Focus: AIDS and mobile populations

Declaration of Commitment

By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services (paragraph 50).

United Nations General Assembly Special Session on HIV/AIDS, June 2001, New York

Migration and mobility play important roles in the HIV/AIDS epidemic. But the relationship is complex. Not all migrants or people on the move face special risks of infection. Still, the links between mobility and AIDS are evident in most parts of the world, as these examples show:

- **Migrant workers:** Of the Filipinos reported to be living with HIV/AIDS, 28% are workers who have returned home after working in other countries. About 41% of HIV-positive Bangladeshis have been migrant workers.
- **Mobile professions:** Research among truck drivers at five South African truck stops revealed an overall prevalence of 56%—well above the national adult prevalence rate.
- **Migrant and trafficked sex workers:** Research in the Terai area of Nepal revealed that the 17% of sex workers who had worked in India accounted for three-quarters of all HIV cases. About 30% reported that they had been coerced; testing revealed that these women were three times more likely to be HIV-infected than other women.
- **Partners of migrant workers:** The beginning of the HIV epidemic in rural Mexico can be traced to the return of agricultural labourers who had been working in the United States of America.

Understanding migration

Never before in human history have more people been on the move. Recent estimates suggest that some 150 million migrants (people who take up residence or who remain for an extended stay in a foreign country) currently live outside their country of citizenship. One-in-ten of these are liable to be refugees and asylum-seekers. Even greater numbers of people move within their countries each year. In fact, economic migration from rural to urban areas is probably the largest single category of modern migration.

The International Organization for Migration (IOM) has devised a useful framework for research and HIV/AIDS programming whereby migration is characterized as a process with four stages. Effective HIV/AIDS responses must address each stage:

- **Source:** where people come from, why they leave, and what relationships they maintain at home while they are away.
- **Transit:** the places people pass through, how they travel and their behaviour while they travel.
- **Destination:** where people go, the attitudes they encounter, and their new living and working conditions.
- **Return:** the changes that have occurred in people's lives, and the conditions they find upon their return.

People move for a variety of reasons—some voluntary, some not. Economic migration is largely (but not entirely) a question of supply and demand. Prosperous countries, notably in North America, Western Europe and the Gulf States, attract people looking for work; others, in poorer regions, are highly dependent on the income earned by citizens who work in other countries. The Philippines, for instance, has about 8% of its citizens working overseas (out of a total population of 77.1 million), the majority of them women.

Tragically, a significant proportion of today's population movement is involuntary. This includes refugees and internally displaced people pushed from their homes by conflict or disaster. The Office of the United Nations High Commissioner for Refugees has estimated that there are currently some 40 million people worldwide who have been driven from their homes by emergencies caused by natural disasters such as earthquakes, drought or floods, or else by war and civil strife, and who are living as refugees in foreign lands or as displaced persons within their own countries. Some have remained in these precarious situations for 20 years or more, and the camps to which they retreated have become more or less permanent settlements.

Also involuntarily on the move are people who are trafficked—as many as 1–2 million annually, according to some estimates—mostly for prostitution and forced labour. Of these, the overwhelming majority are women and children. Such trafficking is thought to be one of the biggest sources of profits for organized crime, following drugs and firearms.

Mobility and vulnerability

Vulnerability is often related to a particular stage of the migration process. For example, some migrants are most vulnerable at their destination, as is often the case with men who work far from home in men-only camps or barracks. For others, the greatest risk occurs in transit, as with women who have to trade sex in order to survive or complete their journeys.

Also vulnerable are the partners of those who become infected while away, especially married women. Their vulnerability is worsened when they lack the right or ability to deny their partner sex or insist he use a condom, even if they suspect he may have had unsafe sex while away.

Nevertheless, it would be incorrect to assume that migrants generally bring AIDS with them. Comparison of forced migrations in Africa reveals that, in some cases, such as Somali

refugees in Ethiopia, prevalence among the migrants is less than that of the host population. The same can be true of labour migration. In India, the more industrialized states of Maharashtra, Gujarat and Andhra Pradesh attract both male and female workers from all over the country, but particularly from those states with lower income levels. Some of these lower-income states have lower levels of HIV infection than the destination states. The fact that migrating men generally leave their wives and families behind increases the likelihood that they will visit sex workers while away from home—a risk factor for both them and their families when they return home.

Action research needed

Efforts to tackle the link between migration and AIDS are complicated by the fact that few countries collect information or do research about the HIV-related needs of migrants. This is true even in countries that have mounted generally successful AIDS responses. For instance, neither Uganda nor Thailand has collected data on HIV among their substantial forced-migrant populations. Yet Uganda hosts about 185 000 refugees, Thailand about 188 000, and both have large numbers of undocumented migrants. Most of what is known about these populations is the result of research by nongovernmental organizations and international agencies.

An important part of a response, then, even before prevention or care programming is planned, is the collection of information. The methodologies for rapid situation assessment already exist. An example is a study carried out by CARE, Family Health International, the Thailand Business Coalition on AIDS, and World Vision Thailand, which looked at the maritime industry in Thailand's Ranong Port. After identifying risk conditions for HIV and for substance use in the area, the researchers were able to pinpoint opportunities to tailor interventions for the various fishing fleets, routes and type of vessel.

Prevention begins at home... but can not stop there

One of the basic rules of HIV prevention is that it is best to start early. This means reaching people before they depart for work overseas or away from home.

The Philippines provides a good example of what can be done. Knowledge levels about HIV are now relatively high among Filipino overseas workers, compared to those of other countries. This is partly due to national programmes (such as the Pre-Departure Orientation Seminars) that include sexually transmitted infections and AIDS in their curricula. A recent study indicated that Filipina maids working in Malaysia were well aware of the risk of AIDS and how to prevent it. In contrast, the study found that, among Bangladeshi women working in Malaysia, the level of AIDS-related awareness was low.

Such findings have led CARAM Asia (Coordination of Action Research on AIDS and Mobility), a partnership of seven nongovernmental organizations in the region, to link programmes in source and destination countries. CARAM Bangladesh now provides pre-departure training for women going to Malaysia, with returned migrants helping to provide the training. Upon arrival, CARAM Malaysia offers them support in protecting their reproductive health. A similar arrangement exists between CARAM Cambodia and CARAM Viet Nam.

Prevention along migration routes in West Africa

Originally launched along the heavily-travelled corridor between Abidjan in Côte d'Ivoire, and Ouagadougou in Burkina Faso, USAID's programme, AIDS Prevention on the Major Migratory Routes of West Africa (*Prévention du SIDA sur les Axes Migratoires de l'Afrique de l'Ouest*), now spans four countries, including those with the highest rates of HIV prevalence in the region. Strategies employed by the project include social marketing, mass media campaigns, and the use of peer education among the target groups, including truck drivers, sex workers and seasonal migrant workers in plantations. Evaluations suggest that safer sexual practices have increased since the beginning of the interventions in 1998. A comparison of data from studies conducted in Burkina Faso in 1997 and 2000 revealed that reported condom use among truckers during their last sexual act with an occasional partner had increased from 69% to 90%.

Prevention at destination

In the case of international migration, destination countries sometimes assume that migrants are particularly hard to reach with HIV/AIDS programming. Reasons cited generally include language barriers, cultural differences, suspicion of government authorities (including health services), and concerns about legal status. However, it seems more useful to recognize that some migrant communities have to be reached in different ways.

As with other vulnerable groups, health authorities have to carefully balance more focused programming with programming for the wider population. One non-stigmatizing approach is to focus programming on situations and geographical zones where substantial numbers of migrants live, work or socialize, rather than targeting specific individuals or groups. For example, programmes aimed not at migrant agricultural workers but at the communities that surround farms have the potential not only to reach migrant farm workers but also sex workers, traders and sales people, and the local men and women who live and work in the area. The South African experience with communities surrounding gold mines is instructive (see 'Focus: AIDS and the world of work').

A good example of partnership is *Ikambere* (the *'welcoming house'* in Kinyarwanda, the Rwandan language) in Paris. Since 1997, Ikambere has provided a locale where HIV-positive women from sub-Saharan Africa (who also run the initiative) can offer mutual support, exchange information, and work together on items they can sell. Ikambere also cooperates with hospitals and outpatient clinics where people from their communities receive AIDS treatment, helping these health facilities extend their outreach.

Care and support

Although authorities in destination countries may initially baulk at the prospect of providing care for foreign nationals, migrants have the same rights to care as those of other citizens. AIDS thrives on exclusion; in contrast, including vulnerable people in all available responses is a way of increasing society's total resistance to the epidemic. As with other populations, voluntary counselling and testing represent an excellent entry point to care, provided they are offered in the migrants' language and with iron-clad confidentiality.

Provision of care and support to migrant communities and workers, such as prevention activities, requires specific training for host-country officials. This holds true for health-care staff, as well as those in social services and immigration authorities, all of whom need to be sensitized to migrants' perceptions of HIV/AIDS, their legal problems and other concerns.

Efforts by international agencies to provide reproductive health services to refugees and internally displaced persons have grown considerably in recent years. The United Nations High Commissioner for Refugees spearheads efforts to provide reproductive health care for refugees. The United Nations Population Fund has also been active, particularly in addressing the health needs of adolescents.

Policy and legal environments

Some laws and regulations governing people on the move can have disastrous effects on public health. People who enter countries as immigrants or workers are often subject to mandatory HIV testing, despite the fact that this is not an effective form of prevention. Regulations aimed at barring HIV-positive people from entry remain in place in several countries, although it has been found that such restrictions have no public health justification (see 'Entry and residence restrictions based on HIV status' box).

Some migrant and immigrant groups are mobilizing effectively around HIV/AIDS issues. In the United Kingdom, the African Policy Network lobbies government officials to change legislation and policies that discriminate against HIV-positive asylum-seekers. The Network performs its lobbying work in collaboration with other organizations such as the Terrence Higgins Trust, the National AIDS Trust and the All Parliamentary Group on AIDS.

HIV and migration in Europe: access and care to the fore

Epidemiological data from Europe show that the proportion of people newly diagnosed with AIDS who are non-national migrants is increasing. In France, for example, where the numbers of new AIDS cases have been decreasing since 1996, rates have been decreasing more slowly among people who live in France but who are citizens of other countries. One-quarter of the non-nationals diagnosed as having AIDS are women, whereas women represent only 16% of the AIDS cases among French nationals. The situation is similar in Switzerland, where data on newly diagnosed HIV infections show that women from sub-Saharan Africa are particularly vulnerable.

Migrants have not benefited to the same extent as nationals from access to antiretroviral therapy and other care. Evidence from Belgium, France and the United Kingdom shows that migrant populations tend to seek both HIV testing and care later than the rest of the population. In France, a survey has found that women of North-African origin received less HIV counselling when they went to a prenatal clinic (despite the fact that they were found to be less knowledgeable about HIV than the general population), and therefore had a greater need for information. The survey also found that immigrant women were also more likely to be tested for HIV without their permission.

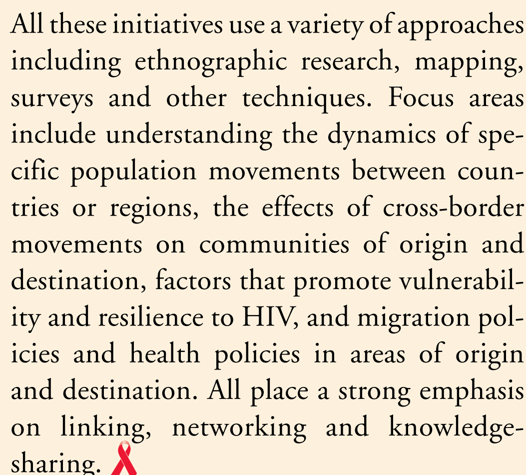
Entry and residence restrictions based on HIV status

HIV-related restrictions on entry and residence should be repealed or modified, based on guidance provided by the *International Guidelines on HIV/AIDS and Human Rights*, issued in 1998 by the Office of the United Nations High Commissioner for Human Rights and the UNAIDS Secretariat. The guidelines state that, "There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status […] Where States prohibit people living with HIV/AIDS from longer-term residence due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residence. In considering an entry application, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations".

Regional responses: spreading out

Given that HIV/AIDS responses for migrant populations must address all stages of the migration process—origin, transit, destination and return—some programming for migrant populations must extend beyond borders. Major regional AIDS and migration initiatives include the following:

- UNAIDS' Inter-Country Team for West and Central Africa has a special focus on mobility, with five partially overlapping programmes: West African countries, Gulf of Guinea coastal countries, Lake Chad Basin, Congo River Basin, and the Great Lakes Initiative on AIDS.
- The HIV and Migration Project in Central America and Mexico, organized by Mexico's National Institute of Public Health with a variety of nongovernmental organizations, governments and other institutions, works in 11 transit stations in Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua and Panama.
- The European project 'AIDS & Mobility' has national focal points in 14 countries, and fosters cooperation between community-based, governmental and nongovernmental organizations.
- The Association of Southeast Asian Nations (ASEAN) is working towards a five-year workplan to tackle HIV among mobile populations. The regional plan will comprise two components, one of which will concentrate on seafarers and truck drivers (and will include the countries of the Greater Mekong area), while the other will focus on preventing HIV/AIDS among migrant workers.



All these initiatives use a variety of approaches including ethnographic research, mapping, surveys and other techniques. Focus areas include understanding the dynamics of specific population movements between countries or regions, the effects of cross-border movements on communities of origin and destination, factors that promote vulnerability and resilience to HIV, and migration policies and health policies in areas of origin and destination. All place a strong emphasis on linking, networking and knowledge-sharing.