

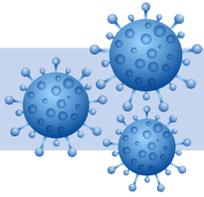
TIME FOR A RESET?

This paper is part of a series of short “think pieces” by IOM’s Migration Research High Level Advisers on the potential changes, impacts and implications for migration and mobility arising from COVID-19. Designed to spark thinking on policy and programmatic responses to COVID-19 as the impacts continue to emerge globally, the papers draw upon existing and new evidence and offer initial exploratory analysis and recommendations.

August 2020

COVID-19 and the transformation
of migration and mobility globally

COVID-19 and women migrant workers: Impacts and implications



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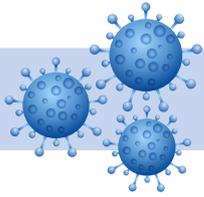
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COVID-19 and the transformation of migration and mobility globally

COVID-19 and women migrant workers: Impacts and implications

Laura Foley and Nicola Piper¹

Introduction

The COVID-19 pandemic has dramatically altered societies and labour markets. In a matter of weeks, severe constraints on mobility were imposed via border and business closures, quarantines and movement restrictions.² The pandemic and subsequent movement restrictions have acutely exposed the front-line nature of much of the work carried out by migrant workers, by laying bare the ways in which economic, social and structural inequalities impact upon some groups of workers and migrants more than others.³ Gender is one such distinguishing factor.

Migrating overseas for work is driven by a number of factors. Many men and women migrate in order to seek higher incomes and better opportunities for themselves and their families.⁴ Women's labour migration is driven by specific factors in countries of origin and destination that are often gender related. One set of factors relates to gender inequalities and gender-based discrimination, which may prevent women from accessing the same economic opportunities both at home and overseas as men, and from exercising the same level of freedom of mobility as men. In addition, there are structural factors in countries of origin such as insufficient social safety nets, the privatization of health care and education, and levels of poverty that drive women's migration in light of men's under- or unemployment or the absence of an income provider. In destination countries, the outsourcing of care work has been one of the key drivers of women's in-migration.⁵ This is starkly illustrated in figure 1, which highlights the significant sex differences in migrant domestic workers by destination.

1 Laura Foley, Postdoctoral Research Fellow, School of Law, Queen Mary University of London; Nicola Piper, Professor of International Migration and Founding Director of the Sydney Asia Pacific Migration Centre, University of Sydney. This paper was made possible through support provided by the Gender Equality Branch of the Australian Department of Foreign Affairs and Trade and builds on the following research paper: L. Foley and N. Piper, *COVID-19 and women migrant workers: Impacts and implications*, IOM, Geneva, 2020.

2 By 22 April 2020, 68 per cent of all workers lived in countries with recommended or required workplace closures (ILO, 2020a).

3 IOM, 2020a.

4 ILO, 2010. The ILO (2018: ix) estimates that there are 164 million migrant workers worldwide, of which 41.6 per cent are women.

5 Hennebray, Williams and Walton-Roberts, 2016.

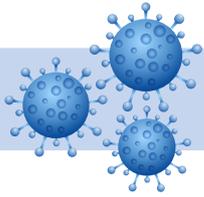
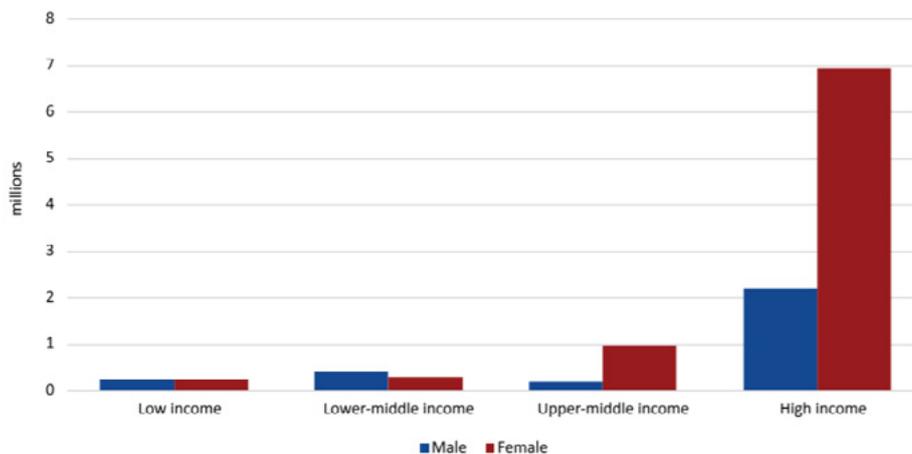


Figure 1. Migrant domestic workers by destination country income level and sex as of 2013



Source: IOM, 2017: 29, based on International Labour Organization (ILO) data.

A migrant worker's choice of jobs is constrained by the gendered division of labour that characterizes the world of work, whereby men and women often enter different sectors, or perform different duties if working within the same sector.⁶ Women, especially migrant women, are often employed in jobs at the bottom ranks, which typically involve tasks that are culturally devalued and receive limited sociolegal recognition.⁷ In migration corridors where bilateral agreements constitute the key regulatory mode, women are directly channelled into a limited range of sectors, particularly domestic work or nursing. There exists a persistent gender wage gap and migrant women disproportionately work in more precarious, insecure and informal employment that receives low pay.⁸ Women are more likely to experience violence within workplaces;⁹ and migrant women, especially those working informally, will face difficulties accessing sexual and reproductive health care and will have little to no social protection.¹⁰ Migrant women are therefore less protected from job losses and economic recession.¹¹ Also, while migrant women are among the lowest earners, they remit a greater percentage of their income than men,¹² leaving the issue of their mental health during their migration an open but necessary question. **Many of these inequalities have been laid bare, and are likely to be made worse, by the COVID-19 pandemic.**

6 Piper, 2011:64.

7 Ibid.; Baron and Newman, 1990.

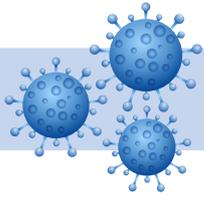
8 Piper, 2008; Holliday, Hennebry and Gammage, 2019; Hennebry and Petrozziello, 2019.

9 Public Services International, 2018.

10 UN-Women, 2020b.

11 UN-Women, 2020a:5.

12 Parreñas, 2001.



This paper examines how the global health crisis both amplifies existing gender dynamics and creates new gender-biased outcomes that disproportionately impact upon women migrant workers.¹³ The core of the study investigates the health, social and domestic care services that migrant women workers provide and which are considered “essential” during the pandemic, and contrasts this with migrant workers’ exclusion from key services and supports. The paper concludes with some recommendations and examples of good practice during the pandemic.

Gendered labour: Migrant women providing front-line services

Lockdown and social distancing measures deployed to curb the spread of COVID-19 have seen numerous employment sectors grind to a halt,¹⁴ with many countries having permitted “essential services” to continue operations during this period.¹⁵ In many countries, migrants (both documented and undocumented) make up a significant proportion of the workforce in essential front-line services and supply chains.¹⁶ These services include the provision of health and social care, transport, and the production, processing, distribution and delivery of food.¹⁷ Migrant women work in all of these sectors, but are particularly highly represented among medical and low-wage service providers.

Migrant women workers in health and social care facilities

The health crisis unleashed by COVID-19 has underlined that it is largely women’s labour that keeps global health- and social care systems running. While the virus itself poses a graver health risk to men who become infected,¹⁸ the responsibility for caring for the sick falls disproportionately on (migrant and non-migrant) women.¹⁹ Women constitute over 70 per cent of global front-line health- and social care workers and are more likely to be working (both paid and unpaid) on the front lines during this crisis in hospitals, in care facilities and in private homes, caring for patients affected by COVID-19.²⁰

13 By migrant workers, we mean international migrant workers, i.e. an international border has been crossed. This paper focuses primarily on migration flows, not migration stocks.

14 In the second quarter of 2020, it is estimated that there will be 305 million job losses (ILO, 2020a).

15 The ILO deems an “essential service” as one that, if interrupted “would endanger the life, health or personal safety of the whole of the population” (ILO, 1948, Article 3).

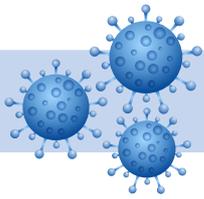
16 ILO, 2020b. Fasani and Mazza (2020) also note that 13 per cent of key workers in the European Union (EU) are migrants.

17 Overseas Development Institute, 2020.

18 Jin et al., 2020.

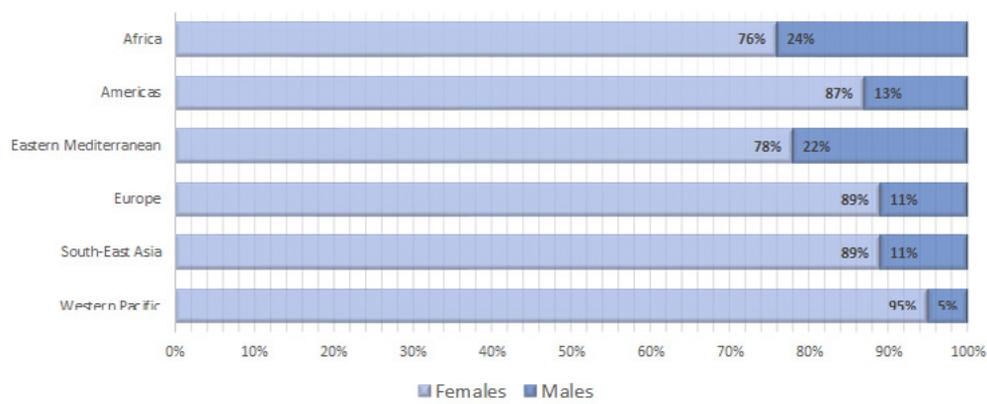
19 Women, both migrants and non-migrants, are disproportionately responsible for caring for the sick, elderly and children. Women constitute the majority of caregivers in their own homes, in hospitals, care facilities and private households. UN-Women (2020a: 6) notes that as health systems become strained, women continue to bear the responsibility of caring for sick family members and the elderly, as evidenced by the Ebola crisis.

20 Boniol et al., 2019; ILO, 2020d. During the Ebola outbreak, due to women’s roles as front-line health-care workers and as caregivers, they were more likely to be infected (Davies and Bennett, 2016).



In many countries, women migrant workers (WMWs) constitute the majority of health workers caring for patients, and many others work as cleaners within hospitals and social care settings.²¹ Women constitute the vast majority of nurses globally (see figure 2) and thus have increased interactions with sick patients. This exposure renders them the most at-risk of contracting and spreading the virus.²²

Figure 2. Percentage of female and male nursing personnel, by World Health Organization (WHO) region



Source: National Health Workforce Accounts, WHO, 2020:10²³

Data from 2019 show that, across Organisation for Economic Co-operation and Development (OECD) countries, 16 per cent of nurses and 30 per cent of doctors are foreign trained.²⁴ There is a global shortage of health-care workers²⁵ and the impact of the pandemic has resulted in some countries – mainly wealthy, highly developed States – now calling for an increased number of migrant workers to support their struggling health-care systems.²⁶ This “call” involves both migrant health-care workers who are already present in countries, but who had been deemed unable to work or whose qualifications were not previously recognized (for example in Ireland, in Germany and in Buenos Aires, Argentina)²⁷ and others who are still in

21 Sykes et al., 2014.

22 UN-Women, 2020a:5.

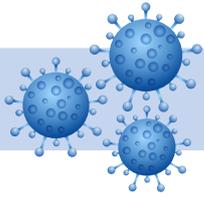
23 WHO, 2020:10. Latest available data reported between 2013 and 2018.

24 OECD, 2019. Figures reveal that migrants constitute 16.5 per cent of all health-care workers in the United States; this figure increases to 36 per cent for those who provide health care at home (New American Economy, 2020).

25 WHO (2020) notes that there need to be at least 6 million new nursing jobs created by 2030 in order to achieve the Sustainable Development Goal on health.

26 This is due to the volume of patients needing care and is exacerbated as health workers become infected and unable to work. Border closures and travel bans also prevented health-care workers from travelling to work overseas.

27 In Ireland, the Irish Medical Council has stated that refugees and asylum seekers with medical training, who were already in the country, may be able to provide essential support during the pandemic (Pollak, 2020). In Saxony, Germany, the State Medical Association has appealed for foreign doctors who are already in the region to help tackle the virus (Connolly, 2020). Buenos Aires, Argentina, has also allowed Venezuelan doctors to practice during the pandemic (Lucesole, 2020).



their countries of origin.²⁸ Attempts to recruit additional Filipino nurses during the pandemic have sparked anger in the Philippines.²⁹

This crisis has driven an increased global awareness, and appreciation, of the vital role that health workers, especially nurses,³⁰ are playing during the pandemic,³¹ yet this does not translate into improved working conditions. UN-Women (2020b) notes that during the pandemic, women migrant workers in health-care settings are at an increased risk of experiencing sexual harassment and violence from patients, patients' family members and other employees.³² WMWs in health-care settings have an additional problem as women (not migrants), which exposes them to greater risk of contracting COVID-19, as personal protective equipment (PPE), while presented as "unisex", is often designed for men's bodies and does not fit women as well.³³ Front-line health- and social care workers often remain overworked and unprotected, as they are unable to practise physical distancing and have insufficient PPE.

Migrant workers, women and ethnic minorities are overrepresented in the care sector and a large proportion of child and elderly care services are provided by migrant women.³⁴ Migrant care workers who are essential for long-term elderly residential care facilities³⁵ are low paid and are primarily part-time, which means that they take on additional jobs in other care facilities to increase their working hours.³⁶ These settings have become COVID-19 epicentres, as the working conditions exacerbated the spread of the virus within these facilities with workers moving between workplaces. This puts the workers and residents at risk of infection. There is also evidence of workers in social care settings, the majority of whom are women, having had less access to PPE than hospital workers.³⁷ In the United Kingdom, the COVID-19 death rate for social care workers was twice that of health-care

28 For example, legislation is passing through Congress that would provide visas and work permits to 40,000 migrant doctors and nurses to come to the United States (*Al Jazeera*, 2020a). The calls for additional workers may, in some instances, contravene WHO's international recruitment code of practice, which discourages the active recruitment of health workers from developing countries facing critical shortages of such workers (WHO, 2010).

29 Santos, 2020. The Philippines trains and supplies many of the world's nurses and care workers, yet the country faces an estimated shortage of 23,000 nurses (Lopez and Jiao, 2020). Following the outbreak of coronavirus in the Philippines, the country declared a state of emergency and to help the national health-care system banned health workers from migrating overseas, a move that has since been overturned for workers who had existing overseas contracts (Calonzo, 2020).

30 For example, Takeshi Kasai, the WHO Regional Director for the Western Pacific, states that "nurses are the unsung heroes of the COVID-19 response" (Moulds, 2020).

31 For example, through mass clapping for carers, health services and front-line responders in various countries including the France, Ireland, Italy, Singapore, the United Kingdom and the United States, among others.

32 UN-Women, 2020b: 2020c.

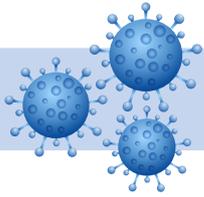
33 Women health-care workers have reported that masks are too big, so do not provide an adequate seal (Porterfield, 2020).

34 As governments have reduced available welfare supports, households have sought out migrant women to fulfil their domestic work and care needs.

35 In some countries such as Australia, Canada, the United States and the United Kingdom, over 20 per cent of workers involved in elderly care are migrants (Smith Sloan, 2018).

36 Walton-Roberts, 2020.

37 Long-term care facilities and retirement homes are not always incorporated into national health-care systems.



workers,³⁸ a fact that was partly attributed to the better access to PPE that health-care workers have, compared with social care workers.³⁹

Due to the pandemic, many WMWs with children are experiencing a double burden. Those who are employed in health, social and domestic care settings are now often working longer hours, not only at work, but also at home, as widespread school closures and a lack of available childcare services place additional caring and educational responsibilities on these women. Furthermore, as health- and social care settings are changing their working patterns in light of the pandemic, women with children may struggle to manage these changes alongside their own child and elderly care responsibilities at home.

Migrant women in domestic work

There are an estimated 67 million domestic workers in the world, 80 per cent of whom are women and 11.5 million of whom are migrants.⁴⁰ In many countries, migrant women constitute a large proportion of domestic workers, whose tasks range from cooking and cleaning to caring for children, the elderly and the sick. Before the current pandemic, the domestic work sector was already one of the most marginalized, least protected and least valued employment sectors,⁴¹ with the working conditions of many migrant domestic workers' (MDWs) "characterized by insecurity and violence".⁴² Now, due to the movement restrictions imposed by countries across the world to try and curb the spread of COVID-19, women MDWs are often placed in even more precarious positions. Due to households' fear of possible transmission of COVID-19, many MDWs are being dismissed from their jobs.⁴³ These women are often unable to find new work or to return to their country of origin, as countries have closed their borders. For those MDWs who had live-in positions, losing this job also means losing their accommodation and often their work permit, as in some countries like Malaysia, Singapore, Qatar and Saudi Arabia, MDWs' work permits are tied to their specific employer.

Women MDWs' work predominantly takes place inside the private home where, due to the intimate nature of domestic work, MDWs are at an increased risk of being exposed to the virus, especially when caring for the ill. Prior to the COVID-19 pandemic, full-time live-in MDWs were entitled to leave the household to meet their friends and support networks on their day off, but this has now been curbed.

38 In the United Kingdom, the percentage of foreign-born care workers was around 18 per cent in 2009, of which around 76 per cent were women (Cangiano et al., 2009; Cangiano and Shutes, 2010).

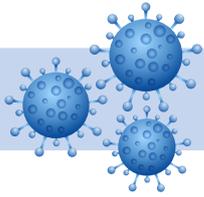
39 BBC News, 2020.

40 ILO, 2015; Peng, 2017.

41 These abuses have been highlighted by many scholars and international organizations, especially in relation to the Gulf States and Malaysia. For example, see Kaur, 2007; D'Souza, 2010; Mantouvalou, 2013; and Elias and Louth, 2016.

42 UN-Women, 2020a:5.

43 This is also the case for local domestic workers (Soares, 2020).



Employers are locking MDWs inside households and not letting them outside due to fears of contamination. As a result, women MDWs are trapped at home all day with their employers and many face violence within these households.

For part-time MDWs, there are different but also grave concerns. Part-time MDWs often work for multiple families, so their movement between workplaces increases their risk of catching the virus. Furthermore, many MDWs work informally (without employment contracts and work permits), so for those MDWs working irregularly during the pandemic, going to work means risking fines, immigration detention and/or deportation if they are asked for their documents while travelling to their workplace.

Care work is essential for global economies to function, but being highly gendered and racialized translates into this form of labour being socially and structurally devalued.⁴⁴ Many MDWs continue to lack labour and social protections, they have little to no access to health-care services and are unable to obtain unemployment or sickness benefits if they lose their jobs. As the ILO (2020) notes, in the absence of these protections, there is a risk of spreading the virus among communities, including those that are in MDWs' care.⁴⁵

Migrant women in need of services and support

Migrant women's labour is keeping many countries' health- and social care systems and households running during this crisis; however, migrant women are also in need of care and support during COVID-19. Due to the pandemic and the subsequent movement restrictions, jobs losses, cramped living situations and economic pressures that households are under, there has been a substantial increase in levels of domestic violence; however, many support services remain temporarily closed.⁴⁶ Migrant women are particularly vulnerable in these situations, due to language and information barriers.⁴⁷

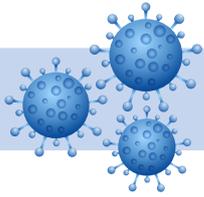
Migrant women, especially those in precarious and informal employment, as well as those with irregular migration status, were already facing barriers to accessing health care and maternity protections before the pandemic. These barriers are now even more detrimental for migrant women's health, as they may fear that seeking medical assistance may jeopardize their employment and, if they are undocumented, they may fear that seeking health care will lead to fines or to their possible arrest,

⁴⁴ Yeates, 2009; Razavi and Staab, 2010.

⁴⁵ ILO, 2020c.

⁴⁶ UN-Women, 2020b: 3–4. An increase in domestic violence has been recorded across the world, including in Bangladesh, Brazil, China, Mexico, South Africa, Spain and the United States (Bettinger-Lopez, and Bro, 2020; Islam, 2020). Due to movement restrictions, many support services and emergency shelters have closed. There have also been reports of MDWs in Lebanon (many of whom will come from South and South-East Asia) being increasingly physically and sexually assaulted by their employers while at home (Chulov, 2020).

⁴⁷ UN-Women, 2020b: 4.



detention and deportation.⁴⁸ For migrant women in domestic and care work in particular, the lack of social protection, including sick leave and unemployment benefits,⁴⁹ is detrimental for their health and well-being as, if they contract the virus, they may feel compelled to continue working and not seek medical assistance.

Migrant women sex workers are also being severely impacted by the pandemic as movement restrictions render them unable to earn money to provide for themselves and their families.⁵⁰ This “hidden” workforce is often unable to access unemployment benefits, and many have barriers to accessing health care.⁵¹ Furthermore, those who continue to work are at an increased risk of contracting COVID-19 due to the intimate nature of the work;⁵² and migrant women are particularly vulnerable in these situations due to language and information barriers.

Millions of migrant workers have lost their incomes due to COVID-19. Migrants who work in the informal sector, as do the majority in South and South-East Asia and in South America, are at a greater risk of losing their jobs and of having no access to severance pay or social security. As migrant women form a disproportionate part of the informal economy, they are particularly vulnerable as they are often the first to be let go, with little to no social protections or unemployment benefits. In contrast with the previous global financial crisis, in which unemployed migrant workers were often able to change sectors, the World Bank (2020a) notes that changing sectors in this crisis may not be as feasible, due to the skills and experience needed for essential sectors such as health care.⁵³

The health-care systems and economies of countries of origin are also being impacted by returning migrant workers, both in relation to the availability of jobs and the ability of health-care systems to cope with the additional number of COVID-19 cases brought in by returning workers. In some labour-sending countries in South-East Asia, women make up to 75 per cent of newly deployed workers and the money that they send home makes significant contributions to their national economies.⁵⁴ Job losses will result in an estimated 20 per cent decrease in international remittances sent this year (a reduction of around USD 110 billion).⁵⁵ This will have a detrimental impact not only on the workers,⁵⁶ but also on the households, families and communities that rely on migrant women’s remittances for their survival.

48 This would then place them at further risk of contracting COVID-19, as detention centres have limited options for social distancing.

49 UN-Women, 2020b:4.

50 UNAIDS, 2020.

51 Platt et al., 2020.

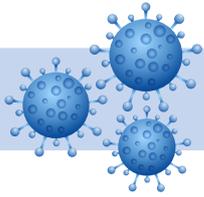
52 Wheeler, 2020.

53 World Bank, 2020a:4. Furthermore, travel bans may also pose a barrier to migrants being able to reach new employment locations.

54 Parreñas, 2001; Piper, 2008.

55 World Bank, 2020b.

56 Many countries’ immigration laws often stipulate that workers’ rights to remain in the country where they are living and working depends on their keeping their jobs.



Need for equity and an inclusive approach

While the threat of COVID-19 is indiscriminate, the impact of the virus does discriminate. Migrant women workers' health, well-being and livelihoods, and that of their families and communities, are being disproportionately impacted, yet these workers are being predominantly excluded by government policy responses to the crisis.⁵⁷ The pandemic has underlined that migrant workers, especially women, do essential jobs in our societies, yet these workers are also most likely to be denied human rights and prevented from accessing essential services. This crisis has thus underlined the need to reconceptualize what – and who – constitutes an “essential” worker, a category marred by political connotations and expediency.

Migrant workers are often excluded from accessing the COVID-19 measures implemented by the countries in which they work, including financial support packages, wage subsidies, income support and social protection.⁵⁸ Many barriers continue to exist which stem from immigration and employment laws that place many migrant workforces, especially migrant women, outside of the scope of health-care provisions.

Global crises such as the current health emergency easily become an (intended or unintended) opportunity to discard labour and human rights, amplifying a situation that is exposing severe structural inequalities, termed by some commentators as “modern forms of slavery”.⁵⁹ The response to COVID-19 both in terms of controlling the spread of the virus and recovering national economies provides an opportunity to address systemic gender inequalities and to include migrant worker populations in countries' responses in the spirit of the Sustainable Development Goals (“leave no one behind”) and the Global Compact for Safe, Orderly and Regular Migration.⁶⁰

Pandemics and their fallout are not gender-neutral, because societies and labour markets are not gender-neutral. This health crisis will have long-term social and economic impacts and it is imperative that governments' policy responses and guidelines are gender-responsive and inclusive of migrant women.⁶¹ Authorities at all levels (city/mayoral, national, diplomatic missions) and employers are responsible for reaching out to all migrant workers, including those placed in private households,

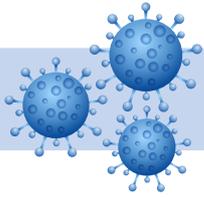
57 Portugal is a notable exception, as in order to ensure that all migrants have access to health care and other vital services and protections during the pandemic, the government announced that all migrants and asylum seekers who had open residency applications would be granted permission for temporary residence (Esteves, 2020).

58 ILO, 2020b: 2.

59 Bales, 1999; 2002.

60 Especially pertinent are Goal 2 (minimizing adverse drivers and structural factors that compel people to leave), Goal 5 (enhancing availability of regular pathways for migration), Goal 6 (facilitating fair and ethical recruitment and ensuring decent work) and Goal 10 (preventing and combating trafficking in persons).

61 Nelson (2015:7) notes that “gender responsiveness refers to outcomes that reflect an understanding of gender roles and inequalities and which make an effort to encourage equal participation and equal and fair distribution of benefits.” More information can be found in UN-Women (2016). See Foley and Piper (2020) for other recommendations in relation to protecting migrant workers during the pandemic.



to disseminate clear information about COVID-19 risks, measures and services, in relevant languages. Some good examples include city authorities across North America and some regional and local authorities across European countries that have been disseminating information on COVID-19 to migrant populations.⁶² However, it is pertinent that the most marginalized migrant workers, such as sex workers and MDWs, are included in this outreach.

Recommendations

Social Protection: For migrant workers, including domestic workers who have lost their jobs, States need to provide the same level of assistance and social protection (unemployment benefits, sick leave, income support and wage subsidies) that they afford to their nationals. Some examples of best practice include **Canada**, where temporary foreign workers in the country's agricultural sectors who lose their jobs, have become ill, or have to quarantine due to the virus, are now able to obtain pay protection and are eligible for employment insurance.⁶³ **Portugal** has granted temporary residency rights to migrants and asylum seekers with open residency applications; this allows them to access key social protection programmes.⁶⁴ In order to ensure that access to health care is not interrupted, **France** has temporarily extended residence permits.⁶⁵ **Peru** also announced that during the pandemic, all migrants awaiting regularization would be classified as regular.⁶⁶ In **Ireland**, the COVID-19 Pandemic Unemployment Payment was made available to all migrant workers (both documented and undocumented) who lost their jobs due to the pandemic.⁶⁷ **Spain** has extended unemployment insurance to domestic workers.⁶⁸ **Qatar** has stated that migrant workers who are in quarantine or undergoing medical treatment will receive their full salaries from their employers.⁶⁹

Health care: All migrant workers, regardless of status, need to have equal access to medical assistance and tests for COVID-19, on a par with national workers. Testing and treatment for COVID-19 needs to be free or low-cost. The exclusion of migrant workers from health-care services and paid sick leave could increase the risk of spreading the virus within the community. Some examples of good practice include **Colombia**, which has permitted its Venezuelan migrant population to access health

62 IOM, 2020f; Li, 2020. These measures are often organized with the assistance of civil society organizations. Furthermore, various migrant associations and migrant rights groups, such as The Asia Pacific Mission for Migrants, have been translating and disseminating information via social media. This has happened in a range of countries including in Italy, Kuwait and Sweden and across Africa (IOM, 2020c; 2020d).

63 UFCW, 2020.

64 IOM, 2020e.

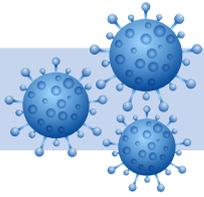
65 European Website on Integration, 2020.

66 R4V, 2020:37.

67 INAR, 2020.

68 Davies, 2020.

69 Al Jazeera, 2020b.



care during the crisis.⁷⁰ In the **United States**, Connecticut, New York and Vermont are petitioning the Supreme Court to allow migrants to access health care during the pandemic.⁷¹ In **Ireland** during the pandemic, testing is available for all migrants, regardless of status.⁷²

Bilateral labour agreements: This crisis has underlined key policy gaps in relation to both health-care provision and repatriation. There are detrimental consequences to excluding migrants from accessing health care; therefore, future labour agreements should also include health-care provisions for migrant workers in destination countries. The health crisis has also underlined the need for repatriation agreements as, due to border closures, many migrant workers have been stranded with no jobs and little money.⁷³ While some countries have arranged to have their nationals brought back home,⁷⁴ there are still many more workers who remain stuck overseas. The difficulties in organizing repatriations, and disagreements about whose responsibility this is, have highlighted the need for Bilateral Labour Agreements between labour-sending and labour-receiving countries to have key clauses detailing the repatriation of workers during crisis situations to ensure that workers are not trapped.

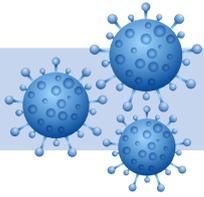
70 Colombia Sin Fronteras, 2020.

71 Bravin, 2020.

72 IOM, 2020g.

73 For example in the UAE and Malaysia (see Hashmi, 2020; *The Star*, 2020).

74 For example, around 600,000 EU citizens needed to be brought back from outside of the EU (European Commission, 2020). Other labour-sending countries arranging to bring back their workers from overseas include Myanmar (IOM, 2020h), India (Godbole, 2020) and Nepal (Mandal, 2020).



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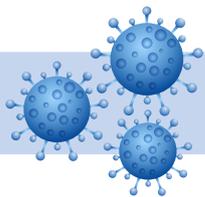
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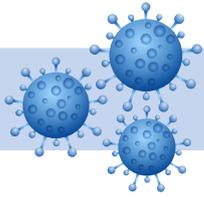
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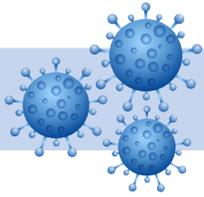
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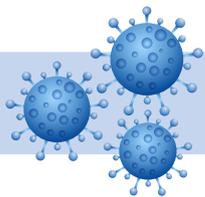
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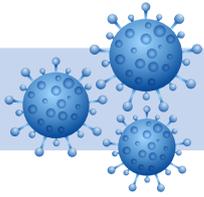
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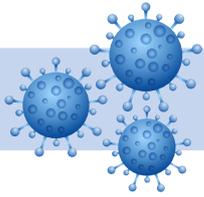
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