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RETHINKING BORDER CONTROL:

LINKING MOBILITY, HUMAN TRAFFICKING AND INFECTIOUS DISEASE

Abstract: Current studies on pandemics explore the links between population mobility and health. These studies usually focus on regular population movement such as those of tourists and legal immigrants. However, less attention has been paid to another type of movement: Human Trafficking victims. The failure to take into account the link between poor public health, this form of population mobility, and infectious diseases leaves a gap in the defences against the emergence of new infectious diseases.

As at 22 June 2009, the WHO recorded at least 95 countries which have officially reported 52,160 cases of H1N1 infections, including 231 deaths.

The lessons learned from the experience of the Severe Acute Respiratory Syndrome (SARS) outbreak in 2002 helped ensure

an orderly response to the emergence of H1N1 in Southeast Asia. However, there is a crack in this surveillance and border control regime.

While many people have unknowingly carried the virus home while travelling for work or pleasure, a totally different category of people are on the move in Southeast Asia and the Asia-Pacific region.

These migrants, often impoverished and searching for a better life, end up becoming undocumented migrants or trafficking victims. Because both types of migrants are undocumented, the status of their health is unknown.

This constitutes a largely unmonitored flow of people who, already at risk to predation and exploitation, now face the added risk of being exposed to H1N1 and slipping under the radar of health authorities.

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Introduction

Prior to the emergence of the novel Influenza A (H1N1) virus, policymakers around the world developed border control measures in their hope to prevent a new influenza pandemic. That effort, which considered the implementation of quarantines, temperature checks and travel warnings, has now been proven to be ineffective.

The world's efforts have now shifted from containment to mitigation. On 11 June 2009, the World Health Organization (WHO) raised the worldwide pandemic alert level to Phase 6 in response to the sustained global spread of the H1N1 virus.

A Phase 6 categorisation indicates that a global pandemic is underway.

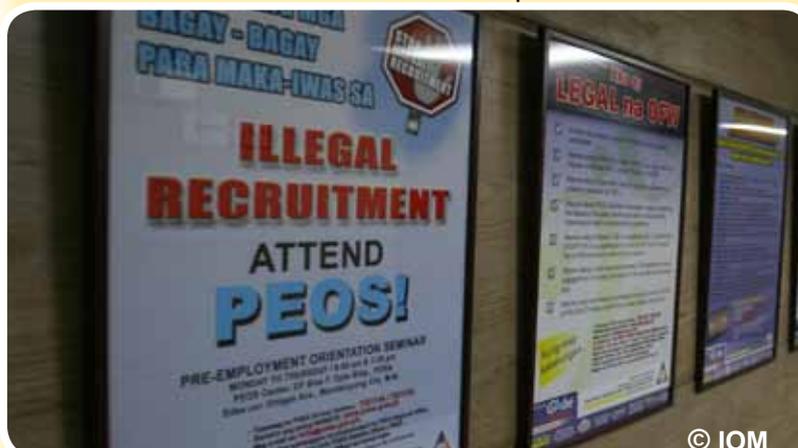
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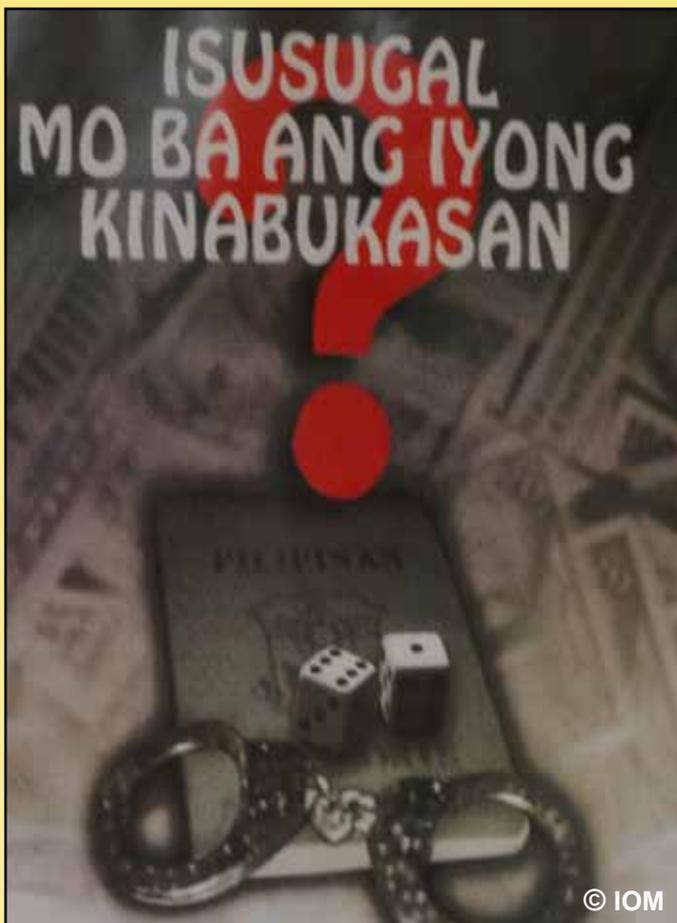
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"Are you willing to gamble your future?"

This poster in Filipino is used to warn people on the danger of human trafficking.

Infectious Disease Control: Past and Present

Measures designed to help contain infectious diseases have existed for a long time. Travel restrictions are among the oldest organised public health activities in the world. The 19th century is replete with examples of such quarantine regimes. Australia had one of the strictest quarantine regimes in the world from the 19th to the mid-20th century, with over 13,000 people detained to prevent the spread of diseases such as smallpox. The United States maintained a quarantine station on Ellis Island to screen out those who were deemed to be a public burden due to poor health. In 1851, 12 European states met in Paris to design a uniform quarantine system for the Mediterranean. The conference produced 137 regulations that eventually evolved into the International Health Regulations system in use by the WHO.

The system of border control created remained fairly constant. It required, for people arriving at international ports, medical evaluation with defined interventions including immunisation, antimicrobial treatment, or isolation for certain diseases. In essence, the system of surveillance, quarantining, and border control established in the 19th century laid a foundation that persists to this day.

However, this regime has not been entirely successful. Despite the widespread installation of thermal scanners and quarantine regimes in many of the affected countries, the disease continues to spread, with hundreds of new cases reported each day.

In the period from 12 to 15 June alone, over 6,259 new cases were reported. Many of the cases originated from people who had travelled to areas where the virus had begun to spread locally, such as Mexico and the United States.

In the Philippines, the seven new cases recorded by the Department of Health on 4 June were all travellers to the United States or Japan. Other countries in Southeast Asia have also quarantined travellers with flu symptoms returning from the United States, Mexico and other areas. This underscores how important travel and mobility are to the spread of H1N1.

This Human Trafficking Alert discusses how improvements in mobility and the greater economic integration of the ASEAN region have enabled the increase in flows of undocumented migrants, both smuggled and trafficked, and how these flows compromise the efforts of national authorities to maintain a border control regime to contain the spread of H1N1.

Linking Mobility and Health

The 20th century has witnessed great advances in transport and telecommunications. These advances, combined with trade liberalisation and more open borders, have facilitated freer movements in goods and services around the world. In China, the coastal areas have transformed into great manufacturing regions linked by air and sea to the rest of the world.

Migrants from the countryside have flocked to urban areas in the millions in search of work – a pattern that is being repeated across Asia. The disparities in income between rapidly industrialising areas and traditionally rural areas have driven many to seek employment elsewhere. Greatly reduced transport costs have enabled the mass movement of people across further distances than ever before. As a result, an estimated 190 million people move across international borders every year, which doesn't include those who migrate within state borders.

However, this process has its negative aspects. Migrants are often the most vulnerable sector in both their origin and host societies. Resistance to acceptance in host societies remains strong, as demonstrated by the studies of children of foreign parentage in Japan, and for spouses of Taiwanese husbands.

The differences in language, culture, and technical skills between origin and host societies also makes it difficult for migrants to find adequate employment upon arrival in host societies, which deprives them of social support services, making them vulnerable to poor living and health conditions.

The determinants of migrant health

Migrant health is determined by a number of factors, including genetics and biological factors, socio-economic status, environmental exposure, and behaviour. Migrants may also encounter health risks from a variety of social determinants such as the migration process itself, risks present in the country of origin, and those which arise from the socio-economic conditions they face in their host countries. This point is crucial, as it stresses that migrants are a group vulnerable to health risks, inasmuch as they can be carriers for infectious disease.

Saker et al. identify several linkages between population mobility and the spread of infectious diseases in the modern world. In essence, these linkages are social determinants that enable the spread of infectious diseases.

The first determinants are conditions that simultaneously stimulate migration and lead to the emergence of new infectious diseases and the breakdown of conventional quarantine regimes. 'Poverty, overcrowding, repression and economic failure' simultaneously encourage people 'to move while leading to the breakdown of housing, safe and sufficient drinking water, sanitation and education.'

Second, mass migration can lead to conditions of crowding where infectious diseases spread more easily, while stymieing efforts to control outbreaks if drugs are used indiscriminately, leading to the emergence of drug resistant diseases (such as drug-resistant tuberculosis).

Finally, migration exposes people to new microbes to which they have not yet developed immunity and different behavioural patterns, which affect rates of infection. These linkages, if applied to the context of trafficked people, all reveal layers of vulnerability where migrants become susceptible to infectious diseases all the way from their origin to their host countries.

It is clear that there is a link between international population mobility and public health. However, the question remains as to how these can be linked to human trafficking victims and the spread of H1N1. The next section answers this question.

Population mobility and infectious diseases

The number of people travelling internationally is increasing every year. According to statistics of the United Nations World Tourism Organization, international worldwide in-bound tourist arrivals in the year 2007 reached 903 million.

In 2007, just over half of all international tourist arrivals were motivated by leisure, recreation and holidays (51 per cent) – a total of 458 million. Business travel accounted for some 15 per cent (138 million), and 27 per cent represented travel for other purposes, such as visiting friends and relatives, religious reasons or pilgrimages, health treatments, etc. (240 million).

Slightly less than half of all arrivals travelled by air (47 per cent) in 2007, while the remainder arrived at their destinations by surface transport (53 per cent) – whether by road (42 per cent), rail (4 per cent) or over water (7 per cent).

In 2008, international tourist arrivals reached 924 million, up by 16 million over the preceding year, representing a growth of 2 per cent. The modes of travel remained relatively unchanged from 2007.

By 2010 international arrivals are expected to reach 1 billion, and 1.6 billion by 2020. The total tourist arrivals by region shows that by 2020 the top three receiving regions will be Europe (717 million tourists), East Asia and the Pacific (397 million) and the Americas (282 million), followed by Africa, the Middle East and South Asia.

Such a dramatic increase in international travel means that health issues no longer remains a localised affair. For example, Mexico experienced its first outbreaks of respiratory illness and increased reports of patients with influenza-like illness (ILI) in several areas of the country in March and early April 2009.

On 12 April, the General Directorate of Epidemiology reported an outbreak of ILI in a small community in the state of Veracruz to the Pan American Health

“Migrant health is determined by a number of factors, including genetics and biological factors, socio-economic status, environmental exposure, and behaviour. Migrants may also encounter health risks from a variety of social determinants such as the migration process itself, risks present in the country of origin, and those which arise from the socio-economic conditions they face in their host countries.”

Organization (PAHO) in Washington, in accordance with the WHO's International Health Regulations.

On 23 April, several cases of severe respiratory illness were confirmed through laboratory testing as swine-originating Influenza A (H1N1) virus infections and were communicated to the PAHO.

During 1 March to 30 April, a total of 1,918 suspected cases were reported, including 286 probable and 97 confirmed cases in Mexico. A total of 84 deaths were also reported. On 12 June 2009, the WHO declared the spread of H1N1 to be a global pandemic.

Patterns of infectious disease transmission: Influenza A (H1N1) in Southeast Asia

The current pattern of H1N1 transmission in Southeast Asia can broadly be divided into two stages:

The first stage is characterised by imported transmission in which cases of H1N1 were detected in those people who had been to affected countries.

The mode of travel was predominantly by air and this proves that at least initially, the H1N1 virus in Southeast Asia was spread through a highly visible regular channel, i.e. air travel.

The second stage is characterised by both imported transmission as well as local/in-country transmission. Transmission at this stage occurs within a country. Almost all countries of Southeast Asia have now confirmed cases of local transmission.

On 18 June, Thailand warned that domestic infections of the flu were soaring, as officials said the number of cases had jumped nearly forty-fold from just eight days earlier.

Thailand has now the largest number of confirmed cases in Southeast Asia characterised by rapid local transmission. It has also increasingly become a source country for H1N1. For example, more than half of Taiwan's 49 cases (as of 14 June) of H1N1 were believed to have been imported from Thailand. (refer to table 1 and 2)

Most, if not all, of the initial cases of H1N1-infected people in the Asia-Pacific region were primarily those who had travelled to affected areas. Most monitoring focused on air travellers.

Responses to H1N1 in Southeast Asia have included temperature screening of inbound international passengers at airports as well as at sea and land checkpoints, issuance of travel advisories to citizens, quarantining of foreign visitors suspected of having the virus or being in contact with others who may have been infected, border controls and tougher

Table 1 Influenza A (H1N1) cases in selected Asia-Pacific countries

Country	Cumulative Total		Newly confirmed since last reporting period	
	Cases	Deaths	Cases	Deaths
Australia	2,436	1	237	1
New Zealand	258	0	42	0
Japan	850	0	160	0
China	739	0	220	0
South Korea	105	0	21	0
Philippines	344	0	33	0
Brunei	1	0	1	0
Laos	2	0	1	0
Vietnam	35	0	8	0
Thailand	589	0	71	0
Malaysia	23	0	0	0
Singapore	142	0	65	0
Asia-Pacific Total	5,524 (~10.6% of global total)	0	859 (~10.9% of global total)	0
Global Total	52,160	167	7,873	1

Source: Adapted from Influenza A (H1N1)-update 52 (as of 07:00 GMT, 22 June 2009): Laboratory-confirmed cases of new influenza A (H1N1) as officially reported to WHO by States Parties to the International Health Regulations (2005).

Note: Chinese Taipei has reported 61 confirmed case of influenza A (H1N1) with 0 deaths. Cases from Chinese Taipei are included in the cumulative totals provided in the table above.

Human Trafficking: A Global Phenomenon

The United Nations established the definition of human trafficking as follows:

“Trafficking in persons” shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.

Human trafficking is a clandestine activity. Traffickers avoid normal points of entry and attempt to evade the authorities. Due to its clandestine nature and the lack of comprehensive counter-trafficking programmes and legislation in Southeast Asia, many victims continue to fall through the cracks, with little or no attention paid to their protection needs and overall well-being. Moreover, because of their irregular status, victims are usually afraid to seek help from law enforcement officials, who treat them as irregular migrants who have broken the law rather than victims of trafficking.

Countries	First Stage: Imported transmission	Second Stage: Imported plus local/in-country transmission
Malaysia	First case confirmed in a student who returned from the United States on 13 May.	First case of local transmission reported on 17 May. Victim contracted the disease within the country from a student who returned from Melbourne.
Philippines	First case confirmed on 18 May through a person who returned from the United States on 18 May.	First case of local transmission confirmed on 27 May when two persons were infected while attending a wedding on 17 May.
Singapore	First case confirmed on 27 May in a person who travelled to New York from 12-24 May.	First case of local transmission confirmed on 18 June.
Vietnam	First case confirmed on 29 May in a person who travelled to the United States.	First case of local transmission reported on 9 June in a person via a Vietnamese-American family who had H1N1.
Thailand	First two cases confirmed in people who travelled to Mexico on 12 May.	First case of local transmission reported on 5 June when a person, whose mother who had returned from a trip to the United States on 25 May, contracted the disease.

Source: Channel News Asia, The Straits Times, Xinhua, Reuters, The Bangkok Post, and others.

Note: Only those countries that reported cases to WHO are included in this tally.

Regions	Number of people in forced labour as a result of trafficking
Asia & Pacific	1,360,000
Industrial Countries	270,000
Latin America & Caribbean	250,000
Middle-East and North Africa	230,000
Transition Countries	200,000
Sub-Saharan Africa	130,000
World	2,440,000

Source: ILO Action Against Trafficking in Human Beings, Geneva, 2008.

Statistics on human trafficking

The International Labour Organization (ILO) - the United Nations agency charged with addressing labour standards, employment, and social protection issues - has developed the first-ever global estimate on the numbers of persons who are held in forced labour, with a breakdown of those who have been trafficked into labour as well as for commercial sexual

immigration policies.

However, these measures were directed at highly visible regular channels of population movements.

Focusing on regular travel fails to take into account the large-scale incidence of irregular migration. Irregular migration makes use of unofficial channels and is relatively difficult to detect.

One such type of irregular migration is human trafficking.

exploitation. Out of 12.3 million forced labour victims worldwide, around 2.4 million were trafficked. The figures present a conservative estimate of actual victims at any given point in time, estimated over a period of 10 years.

Forms of human trafficking

The ILO further estimates that 32 per cent of all victims were trafficked for exploitative labour, while 43 per cent were trafficked for sexual exploitation, and 25 per cent for a mixture of both.

Women and girls make up 98 per cent of those trafficked for the purpose of sexual exploitation and international migrant workers represent a large number of identified trafficking victims for forced labour purposes.

The United States' Trafficking in Persons Report 2008 on the other hand estimated that approximately 800,000 people are trafficked across national borders annually, out of which 80 per cent are women and girls and up to 50 per cent are minors.

Consistent with these findings was the United Nations Office for Drugs and Crime Report which estimated that trafficking for the purpose of sexual exploitation constitute 79 per cent, and is by far the most commonly identified form of human trafficking, followed by forced labour at 18 per cent.

Linking Human Trafficking, Border Control and Health

Human trafficking, a form of mobility that evades conventional border control measures, has become a means by which public health threats can move across borders. While all forms of population movements enable the spread of infectious diseases, human trafficking is a special category because of the nature of trafficking victims.

Generally, they are forced to endure conditions that increase vulnerability to illness and infection, and are exposed to different populations. They also face additional vulnerabilities stemming from the social and economic conditions of source communities that can be amplified by the conditions faced by victims during transit and at their destinations.

As noted earlier, the predominant forms of human trafficking are those for sexual exploitation and forced labour.

A large proportion of victims are women, girls and minors. With regards to infectious disease, some of the factors that heighten risks and increase vulnerability among trafficked victims are:

- Victims of trafficking often endure brutal conditions that may result in psychological trauma such as anxiety, depression, sleep disorders, post-traumatic stress disorder, disorientation, confusion, phobias and panic attacks;
- Feelings of helplessness, shame, humiliation, denial, disbelief or culture shock from being in a strange country;
- Dirty and crowded living conditions, coupled with poor nutrition, cause health conditions such as scabies, tuberculosis and other communicable diseases; and
- Malnourishment which may be present especially in child victims, and which may inhibit their physical growth and development.

According to the Center for Health Education and Research, 'it is now more widely understood that individual behaviours and their health outcomes are strongly affected by their larger social, political and economic contexts in which these individuals live and work'.

It is therefore clear that issues such as exploitation, the underdevelopment of health infrastructure in their countries of origin, the lack of legal and health protection from both origin and host communities, and limited participation in the host community are linked to ill health and increased vulnerability to H1N1.

The weaknesses of border control

In the past, fear of imported diseases prompted health authorities to design quarantine regimes centred on the inspection and exclusion of goods, vessels and people with the aim of protecting inhabitants from imported diseases. Efforts in international health cooperation in the 19th century focused precisely on preventing the spread of infections by restricting mobility.

At present, border control regimes continue to emulate the 19th century model in the event of an outbreak, with poor results.

In the case of the SARS outbreak in China, rapid population mobility and the high speed at which information (and rumours) about SARS were disseminated led to a circumvention of the quarantine regime around Beijing, as hundreds of thousands sought to leave the city to escape the quarantine, SARS, or the rumoured imposition of martial law. This model of regulating disease by regulating mobility is no longer feasible today, considering the fast pace of population mobility and the multiple points of entry made available by globalisation.

Unlike international tourist arrivals, human trafficking is routed through unregulated or unmonitored transportation routes. Victims are trafficked by aircraft, boat, rail, ferry and road or simply on foot in order to reach the country of destination. The route may include a transit country or it may be directly between the origin and destination locations.

Trafficking victims also risk criminal prosecution for violations of immigration and border control laws, corrupt officials, forgery of documents, acts of coercion, unlawful confinement and the withholding of identity papers and other documents.

Traffickers are generally at least one step ahead of law enforcement officials, regularly changing routes and operating strategies. In the face of increasing anti-immigration policies and strict border controls in the aftermath of a global pandemic crisis, potential migrants resort to more extreme measures in an attempt to reach their destinations.

For example, Pengerang on Johor's east coast has increasingly become a favourite haunt for human trafficking syndicates.

According to the Malaysian Maritime Enforcement Agency (MMEA), more than 15 sea routes in the waters off Pengerang in Kota Tinggi are commonly used by smugglers and human traffickers to transport their cargoes to and from Batam in Indonesia.

Since March 2009, four boats with 114 Indonesians, 58 Afghans, 37 Pakistanis and three Iraqis have been caught trying to cross from Malaysia to Indonesia, according to statistics from the marine police and the MMEA. This prompted Malaysian Home Ministry Secretary General Mahmood Adam to describe this new phenomenon as 'a new trend to us in Malaysia.'

Thus the multiplicity of transport routes and entry points and the diverse methods employed makes it difficult to detect human trafficking.

This case provides an example of how existing surveillance and reporting systems currently in place at airports and border checkpoints cannot account for the movement of undocumented migrants and trafficking victims. An outbreak of H1N1, once it occurs among them, can quickly get out of control.

What is worse is that it will be difficult to record the extent of an outbreak. Human trafficking thus

increases and complicates global health risks; border control measures are ineffective against it.

Aside from the vulnerabilities encountered in the process of trafficking, victims also carry the public health vulnerabilities from their countries of origin, allowing for the transmission of illnesses from their origin to their destination countries.

In addition, their health largely goes unmonitored by the public health authorities of destination countries, as their bureaucratic processes do not incorporate health care and inspection for infectious diseases. This may largely be due to the fact that most international agreements regarding human trafficking focus on the prompt repatriation of victims to their countries of origin.

“It is important to recognise the health consequences of trafficking in order to reduce victims’ vulnerability to infectious diseases. This entails the recognition of trafficked victims’ rights to health and health services as primary and fundamental elements of their legal and human rights...denying them proper healthcare will increase the potential for the further spread of pandemics through irregular channels.”

By the time this occurs, the transmission of illness may already have occurred. Attention to this problem should by no means be limited to H1N1, as many diseases such as other forms of influenza, tuberculosis, malaria, sexually transmitted diseases, parasitic diseases and other health conditions all afflict migrants from less developed regions, and could also affect human

trafficking victims.

Policy Recommendations

It is important to recognise the health consequences of trafficking in order to reduce victims’ vulnerability to infectious diseases. This entails the recognition of trafficked victims’ rights to health and health services as primary and fundamental elements of their legal and human rights.

Give greater importance to public health

Given that victims of human trafficking and irregular migrants are susceptible to diseases and poor health owing to vulnerabilities in the environment in which they operate, denying them proper healthcare will increase the potential for the further spread of pandemics through irregular channels.

Therefore, allocating sufficient resources to healthcare has significance for both origin and destination countries.

Origin countries benefit from extending healthcare to trafficked people and other irregular migrants, because ensuring their health eliminates a possible source of infectious disease.

Sending countries that increase their investment in public health also benefit in the same way, but also simultaneously increase the productivity of their own populations, which increases wealth and helps reduce the impetus for people to migrate through irregular channels.

Having outlined the need to pay greater attention to the health of migrants and trafficking victims, policies can then be implemented at various levels.

At different stages in the trafficking process

Identifying the social determinants of infectious disease vulnerability can help policymakers determine weaknesses in the public health structure, and to allocate resources to strengthen their health sectors to prevent the emergence and spread of disease.

Measures may include the strengthening of public health and sanitation infrastructure, and training for health and healthcare workers. Based on these, some policy recommendations are listed in the following section.

Pre-departure stage

(1) Incorporate health-related information into anti trafficking programs and prevention campaigns.

(2) Provide information to migrants prior to their departure on basic health issues, rights to health services, and contact details of service providers in destination countries.

(3) Promote the development of ASEAN and/or WHO documents to be distributed to migrants from known countries of origin (produced in various languages) that include, but is not limited to:

- Summaries of primary health risks and consequences related to migration and trafficking;
- Definitions and descriptions of symptoms of common and severe illnesses among migrants and related treatment options;
- Definitions of trafficking, various forms of gender-based violence, and forms of exploitation, including descriptions of health implications; and
- Translations of key health words and phrases in the relevant languages of origin and destination countries.

Travel and transit stage

Develop and disseminate information on health, health services, and emergency contacts to migrants

from known countries of origin at points of departure, transit, and entry (e.g. consulates, embassies, train stations, airports, taxi cabs, harbours, immigration checkpoints, motels, hostels, and travel agencies).

Destination stage

(1) Require ministries of health and other key policymakers to formally recognise trafficking as a health problem, include trafficking as a health issue in strategic planning, and allocate funds for health interventions.

(2) Fund and promote health outreach services to vulnerable migrants in sectors known to employ trafficked women and children in destination countries, and ensure that care is offered in appropriate languages.

At the international level

While international bodies such as the International Organization for Migration help promote orderly migration and advocate the humane treatment of migrants, an international framework for cooperation between sending and receiving countries does not yet exist. Such a framework between sending and receiving countries could study migrant flows and how vulnerable they are to health risks, and enable the implementation of a cooperative solution to guarantee their health. This type of framework could also facilitate the sharing of resources and information, which could study the factors enabling human trafficking, and help devise policy recommendations to end it.

References

Carballo, Manuel, and Aditi Nerukar, 'Migration, Refugees, and Health Risks', Panel Summary from the 2000 Emerging Infectious Diseases Conference in Atlanta, Georgia, Centers for Disease Control, Atlanta, USA, 11 June 2001. Available at <http://origin.cdc.gov/ncidod/eid/vol7no3_supp/carballo.htm>.

Centers for Disease Control and Prevention, Update: Novel Influenza A (H1N1) Virus Infection—Mexico, March-May 2009. Available at <<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5821a2.htm>>.

deLisle, Jacques, 'SARS, Greater China, and the pathologies of globalization and transition', *Orbis* (ScienceDirect) 47, no. 4, Fall 2003, pp. 587-604.

Department of Health, Update No. 33 - Duque Reports 7 New Cases of Influenza A (H1N1); Reacts to Possible Announcement of Level 6 by WHO, Manila, Philippines DOH, 4 June 2009.

ILO Action Against Trafficking in Human Beings, Geneva, 2008. Available at <http://www.ilo.org/sapfl/Informationresources/ILOPublications/lang--en/docName--WCMS_090356/index.htm>.

MacPherson, Douglas, Brian Gushulak, and Liane MacDonald, 'Health and foreign policy: Influences of migration and population mobility', *Bulletin of the World Health Organization*, March 2008, pp. 200-06.

'Over half of Taiwan H1N1 cases originate in Thailand', Taiwan News, 14 June 2009. Available at <http://www.etaiwannews.com/etn/news_content.php?id=976573&lang=eng_news>.

Saker, Lance, Kelley Lee, Barbara Cannito, Anna Gilmore and Diarmid Campbell Lendrum. *Globalization and Infectious Disease: A Review of the Linkages*. SEB Series, Special Topics in SEB Research, Training in Tropical Diseases Steering Committee for Social, Economic and Behavioural (SEB) Research, Geneva: World Health Organization, 2004.

'Thailand on flu alert', *The Straits Times*, 18 June 2009. Available at <http://www.straitstimes.com/Breaking%2BNews/SE%2BAsia/Story/STISStory_392121.html>.

United Nations, Article 3, Use of Terms (a) *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Conventions against Transnational Organized Crime*, 2000, UN, p. 2. Available at <http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf>.

United Nations Office on Drug and Crime, Global Report on Trafficking in Persons, UNODC, February 2009. Available at <http://www.unodc.org/unodc/en/human-trafficking/global-report-on-trafficking-in-persons.html>.

United Nations Office on Drug and Crime, Human Trafficking: An Overview, UNODC 2008, p. 13. Available at <<http://www.ungift.org/docs/ungift/pdf/knowledge/ebook.pdf>>.

University of Washington Center for Health Education and Research, The Synergy Project, 'Keeping Up With the Movement Preventing HIV Transmission in Migrant Work Settings', University of Washington, Washington, USA.

'International Tourism Challenged by Deteriorating World Economy', United Nations World Tourism Organization, UNWTO press release, 27 January 2009. Available at <http://www.unwto.org/media/news/en/press_det.php?id=3481&idioma=E>.

Vergnani, Linda, 'A medical means to "separate the clean from the unclean, the pure from the polluted"', Times Higher Education, 7 May 2004. Available at <<http://www.timeshighereducation.co.uk/story.asp?storyCode=188519§ioncode=26>>.