy.org/article/domestic-workers-little-protection-underpaid.
116. *Immigrant Domestic Workers, supra* note 112.

the legality of their entry, they can be victims of trafficking, having been deceived about the conditions they will encounter in their employment. Yet their legal status does not protect them from abuses and, because of their coming to escape poverty, they choose to endure human rights violations rather than deportation.[117]

The agricultural sector draws an increasing number of women migrants. In the U.S., female migrant agricultural workers, mostly foreign and undocumented, face hazards similar to the nannies and domestic workers. Among the fastest growing populations of farmworkers are migrants from indigenous communities in Mexico[118] and Central America.[119] Like all women migrants, women in agriculture—an estimated 560,000 women work on U.S. farms—face sexual violence, rape, harassment, and pregnancy.[120] Farmworkers' vulnerability, much like the nannies' and domestic workers', is exacerbated by low wages and poverty. They also face health risks that arise from their working environment. Moreover, women migrants' plight is exacerbated by the additional exposure to extreme heat and chemicals, and once pregnant—either voluntarily or from rapes—complications from lack of reproductive services and rest.[121]

Migrant women's children face a special kind of marginalization. Because the mothers might not be documented, the children may be denied equal or even adequate access to medical facilities. In extreme cases, babies born on U.S. soil might even be denied birth certificates, as was recently the case in Texas, because of their mother's legal status.[122]

In addressing women having children in the U.S., some groups are more heavily scrutinized than others.[123] Some even face harsh consequences for even attempting to have their children in the U.S. In

117. *See Hidden in the Home*, *supra* note 113.
118. Lisa Gale Garrigues, *Indigenous Farmworkers Are Breaking New Ground in California*, INDIAN COUNTRY MEDIA NETWORK (Jan. 25, 2013), http://indiancountrytodaymedianetwork.com/2013/01/25/indigenous-farmworkers-are-breaking-new-ground-california-147229.
119. Alexis Guild, *Indigenous Farmworkers Face Unique Barriers to Healthcare*, FARMWORKER JUSTICE (Apr. 26, 2012), https://www.farmworkerjustice.org/fj-blog/indigenous-farmworkers-face-unique-barriers-healthcare-0.
120. Allison Gatlin, *Female Workers Face Rape, Harassment in Farm Fields*, USA TODAY (Jun. 25, 2013 3:41 PM), http://www.usatoday.com/story/life/tv/2013/06/25/frontline-rape-in-the-fields/2455505/.
121. For information about the health risks of pesticide exposure *see* Jennifer Runkle, Joan Flocks, Jeannie Economos, J. Antonio Tovar-Aguilar & Linda McCauley, *Occupational Risks and Pregnancy and Infant Health Outcomes in Florida Farmworkers*, 11 INT'L J. ENVTL. RES. PUB. HEALTH 7820, 7820-40 (2014); *see* Jennifer Runkle *et al., Pesticide Risk Perception and Biomarkers of Exposure in Florida Female Farmworkers,* 55(11) J. OCCUPATIONAL ENVTL. MED. 1286, 1286-92, (2013); *see* Joan Flocks et al., *Female Farmworkers' Perceptions of Heat-Related Illness and Pregnancy Health,* J. of Agromedicine 350, 350-8 (2013); *see* Kelley MA et al., *Female Farmworkers' Health During Pregnancy-Health Care Providers' Perspectives,* 61(7) *Workplace Health and Safety* 308, 308-313 (2013); *see* Joan Flocks et al., *Female Farmworkers' Perceptions of Pesticide Exposure and Pregnancy Health,* 14 J. OF IMMIGR. AND MINORITY HEALTH, 626, 626-632 (2012); *see* Joan Flocks et al., *The Environmental and Social Injustice of Farmworker Pesticide Exposure,* 19(2) GEO. J. ON POVERTY L. AND POL'Y, *255,* 255-282 (2012).
122. Amanda Sakuma, *Texas Allowed to Deny Birth Certificates to US-Born Kids of Undocumented Parents*, MSNBC (Oct. 19, 2015 1:07 PM) http://www.msnbc.com/msnbc/texas-allowed-deny-birth-certificates-us-born-kids-undocumented-parents .
123. Some migrants are encouraged and even assisted in coming to the U.S., even if they are not always coming for work. Because of the 1966 Cuban Adjustment Act, notwithstanding the recent *rapprochement*, Cubans are welcomed (legally speaking – socially can turn out to be a different story) into the US, never having to worry

the current anti-migrant climate, the tightening of the U.S.-Mexico border extends to those who might be crossing the border to give birth. Stories from El Paso show that until 1993 those who crossed to the U.S. underneath the bridges were not hassled.[124] However, the 1993 "Operation Hold the Line" brought technology and human power to reduce border-crossing by those who lacked documents.[125] The move to suppress border-crossing extended to pregnant women trying to cross the border to have children on U.S. soil—what politicians derisively call "anchor babies."[126] Even those women who have visas to legally enter the U.S. encounter guards who deny them entry and rip up their legal documentation, if they are pregnant.[127]

Whether "legal" or "undocumented," marginable foreign populations face discrimination when attempting to access health services. Many remain unable to claim Medicaid and are forbidden from purchasing it for themselves if they have the funds. Denied reproductive services and education, many women turn to midwives and local charities for prenatal care and pediatrics.[128] It is fortunate that these sectors exist to provide the necessary care.

Glocalizing maternal health issues, however, it is noteworthy that in the U.S. there are some serious concerns with marginable women's maternal health and their infants' survival regardless of whether the women are documented or undocumented, citizens or foreigners. To be sure, 99% of maternal deaths occur in so-called developing countries.[129] The majority of such deaths can be prevented through accepted interventions. Worldwide, preventable maternal deaths occur with most frequency among marginable populations.

Worldwide, pregnancy is the leading cause of death for young women ages 15-19. This group is twice as likely to die during pregnancy or childbirth. Young women under age 15 are five times more likely to die. The reasons are biological, economic, social and cultural, including gender inequities.[130]

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about being undocumented, and given 9 months' worth of food and housing assistance to give them time to adjust, learn the language, and get a job. Cuban Adjustment Act, Public Law 89-732. To be sure, one can see images of Cubans, including pregnant women, being flown to Nuevo Laredo courtesy of Costa Rica. *See*, *Cuban refugees arrive at Nuevo Laredo*, RGV PROUD (Feb. 11, 2016) http://www.rgvproud.com/news/local-news/cuban-refugees-arrive-at-nuevo-laredo (last visited May 26, 2016). Significantly, these persons seem to be flooding the US because they fear that the special immigration status conferred by the Cuban Adjustment Act will be terminated due to the renewed relations between US and Cuba. *See*, Jessie Degollado, *First of 180 Cuban Refugees Arrive in Laredo*, ABC KSAT (Jan. 15, 2016 12:03 PM), http://www.ksat.com/news/first-of-180-cuban-refugees-arrive-in-laredo (last visited May 26, 2016). With Cubans easily crossing the border while many others have had the perilous voyages described in this essay, tensions are rising. *See*, *e.g.,* Julia Preston, *Tension Simmers as Cubans Breeze Across U.S. Border*, N.Y. TIMES (Feb. 12, 2016), http://www.nytimes.com/2016/02/13/us/as-cubans-and-central-americans-enter-us-the-welcomes-vary.html.

124. Alana Semuels, *The Midwives of El Paso*, THE ATLANTIC, (Feb. 4, 2016) http://www.theatlantic.com/business/archive/2016/02/midwives-el-paso/459969/ (last visited May 26, 2016).
125. *Border Patrol History,* U.S. CUSTOMS AND BORDER PROTECTION, https://www.cbp.gov/border-security/along-us-borders/history (last visited June 10, 2016).
126. Jo Craven McGinty, *Fact-Checking the Figures on 'Anchor Babies,'* THE WALL STREET JOURNAL (Sept. 11, 2015 3:05 PM), www.wsj.com/articles/fact-checking-the-figures-on-anchor-babies-1441963800.
127. Semuels, *supra* note 124.
128. *Id*.
129. *Maternal Mortality: Fact Sheet,* WORLD HEALTH ORGANIZATION (Nov. 2016), http://www.who.int/mediacentre/factsheets/fs348/en/ (last visited May 31, 2016).
130. *Id*.

Significantly, notwithstanding the U.S.'s aspiration to be #1 in everything, the reality in healthcare and maternal health is far from that. In "general quality" of healthcare, the U.S. ranks 37th in the world,[131] although the total spent on healthcare is greater than in any other country.[132] In maternal mortality, the U.S. ranks 48th worldwide.[133] The likelihood that a woman will die in childbirth in the U.S. is ten times greater than for women in Belarus, Poland, and Austria;[134] seven times greater than in Greece; and over three times greater than in Germany or Spain.[135]

More than two women die every day in the U.S. from pregnancy-related causes. Sadly, in recent years, while other countries reduced their maternal mortality figures, maternal mortality has increased in the U.S. These depressing figures exist notwithstanding the reality that hospitalization related to pregnancy and childbirth costs in the U.S.—around 86 billion USD a year[136]—are the highest in medicine (which has already been established as the highest in the world). Equally as unacceptable as these maternal mortality figures, is U.S.'s rank of 56th in infant mortality worldwide and 27th among the 34 developed countries of the OECD.[137]

These figures alone do not tell the entire story as they are aggregated numbers. Marginability—race and ethnicity, regardless of legality of status and even U.S. citizenship—play into the figures. The racial and ethnic impact is not necessarily because of biology or culture, but often due to structural disparities that perpetuate unequal delivery of health services to these populations. Thus, in order to ensure that maternal and child health services are improved for all persons, it is imperative not only that the medical condition be considered, but also that the social, political, economic, cultural conditions which are the root causes of such disparities be addressed.[138]

African-American women are at especially high risk; they are nearly four times more likely to die of pregnancy-related complications than white women.[139] This is in the context in which even for

131. *World Health Organization's Ranking of the World's Health Systems*, THE PATIENT FACTOR, http://thepatientfactor.com/canadian-health-care-information/world-health-organizations-ranking-of-the-worlds-health-systems/ (last visited May 31, 2016).
132. Melissa Hellman, *U.S. Health Care Ranked Worst in the Developed World*, TIME (June 17, 2014), http://time.com/2888403/u-s-health-care-ranked-worst-in-the-developed-world/ (noting U.S. ranks worst among 11 wealthy nations "[a]lthough the US has the most expensive health care system in the world").
133. *The World Factbook, Country Comparison: Maternal Mortality*, CENTRAL INTELLIGENCE AGENCY, https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html (last visited July 25, 2016) [hereinafter *The World Factbook*].
134. Eliana Dockterman, *U.S. Ranks Worst Developed Country for Maternal Health*, TIME, (May 5, 2015), http://time.com/3847755/mothers-children-health-save-the-children-report/ (last visited May 31, 2016).
135. *The World Factbook*, *supra* note 133.
136. Francine Coeytaux, Debra Bingham & Nan Strauss, *Maternal Mortality in the United States: A Human Rights Failure*, ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS (Mar. 2011), http://www.arhp.org/publications-and-resources/contraception-journal/march-2011 (last visited May 31, 2016).
137. Cari Romm, *Why American Babies Die*, THE ATLANTIC, (Oct. 1, 2014), http://www.theatlantic.com/health/archive/2014/10/why-american-babies-die/381008/ (last visited May 31, 2016).
138. *Maternal Mortality*, *supra* note 129; *see also Health Disparities: Practice Update - Reproductive Health Disparities for Women of Color,* NATIONAL ASSOCIATION OF SOCIAL WORKERS (Dec. 2004), http://www.naswdc.org/diversity/Equity1204.pdf (last visited May 31, 2016).
139. *Maternal Mortality*, *supra* note 129.

white women in the U.S. the maternal mortality ratios are higher than for women in 24 other industrialized countries. These rates and disparities have not improved in more than 20 years. Maternal mortality ratios have actually increased from a low of 7.2 deaths per 100,000 live births in 1987 to 15.9 deaths per 100,000 live births in 2012.[140]

Child health and infant mortality disparities based on race also exist. Black babies are still nearly 2.2 times more likely than white babies to die before reaching their first birthday, with 11.11 deaths per 100,000 for black babies, as compared to 5.06 deaths per 100,000 for white babies.[141] In some states, black infant mortality is increasing. Factors for these outcomes include socioeconomic status, nutrition, prenatal care, cuts in programs that assist the poor, and jobs that do not include medical benefits.

The maternal and child mortality disparities do not exist only in the black community, they also exist for other women of color, regardless of legality of status as the data is not disaggregated along those factors. Shockingly, in the 2011-12 period, the death rates per 100,000 live births were 11.8 for white women, 41.1 for black women,[142] and 15.7 for other races.[143] Data from the 2005-07 period confirms that such racial disparities are not an accident, but rather a consistent tragic reality. In that period, maternal mortality was highest among black women (non-Hispanic) with 34 deaths per 100,000 followed by American Indian/Alaska Native women, whose maternal mortality rates were 16.9, Asian/Pacific Islanders with 11, non-Hispanic whites with 10.4 and Hispanics with 9.6.[144]

An Amnesty report observes that:

> Discrimination profoundly affects a woman's chances of being healthy in the first place. Women of color are less likely to go into pregnancy in good health because of a lack of access to primary health care services. They are also less likely to have access to adequate maternal health care services. Native American and Alaska Native women are 3.6 times, African-American women 2.6 times, and Latina women 2.5 times as likely as white women to receive late or no prenatal care. They are also more likely to experience poorer quality of care, discrimination or culturally inappropriate treatment.[145]

The tragic reality of racial disparities is also true with respect to infant mortality. American Indian and Alaskan Natives have 7.61 infant deaths per 100,000 as compared with 5.06 for Non-Hispanic whites, 5.00 for Hispanics, and 4.07 for Asian/Pacific Islanders.[146] Interestingly, there are differences

140. *Reproductive Health, Pregnancy Mortality Surveillance System,* CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html (last visited May 31, 2016) [hereinafter *Reproductive Health*].
141. T.J. Matthews et al., *Infant Mortality Statistics from the 2013 Period Linked Birth/Infant Death Data Set,* Nat'l Vital Statistics Reports vol. 64 no. 9, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 6, 2015), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf.
142. *Reproductive Health*, *supra* note 140.
143. *Id*.
144. *Deadly Delivery: The Maternal Health Care Crisis in the USA: One Year Update* 6, AMNESTY INTERNATIONAL *(Spring 2011), available at* https://www.amnestyusa.org/sites/default/files/deadlydeliveryoneyear.pdf.
145. *Deadly Delivery: The Maternal Health Care Crisis in the USA* 19, AMNESTY INTERNATIONAL (2010) *available at* http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf.
146. Matthews et al., *supra* note 141.

among the Hispanic populations with the infant mortality rates being 4.90 for Mexican populations, 5.93 for Puerto Rican populations, 3.02 for Cuban populations and 4.30 for Central and South American populations.[147]

In its 2008 concluding observations, the UN's CERD committee underscored the reality of "wide racial disparities [that] continue to exist in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among women and children belonging to racial, ethnic and national minorities, especially African Americans."[148] Indeed, the Committee recognized factors that result in health care disparities of marginable populations and recommended that the U.S. seek to eliminate obstacles to health equality "such as lack of health insurance, unequal distribution of health care resources, and persistent racial discrimination in the provision of health care and poor quality of public health services."[149] I would add to this list lack of cultural competence of health providers, as well as other social, economic and political factors. Significantly, in 2014 the Committee "reiterate[d] its previous concern at the persistence of racial disparities in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among African American communities."[150]

But maternal and infant survival are not the only concerns. Childbirth is not a finish line for women or motherhood; rather, it is a starting point. Even when marginable women—be they migrants, racial/ethnic "others", or migrants who also are racial and ethnic "others"—manage to receive some degree of prenatal care, it is important to also contemplate their conditions of work. Many marginable women work until childbirth, often in labor intensive jobs, in order to support their families. Moreover, for the same reasons, they also return to work as soon as possible. These circumstances have numerous health consequences. For one, returning to work early reduces the amount of time newborns can nurse depriving babies of the proven advantages of breastfeeding including reduction of child mortality, "promot[ion of] sensory and cognitive development, and protect[ion of] the infant against infectious and chronic diseases."[151]

But breastfeeding also has a positive impact on mothers' health, causing a cutting on breastfeeding to also affect the mothers. For instance, breastfeeding "helps to space children, reduces the risk of ovarian cancer and breast cancer, increases family and national resources, is a secure way of feeding, and is safe for the environment."[152] Sadly, mothers who return to work very soon after giving birth are

147. *Id*.
148. Comm. on the Elimination of Racial Discrimination, Concluding Observations of the Committee on the Elimination of Racial Discrimination, CERD/C/USA/CO/6 (2008) (¶ 33) (art. 5 (e)), *available at* https://www1.umn.edu/humanrts/CERDConcludingComments2008.pdf.
149. *Id.* at ¶ 32.
150. Comm. on the Elimination of Racial Discrimination, Concluding Observations on the Combined Seventh to Ninth Periodic Reports of the United States of America, CERD/C/USA/CO/7-9, (2014), *available at* http://www.state.gov/documents/organization/235644.pdf.
151. *Maternal, Newborn, Child and Adolescent Health: Breastfeeding*, WORLD HEALTH ORGANIZATION, http://www.who.int/maternal_child_adolescent/topics/newborn/nutrition/breastfeeding/en/ (last visited June 1, 2016).
152. *Id*.

likely to stop breastfeeding for various reasons, including lack of time, an appropriate place, or storage facilities for the expressed milk.[153]

Returning to work immediately after birth also affects the mother's health. Generally, recovery time from giving birth is approximately six weeks.[154] When mothers return to work immediately after childbirth, they fail to have the necessary time for healing. Indeed, the women who return to the fields without fully healing risk injury. It is important to recall that the jobs marginable women have are often highly physically demanding. For example, agricultural workers engage in the repetitive motions involved in harvesting crops, which also include squatting and bending over and lifting great weights oftentimes in excruciatingly hot weather conditions.[155] Under these circumstances, women who have given birth risk injury when they do not—most likely because they cannot, given the conditions of work under which they toil—take the time to recover from their labor.

The children of agricultural workers, as well as the workers themselves, also face risks past birth beyond the deprivation of breastfeeding. The agricultural workers themselves, are exposed to many occupational hazards, including exposure to pesticides. When mothers and fathers return home from agricultural work, for example, they bring chemicals clinging to their clothes. This results in the children's secondhand exposure to pesticides.

As this section has shown, labor becomes a precarious endeavor for marginable women. This dangerousness unveils ostensible failures of the promises and possibilities the human rights systems offers to deal with the problems of migrants, and other marginable populations: the perils of migration, the feminization of migration, the perils of migrant women's work, and the precariousness of their labor, both in terms of the risk of pregnancy from rape in migration and in the problems of their work creating risks for mother and child—a precariousness that the piece has glocalized by incorporating the information about maternal and infant mortality for marginable women in the United States. The locations of danger are along a continuum of rights denied, all of which are protected human rights: non-discrimination, health, safety, security of the person, work, adequate standard of living, and a healthy work environment to name a few. The following section provides hope in sharing the route to a successful use of the human rights project to help marginable women attain human flourishing.

VI. CONCLUSION

To come full circle and see how the human rights system can be a source of protection for challenges migrant women confront, including health concerns, this work closes with two cases—one from the Constitutional Court of South Africa and one from the CEDAW Committee—that show how both the human rights regime and existing rights can effect the necessary paradigm shift needed to promote the protection of migrants and of maternal and child health.

153. *10 Facts on Breastfeeding*, Fact 9, WORLD HEALTH ORGANIZATION, http://www.who.int/features/factfiles/breastfeeding/facts/en/index8.html (last visited June 1, 2016).
154. Mayo Clinic Staff, *What to Expect After a Vaginal Delivery,* MAYO CLINIC, http://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/postpartum-care/art-20047233 (last visited June 1, 2016).
155. *See supra* note 121.

In *Treatment Action Campaign v. Minister of Health,*[156] the Constitutional Court of South Africa dealt with the country's HIV/AIDS pandemic, which, by 2000, had more than 6 million people infected. Treatment Action Campaign (TAC), a civil society group that works with HIV/AIDS, together with other such groups, brought the case to challenge a government program that limited the availability of an anti-retroviral drug.

The facts of the case indicated that one of the most common methods of transmission of HIV in children is from mother to child at and around birth. The government estimated that since 1998, 70,000 children per year had been so affected.[157]

The anti-retroviral drug, Nevirapine, was registered for use to reduce the risk of mother-child transmission. Its registration by the state meant that it had been evaluated, found suitable for the prevention of mother-child transmission of HIV, and found to be a safe, effective drug of appropriate quality.[158] Neviraprine had the potential of preventing infection of tens of thousands of children every year. Because the drug was registered, doctors in private practice could prescribe the drug when they deemed appropriate.

In July of 2000, the manufacturer offered the drug to the government at no cost for 5 years.[159] The government then established a pilot program for distribution of the manufacturer's supplied drug around the country.

TAC challenged the government's pilot program because it limited the access to Nevirapine.Under the designed program, the drug would be available only at established pilot sites. There would be only two pilot sites per province[160] and, while doctors in the private sector could prescribe the drug freely, under the pilot program doctors in the public sector who were not part of the pilot sites could not prescribe it.[161]

The basis of TAC's challenge of the pilot program was the South African Constitution which, in section 27(1), provides for a right of access to "health care services including reproductive health care" and in section 27(2) imposes an obligation on governments to achieve the progressive realization of the right.[162]

The government defended the pilot program claiming efficiency, resistance, safety and reasonableness considerations. The Constitutional Court struck the program finding that the pilot program fell short of the constitutional requirements and put children's rights in peril. In light of the Constitutional rights' guarantees, the Court ordered the government to remove the restrictions that kept the drug from being available at all public hospitals and clinics that were not research and training sites. The

156. 2002 (1) SA 1 (CC), *available at* http://www.tac.org.za/Documents/MTCTCourtCase/ConCourtJudgmentOrderingMTCTP-5July2002.pdf [hereinafter TAC].
157. TAC *supra* note 156, at ¶ 19 (quoting TAC affidavit ¶ 22.2).
158. *Id.* (quoting TAC affidavit ¶ 22.4).
159. *Id.* (quoting TAC affidavit ¶ 22.6*).*
160. *Id.* quoting TAC affidavit ¶ 22.7).
161. *Id.* (quoting TAC affidavit ¶ 22.8).
162. S. Afr. Const., 1996, *available at* http://www.gov.za/documents/constitution-republic-south-africa-1996.

right to health mattered, the right to non-discrimination mattered, and the rights of children mattered. The paradigm shifted to center human thriving.

Similarly, the other significant decision, an international one —the 2011 decision of the CEDAW Committee in *Alyne da Silva Pimentel v. Brazil*- focuses on humans' well-being.[163] Importantly, this is the first human rights decision issued by a human rights body on maternal health and maternal mortality issues as human rights concerns. Alyne da Silva Pimentel was a Brazilian woman of African descent whose mother brought the case to the Committee claiming a violation by Brazil of articles 2[164] and 12[165] of CEDAW.[166] The basis of the communication was Alyne's death of pregnancy-related causes.

Alyne, when 6 months pregnant went to a local health provider complaining of nausea and severe abdominal pain. The local health provider gave her some medication, scheduled some tests for several days later, and sent her home. Alyne returned to the local clinic because her condition was not improving. At that time, when she was examined, the health care workers found that the fetus lacked a heartbeat. They induced delivery and Alyne delivered a stillborn child. Some days later, they carried out a procedure to remove part of the placenta that had not been expelled with the delivery of the stillborn.

A few days after the procedure, when Alyne's condition still did not improve, she was transferred to a hospital that could offer a higher level of obstetric care. Even this transfer saw delays because the hospital did not want to use its only ambulance to make the transport and Alyne's mother and husband were unable to obtain a private ambulance. When the transfer did take place, the local health clinic did not send Alyne's records with her. Alyne never recovered and eventually died.

Alyne's mother claimed that the clinic failed to provide timely obstetric care after misdiagnosing her daughter's symptoms. The Committee concluded that "Alyne's death was indeed linked to obstetric complications related to pregnancy."[167] The Committee referred to its, "general recommendation No. 24, in which it states that it is the duty of State Parties to ensure women's right to safe motherhood and emergency obstetric services, and to allocate to these services the maximum extent of available resources."[168]

The Committee also noted, "that the State is directly responsible for the action of private institutions when it outsources its medical services."[169] Moreover, the Committee recognized the notion of intersectionality/multidimensionality when it acknowledged the claim that Alyne suffered discrimination, not only based on gender but also based on race—being a woman of African descent—as well

163. Comm. on the Elimination of Discrimination against Women, Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008, (July 29, 2011), *available at* http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Alyne%20v.%20Brazil%20Decision.pdf. (last visited June 1, 2016).
164. CEDAW, *supra* note 36, at art. 2 (prohibiting discrimination).
165. *Id*. at art. 12 (prohibiting discrimination in health care and ensuring women appropriate services concerning pregnancy and in the post-natal period).
166. *Id*.
167. CEDAW, Commc'n No. 17/2008, *supra* note 163, ¶ 7.3.
168. *Id*.
169. *Id*. at ¶ 7.5.

as based upon her socio-economic status. In this regard, the Committee referred to its 2007 Concluding Observations on Brazil in which the Committee had, "noted the existence of de facto discrimination against women, especially women from the most vulnerable sectors of society such as women of African descent" which can also be exacerbated by "regional, economic and social disparities."[170] Further, the Committee referred to its, "general recommendation No. 28 … recognizing that discrimination against women based on sex and gender is inextricably linked to other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, cast, and sexual orientation and gender identity."[171]

In sum, the committee concluded that states have an obligation under the human rights provisions of CEDAW to guarantee women of all racial and economic backgrounds adequate and non-discriminatory access to their conventionally guaranteed right to maternal health services. The Committee recommended taking measures that will effect a reduction in maternal deaths, including ensuring a woman's right to safe motherhood and affordable access to emergency obstetric care.

These two cases, one from a State court and the other from the international system, show how states' obligations to ensure human rights protections—here to provide health care generally, and maternal health care in particular—can serve to improve the lives of marginable populations. The reality is that migrant women, in their journeys and in their work, as well as all women in their reproductive labor, are entitled to the protection of the myriad rights set out in the documents discussed in Part II above. The right to health during the journey, the right to health at work, the right to maternal health in labor are not only explicitly stated, but also corollaries to other rights, such as education, information, bodily integrity, privacy, movement, family life, and non-discrimination on multiple grounds to name a few.

The lens of glocalization enables a clarity about marginable peoples' rights—be they migrants or simply invisible citizens who also live at the margins of society. Migrants, especially migrant women, often are deprived of many of the rights that reduce vulnerability to ill health, such as: the rights to information, education, food and nutrition, water, free movement, non-discrimination, and privacy. Significantly, the health status of women who are migrants is tied into their knowledge about health, the type of work they will engage, their access to service and information about such services, the linguistic ability to communicate in the destination country, and the degree of discrimination, such as racism, that health care delivery providers perform.[172] Sadly, many come from States where substandard health conditions prevail, which feeds into the lack of general knowledge about health.[173] Indeed, migrants who are low-skilled, seasonal workers, often are exposed to high occupational health risks.[174]

Moreover, migrants often are subjects of violations that result in ill health, such as violence, torture, and existing in slave-like conditions. For example, a person who experiences violence suffers physical

170. *Id*. at ¶ 7.7.
171. *Id*.
172. Caritas, *supra* note 63.
173. *Id*.
174. *Health of Migrants: Report by the Secretariat*, EB122/11, WORLD HEALTH ORGANIZATION (December 20, 2007), *available at* http://www.who.int/hac/techguidance/health_of_migrants/B122_11-en.pdf.

harms that are likely to have long-lasting health consequences. Similarly, human trafficking victims, particularly women, are especially subject to health issues such as communicable diseases, as well as non-communicable diseases.[175] Some studies have shown that "the frequency of health outcomes among migrants is higher than that seen in the host population."[176] Legally, human rights norms prohibit these practices that plague the health and safety of marginable migrant women.

But let's not forget the invisible within their own societies. As the figures on maternal and infant mortality show, there are marginable women existing within their own citizenship borders. The status becomes irrelevant as the powerless lack the protection of all the rights to which they are entitled. Glocalization provides the needed link between and among all marginable populations—the local get lost in the global; the global get lost in the local. They become invisible; they are rendered disposable people.

Particularly in considering marginable populations and their disproportionate exposure to safety and health risks, a paradigmatic shift that embraces the human rights indivisibility and interdependence of rights model is hugely attractive. Beyond providing specific rights to marginable populations—be they global or local, it provides a methodological approach that embraces the multidimensional levels at which marginable women of color experience disproportionate exposure to harm because of the intersection of race, sex, ethnicity, class, sexuality, gender identity and immigration status. All these classifications constitute prohibited bases of discrimination.

175. *Id.*
176. *Id.*