The failure to address HIV in relation to migration, and migration in relation to HIV, potentially entails heavy social, economic and political costs.

INTRODUCTION

In HIV/AIDS the world is facing a crucial social issue, as the pandemic threatens to undo decades of investment in health, education and human resource development. In the countries most affected by AIDS, all economic sectors are affected by a weakened and ultimately dwindling labour force. Societies must find new approaches to care for and socialize millions of children who have seen their parents fall ill and die. Along with migrant health in general, the link between HIV and population mobility is one of the most critical challenges currently confronting governments, donors and humanitarian and development agencies.

The failure to address HIV and AIDS in relation to migration, and migration in relation to HIV and AIDS potentially entails enormous social, economic and political costs; yet the field continues to be seriously under-researched and either not addressed, or only inappropriately addressed by policymakers. This chapter draws on presentations made during the International AIDS conference held in Thailand in July 2004, and on recent publications, to summarize the debates concerning global mobility and HIV, and to posit some policy actions that could make a difference.

HIV/AIDS IN GENERAL

By 2004, virtually every country was affected by the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) and between 35 and 42 million adults and children were infected with HIV. In 2003, almost 5 million people were newly infected, and almost 3 million died worldwide. About half of those infected are women and girls. Half of all new HIV infections strike people between the ages of 15 and 24 years (UNAIDS, 2004a).

What distinguishes the AIDS pandemic is its unprecedented and devastating impact on social and economic development in some of the poorest countries. If other epidemic diseases typically affect the more vulnerable, such as children and the elderly, AIDS strikes workers and parents at the height of their productivity and it strikes slowly. For the affected individuals, as for households and communities, the impact of the illness is one of progressive and profound changes over many years: “by the time the wave of HIV infection makes itself felt in the form of AIDS illness in individuals, the torrent of the epidemic is about to overwhelm medical services, households, communities” (Barnett and Whiteside, 2002). AIDS is thus both an emergency and a long-term development issue.

1. The author of this chapter is Mary Haour-Knipe, Senior Adviser, Migration and HIV/AIDS, IOM, Geneva.
2. Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).
3. The initial infection, which may barely be noticed, is followed by a period without symptoms, which may last 8 to 10 years in developed countries, less in developing countries. This is followed by a period of increasingly severe ill health. AIDS deaths are preceded by a period of long and debilitating illness.
In response, intensive research has led to the development of antiretroviral (ARV) treatment to fight HIV infections, financing has increased considerably, the cost of ARV drugs has dropped, concerted efforts are making it possible to extend treatment to millions of people in low- and middle-income countries whose lives depend on it, and increased attention is being given to prevention.

However, all this is not yet sufficient to halt or reverse the epidemic and the long-term consequences of AIDS can have wide-reaching effects. If current infection rates continue and there is no large-scale treatment programme in the worst affected Sub-Saharan African countries, up to 60 per cent of today’s 15-year-olds in those countries will not reach their 60th birthday. Impoverished households will break up as the orphaned children of deceased parents and grandparents migrate elsewhere; children will become more vulnerable to infection where there are no publicly supported services, and the number of health workers will be progressively depleted as they, too, become infected.

**HIV/AIDS AND POPULATION MOBILITY**

**THE SESSION** on population mobility at the XV International AIDS conference in Bangkok, July 2004, was part of ongoing international effort to increase understanding of the complex relationship between migration and HIV/AIDS. Presentations given at that session form the backbone of this chapter. Some of the recent data concerning HIV and migration are reviewed, and the key challenges of responding substantively to the issue are discussed. Case studies from Uganda and Thailand are used to illustrate migrant risk and vulnerability.

**DATA CONCERNING HIV, AIDS AND POPULATION MOBILITY**

As our understanding of HIV and AIDS increases, so does our understanding of the complex and circular relationship between HIV and population mobility. At the beginning of the epidemic before human immunodeficiency virus is prevalent, and in countries or regions with adequate epidemiological monitoring, the first cases of HIV can sometimes be traced to individuals or groups passing through, such as truck drivers, people displaced by conflict, military personnel, or returning migrant workers. But, HIV is now present in every country of the world. At later stages in the epidemic, when HIV is already entrenched in a particular area, migrants, refugees, internally displaced people (IDPs) and individuals in transit for professional or other reasons may find themselves in situations where they are at increased risk of becoming infected with the virus, and thus becoming vehicles of its further spread.

**THE RELATIONSHIP BETWEEN POPULATION MOBILITY AND HIV**

Work undertaken at Erasmus University in the Netherlands uses country data from demographic and health surveys to plot the correlation between the proportion of recent immigrants in urban populations and the urban HIV prevalence in Africa using sentinel surveillance data (Voeten et al., 2004). Graph 20.1 shows HIV prevalence among pregnant women by the proportion of female urban residents aged 15 to 49, who moved to their current location during the last 12 months, by country and by region, for 26 Sub-Saharan African countries. It clearly shows that, overall the higher the proportion of immigrants, the higher the HIV prevalence. For example, HIV prevalence among pregnant women was negligible in Senegal, where demographic surveys showed that less than 3% of
women had recently moved to their current home, but far higher in Malawi where more than 20% had done so.

The data shown in Graph 20.1 is gross, but intriguing. Another recent study examines in more depth the relationship between mobility, sexual behaviour and HIV infection in an urban population in Yaoundé, Cameroon. Among a representative sample of 1,913 urban residents, an HIV prevalence of 7.6 per cent was found among men who had been away from home for periods longer than 31 days during the previous year; 3.4 per cent among men who had been away for less than 31 days, but only 1.4 per cent among those who had not been away from home in the previous year. The association between men’s mobility and HIV remained significant after controlling for other important variables, and was related to risky sexual behaviour (Lydié et al., 2004). However, there was no correlation between women’s mobility and HIV infection, a finding that needs to be explored in other populations.

LABOUR MIGRATION

For labour migrants, some information on HIV is available, in part because a number of countries, particularly in Asia, systematically require HIV tests for departing, and occasionally also for returning migrants. In the Philippines, as of July 2004, the National AIDS Council estimates that 32 per cent of the 2,073 Filipinos infected with the virus were overseas workers (Philippines Social and Environmental News, July 14, 2004). In Bangladesh, the figure for returning migrants is around 41 per cent. In both instances, the high prevalence of HIV

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**GRAPH 20.1**

**HIV PREVALENCE AMONG PREGNANT WOMEN, BY PROPORTION OF NEW IMMIGRANTS, 26 SUB-SAHARA AFRICAN COUNTRIES**

Source: Voeten et al., 2004.
among migrants may be simply because migrant workers undergo more HIV tests than non-migrants.

Several studies from Asia show that migrant women are particularly affected. In Indonesia, a support group reported that as of April 2003, 15 of the 24 individuals who had recently tested HIV positive in Banyuwangi, East Java, were women. Most were migrant domestic workers and sex workers. The migrant domestic workers had been infected during employment in Taiwan and Hong Kong, some apparently through sexual contact with their employers or their employers’ sons.

Reports from several developed countries show that non-nationals are disproportionately affected by HIV and AIDS. In Japan, by the end of 2002 non-nationals accounted for 33 per cent of HIV cases and 72 per cent of the females infected with HIV, remarkably high rates in proportion to the 2 per cent foreign population in Japan (Japan Center for International Exchange, 2004). Several West European countries, e.g. Belgium, Norway, the UK and Switzerland, have been reporting for years that migrants were missing out on HIV prevention efforts, because they either find the efforts targeted at the ‘general populations’ in these countries inappropriate, or irrelevant, or because they fail to understand the relevant messages in a foreign language, and with foreign images.

When local counselling and testing facilities, and health services, fail to reach out to people of a different language and culture, these normally discover their HIV infection status later, and fail to receive early treatment (Haour-Knipe, 2000). More recently, several European countries have seen an increase in infections reported among people coming from countries with generalized epidemics, predominantly Sub-Saharan Africa (UNAIDS, 2004a), many of whom were unaware that they were infected. It is difficult to ascertain whether they arrived already infected, or became infected once in the destination countries.

It is frequently assumed that migrant men acquire HIV while away from home, and transmit the virus to their wives or partners on return. However, this assumption is being challenged by recent studies in South Africa (Lurie et al., 2003, Lurie, 2004). In a region with an advanced AIDS epidemic (at the end of 2003, South Africa reported HIV prevalence of 21.5 per cent (UNAIDS, 2004a)), studies of couples with only one infected partner revealed a surprising number where only the woman was HIV positive. The reasons have not yet been determined, but could be related to the fact that only about half of the migrant men sent money back home to their families, leaving their partners with little choice but to sell sex in order to support their families. Clearly, more research is needed to understand women’s vulnerability, as both migrants and partners of migrant men.

THE INTERRELATIONSHIP BETWEEN HIV, AIDS AND CONFLICT

Increasing attention has recently been given to the relationship between HIV and conflict situations. There are several well known ways in which armed conflict can increase the risk of exposure to HIV infection, including disruption of traditional sexual norms when population displacement occurs in chaotic circumstances, and conditions of severe deprivation for women and girls, who may be coerced into exchanging sex for money, food or protection. The presence of large numbers of armed men in or out of uniform is often accompanied by the creation of a sex industry in the affected area, increasing the risk of HIV infection for both the sex workers and the men. Recourse to rape as a weapon or means of subjugation also multiplies the risk of HIV. In Rwanda, 17 per cent of the women who had been raped tested HIV positive, compared with 11 per cent of women who had not been raped (Spiegel, 2004).

7. Reported in the Suara Pemberuan daily, a support magazine published by the NGO Yayasan Pelita Ilmu (Fernandez, 2004).
Other risks are the result of collapsing health systems, including the breakdown of HIV prevention and care programmes, and safe blood transfusion systems. During the war in Sierra Leone, epidemiological surveillance in antenatal clinics showed that HIV prevalence rose from 4 to 7 per cent between 1995 and 1997, and that 11 per cent of the peacekeepers returning home to Nigeria from Sierra Leone were HIV positive - more than double the prevailing rate in Nigeria at the time (UNAIDS, 2004).

However, the interface between HIV and conflict is not a simple or uniform one. The factors that can increase HIV risk during conflicts are sketched in Textbox 20.1. Those that may decrease HIV transmission in such situations have received less attention. They include such structural factors as reduced mobility and accessibility (e.g. destroyed infrastructure reducing travel to high prevalence urban areas, displacement to remote locations) and, in the case of long-term post-emergency refugee camps, the possibility of improved protection, health, education, and social services. Key factors to be considered include HIV prevalence in affected communities prior to conflict, HIV prevalence in communities surrounding displaced populations, exposure to violence during conflict and flight, and the interaction between displaced persons and local communities (see Figure 20.2).

It is often assumed that because of the HIV vulnerability associated with conflict, refugees must have a higher rate of HIV prevalence than the surrounding host population, and that they exacerbate the epidemic. Recent studies by UNHCR are challenging this assumption, showing that globally people seeking asylum tend to move from countries of lower HIV prevalence to countries of higher prevalence. In Africa and in Europe especially, countries of asylum report levels of HIV prevalence higher than those that had prevailed in countries of origin (Spiegel, 2004). A study carried out after the war in Sierra Leone in 2002 found that HIV infection levels were much lower (1-4%) than those documented during the conflict (Kaiser et al., 2002). Similarly, although Bosnia and Herzegovina was a war zone from 1992 to 1995, the country has continued to record very low HIV prevalence (0.0003% of the population in 2001) (UNAIDS, 2004a). The same appears to be true for Angola and southern Sudan.

Studies of HIV prevalence among pregnant women recently carried out in more than 20 refugee camps

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**Figure 20.2**

**HIV Risk Factors: Conflict and Displaced Persons**

<table>
<thead>
<tr>
<th>Key Factors</th>
<th>Increased Risk</th>
<th>Decreased Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Area of origin HIV prevalence</td>
<td>● Gender violence/transactional sex</td>
<td>● Reduced mobility</td>
</tr>
<tr>
<td>● Surrounding host pop. HIV prevalence</td>
<td>● Reduction in resources and services (e.g. health, education, community services, protection, food)</td>
<td>● Reduced accessibility</td>
</tr>
<tr>
<td>● Length of time: conflict, existence of camp</td>
<td></td>
<td>● Slower urbanisation</td>
</tr>
</tbody>
</table>

**Source:** Spiegel, 2004.

10. In countries with more than 10,000 refugees, and for Africa in 2003, overall HIV prevalence was about 5.5 per cent in countries of asylum, compared with rates of just over 4 per cent in countries of origin. Figures for Europe are about one half of one per cent for countries of asylum compared to less than a quarter of one percent for the refugees’ countries of origin.

housing some 800,000 refugees in Kenya, Rwanda, Sudan and Tanzania show that three of the four countries’ refugee populations had significantly lower HIV prevalence than the surrounding host communities. Depending on their level of interaction and behaviour, refugees living for many years among a host population with higher HIV prevalence may become infected. When repatriation occurs, returning refugees may have a higher HIV prevalence than those who did not leave the country of origin; but they may have better HIV/AIDS knowledge and more consistently engage in protective behaviour than those who stayed. This appears to be the case in Angola (Spiegel and De Jong, 2003).

These counter-intuitive and paradoxical findings concerning HIV and conflict are important, as they go beyond myths and stereotypes to help increase understanding of the complex dynamics behind vulnerability. Most importantly, they point to areas where populations are liable to move between areas of different HIV prevalence, and where it will make a difference to intervene with prevention and care.

Uganda was one of the first countries to be affected by AIDS, but has managed to reduce its HIV prevalence from 18 per cent in 1990 to 6.2 per cent in 2003. It is often cited as an example of sustained success in addressing HIV and AIDS (UNAIDS, 2004). The government first established a National Committee for the Prevention of AIDS in 1985, and since then has pursued and strengthened policies to integrate HIV and AIDS awareness, counselling, treatment and prevention into all its activities. It has given strong political leadership on reducing the stigma attached to HIV and AIDS.

The right to state-provided health services is enshrined in the 1995 Constitution of the Republic of Uganda and, as of June 2004, free ARV treatment is becoming progressively available to those who need it. At the Bangkok AIDS conference, the Honourable Christine Amongin Aporu, State Minister for Disaster Preparedness and Refugees in Uganda, pointed out, however, that the country had not yet adequately integrated mobile and displaced populations into its HIV/AIDS strategies and programmes.

As of April 2004, Uganda, with a population of 26 million, counted almost two million refugees and IDPs, including over 1.6 million people displaced by the Lord’s Resistance Army in north and northeastern Uganda, most of them women and children. Every evening some 44,000 children and youth leave their homes to seek safety in the towns for the night. The risks for such young IDPs are very high. They include psychological and physical trauma, hopelessness, stigmatization and lack of education when schools close and teachers flee to safer locations. HIV-related risks include rape, as well as the necessity to sell sex in exchange for food or protection. Contraceptive use is limited, fertility rates are high, and the likelihood that HIV will be transmitted from mother to child is also high as appropriate care is lacking.

The impediments to AIDS prevention in such circumstances are manifold; starting with the prioritization of immediate basic needs, that pushes AIDS to a distant level of priority. As the situation continues, poverty and chronic insecurity give rise to hopelessness and demoralization, making it less likely for IDPs to take up opportunities to receive counselling. Such opportunities can also be hampered by the difficulty of establishing programmes in insecure areas, or maintaining health units when health workers flee, and impassable roads that make the effective use of mobile clinics impossible. Funds to finance HIV and AIDS activities in refugee settlements and IDP camps are lacking, and the cost of HIV and AIDS treatment is prohibitive. Even gathering the evidence on which to base programmes may be difficult, since data regarding HIV and AIDS in camps is unreliable as IDPs frequently move on in search of safety.

12. For example, prevalence was estimated to be 5 per cent among the 80,000 refugees in Kakuma camp in northwest Kenya in 2002, compared to 18 per cent in the surrounding Lodwar district. Among the 120,000 refugees in the Dadaab camp on the opposite side of the country, HIV prevalence was estimated at 0.6 per cent in 2003, compared with 4 per cent in neighbouring Garissa in 2002 (Spiegel, 2004).
TEXTBOX 20.1  

HIV/AIDS IN UGANDA

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KEY CHALLENGES

Key challenges to addressing HIV and AIDS within the context of migration include inadequate and inappropriate attention, stigma and discrimination, and the lack of access to prevention, care and support available to migrants.

INADEQUATE ATTENTION TO HIV/AIDS AND MIGRATION

The last few years have seen a massive increase in donor funding of HIV and AIDS initiatives. Bilateral aid has risen from USD 822 million in 2000 to USD 1.35 billion in 2002, a 64 per cent increase over three years, while multilateral aid rose from USD 314 million to USD 460 million during the same period. Contributions to the Global Fund to Fight AIDS, TB and Malaria reached USD 917 million by the end of 2002 (UNAIDS, 2004b). Encouraging as this may seem, it must be seen against other efforts taking place – or not taking place – to reduce the global inequalities that fuel the epidemic. For example, the cost of debt servicing in developing countries clearly affects the amount of money available for health and social services: Zambia, for instance, a country with almost one million HIV-positive people, spends 30 per cent more on servicing
its debt than on health.\textsuperscript{13} Cameroon spends 3.5 times as much on debt repayment as on health, and Mali spends 1.6 times as much (Oxfam, 2002).\textsuperscript{14}

HIV rates continue to rise, and total funding is still far short of what is needed to combat the epidemic. UNAIDS recently estimated that the USD 4.7 billion committed to HIV and AIDS in 2003 would need to be doubled by 2005 to fund treatment and prevention programmes. The need will double again by 2007 (UNAIDS, 2004). Given the shortfall, efforts are being made to ensure efficient use of resources and improved coordination among donors: a recent encouraging development has been widespread support for the ‘three ones’ approach at country level. Key principles of the “three ones” are one agreed HIV/AIDS action framework, one national AIDS coordinating authority, and one country-level monitoring and evaluation system (ibid).

But Michael O’Dwyer, Senior Health and Population Adviser, DFID Southeast Asia, questions to what extent, if any, these rapidly growing resources are being used to address the needs of mobile and displaced populations. At the Bangkok AIDS conference, O’Dwyer pointed out that the coordinated ‘three ones’ approaches will not meet the needs of migrant populations, unless the needs are explicitly addressed in a national strategy and action framework. Precisely this is lacking: countries’ resources have been allocated to nationals, neglecting people just passing through. Although the Declaration of Commitment by the UN General Assembly requires countries ‘By 2005, (to) develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programs for migrants and mobile workers, including the provision of information on health and social services’,\textsuperscript{15} by 2003 fewer than half had done so. Only 47 per cent of the states responding to the Secretary General’s survey reported having an HIV prevention policy for cross-border migrants (UNAIDS, 2004a). In countries such as Malaysia, migrant workers do not feature in the National HIV/AIDS Strategic Plan, although more than 20 per cent of the population comprises migrants. The situation is similar for refugees.\textsuperscript{16}

Cynthia Maung, Director of the Mae Tao Clinic, Mae Sot, Thailand, and recipient of the 1999 Jonathan Mann Award for health and human rights, brought these observations into vivid perspective at the XV AIDS conference in her discussion of the particularly marginal condition of internally displaced populations and migrant communities in Thailand, another country cited as successfully addressing AIDS. Approximately two million migrant workers from Cambodia, Laos and Myanmar live in Thailand. Most are not registered by the government and thus have no access to the Thai public health system. Such populations are overlooked in national HIV surveillance.

The HIV epidemics in China and India are expanding, but the regions bordering Myanmar face the worst localized epidemics in both countries, and Burmese communities on the Thai-Myanmar border also face a generalized epidemic.\textsuperscript{17} The neighbouring countries of Thailand and Cambodia have reversed their HIV epidemics over the past decade through major investment in prevention strategies, in particular condom promotion, but there has been little effort to address the HIV and AIDS-related needs of communities on the other side of the borders. Lack of access to the Thai public health system hinders the communities’ ability to address such public health and social issues as

\begin{itemize}
\item \textsuperscript{13} In 2004 the proportion of government revenue absorbed by debt was expected to rise to 32 per cent (Oxfam, 2002; World Bank/IMF/IDA, 2003, cited in UNAIDS 2004, p. 148).
\item \textsuperscript{14} Along similar lines, Kenya spends USD 0.76 per capita on AIDS, and USD12.92 per capita on debt repayments (Kimalu, 2002, cited in UNAIDS 2004, p. 148); and the first 14 countries identified as key recipients of the United States President’s Emergency Plan for AIDS Relief together spent USD 9.1 billion in servicing their debt in 2001 (Ogden and Esim, 2003, cited in UNAIDS 2004, p. 148).
\item \textsuperscript{15} Para. 50, United Nations General Assembly. Declaration of Commitment on HIV/AIDS. UN, 2001.
\item \textsuperscript{16} Of the 29 countries in Africa with more than 10,000 refugees, UNHCR has been able to review 22 National HIV/AIDS Strategic Plans. While 14 mention refugees, 8 fail to do so. Of those that do mention refugees, 4 fail to list the specific activities planned (Spiegel and Nankoe, 2004).
\item \textsuperscript{17} For example, the Mae Sot clinic, which provides antenatal services to over 2,000 people from Myanmar per year, has noted a rise in HIV prevalence among pregnant women from 0.8 per cent in 1999 to 1.5 per cent in 2004. Data from the clinic’s blood donor programme show a similar trend, reaching 1.6 per cent in 2004.
\end{itemize}
drug and alcohol abuse, gender-based violence, teenage pregnancy and unsafe abortions. When services are available, language barriers, fear of police, lack of transportation and the negative attitudes of health workers and employers can still pose significant barriers. Migrants often delay the decision to seek health care, leaving minor illnesses untreated until they become severe enough to require emergency care.

Maung pointed out that services for voluntary HIV counselling and testing for migrant workers are lacking within the Thai public health system. Grass-roots health organizations have recently begun to offer such services, but interest remains low because of community stigmatization, and the few options available for treatment. There is little job security, and migrants fear they may lose their positions if found to be HIV positive. In addition, although many of the Burmese fled their country for political reasons, they are not systematically recognized as refugees, but considered ‘illegal migrant workers’. This means the host government cannot recognize the grass-roots organizations that serve them: for example, the ‘back­pack’ health teams working with the Mae Tao Clinic have no official status, and their training certificates are not recognized.

The long-term consequences of such marginalization are potentially grave: denied official status, the children of such unrecognized populations face the same barriers to health and education - cycles of vulnerability thus continue when the status of migrants is linked to access to health services and to education.

**INAPPROPRIATE PUBLIC ATTENTION TO AIDS AND MIGRATION**

It is rare in any country to find recognition of the wide range of migration issues within the HIV and AIDS discourse, in particular recognition of the ways in which migration can be an integral part of poverty alleviation and international development. Instead, there is a widespread perception that migrants consume more than their share of limited resources and contribute disproportionately to the spread of diseases. A number of factors contribute to this perception, including governments’ lack of capacity to carry out the epidemiological analysis that can put HIV prevalence in perspective, and unwillingness to devote scarce resources to meet the needs of ‘alien’ populations.

The Bangkok AIDS conference symposium on migration stressed that stigma can be a major handicap to addressing AIDS and migration. In the words of Irene Fernandez, Chair of CARAM-Asia and recipient of the 2002 Jonathan Mann Award for health and human rights: “Migrants are seen as aliens or outsiders, as people who do not belong to our community or nation. Political leaders refer to them as ‘illegals’. There is no such thing as an illegal human being on earth, but we have drawn our territorial boundaries according to countries, and the right to stay is determined by fulfilling conditions established by the countries.”

Fernandez pointed out that the media in many countries often portray migrants as responsible for an increase in crime rates or diseases in the country - especially of communicable diseases. She noted that the Malaysian government, among others, carries out raids at entertainment centres, during which foreign women are arrested and detained. The result is not only stigmatization of foreign women but also arbitrary arrest, detention and deportation. Stigma and discrimination have long been recognized as a constraint to identifying the people who need prevention, care or treatment services in the first place, and to gaining access to such services thereafter. It was noted that stigmatization and discrimination against migrants are pervasive, including among health workers.

The speakers also pointed out that governments have often dealt with the issue of AIDS and migration by imposing requirements for HIV testing of immigrants. CARAM-Asia noted that many receiving countries in Southeast and Northeast Asia, as well as in the Middle East, require overseas semi-skilled and unskilled migrant workers to undergo testing for HIV and other infectious diseases. CARAM noted that such testing is often carried out with a patent disregard for good practice, including informed consent and pre- and post-test counselling.
CONCLUSION

This chapter has explored the relationship between HIV/AIDS and migration, in particular those factors driving migration that can also increase migrants’ vulnerability to HIV, such as human rights abuses, economic deprivation, social inequality and socio-economic instability.18 It has shown how mobile persons can become vulnerable to HIV through the migration process itself, and that this can be gender-differentiated. Women may well be vulnerable as migrants and as partners of migrants, but can also become vulnerable when their partners have migrated. There is need for wider research on the situation of women migrants.

The complex relationship between conflict and HIV/AIDS has been illustrated by a case study from Uganda. Recent evidence shows that in some situations, and for reasons about which one can only hypothesize at this stage, populations isolated in regions of protracted conflict may actually be protected from HIV.

Government policies on HIV and AIDS have to date given limited attention to migrants.19 In some receiving countries migrants lack access to health and social services; they may fear host country authorities, including health authorities, and often suffer from discrimination by employers, police, social services and a wide range of others, including health workers. Some key challenges in this regard are discussed in the context of Burmese migrants in Thailand.

The chapter describes AIDS as a long and slow event, hard to perceive or measure other than in retrospect (Barnett and Whiteside, 2002), thus highlighting the need to plan and react long before the full effects become apparent. Some of this planning should focus on the larger global problems, such as reducing economic imbalances, or shifting expenditure from debt servicing to public health, fostering the poverty alleviation effects of migration, and preventing and resolving conflicts. A first direct policy priority is to ensure that migration is included in national AIDS Strategic Plans and proposals to funding institutions such as the Global Fund to Fight AIDS, TB and Malaria. HIV and AIDS issues should also be factored into migration policymaking and actions to address the consequences of natural disasters, conflict, development or any other actions or events that cause population movement.

Related to this is the need to improve the evidence base by gathering HIV and AIDS epidemiological data that take account of migration, analysing social and economic factors that increase HIV vulnerability and transmission, qualitative research around some of the surprising findings presented in this discussion, and comprehensive reviews that will feed policy formulation.

Effective prevention policies begin with an assessment of who should best be targeted. For example, although women are especially vulnerable in this area, it would be unfair and inappropriate to place sole responsibility for AIDS prevention on them. Clearly, men should also be engaged. A basic policy dilemma in AIDS prevention is whether to focus on populations seen to be particularly at risk, or to expand the focus to others. The chapter gives some policy guidance on this: HIV risks created by mobility concern not only those who are mobile, but also surrounding communities and communities of origin. AIDS prevention efforts should thus address all affected parties on the migration continuum.

Another key policy challenge is how to address the ‘double stigma’ of the disease and the ‘foreignness’ of migrants. International efforts to reduce the stigma

18. Among the many themes the chapter was unable to cover is the migration of health workers. Critically important to efforts led by WHO to assure that 3 million people in developing countries are on antiretroviral therapy by the year 2005 is the availability of health personnel to correctly administer and monitor such treatment. One way to ensure such availability would be to reverse the loss of health personnel from developing countries, recruited to work in developed countries, or in the private sector in their own countries. See also the chapters “Investing in Migration Health” and “Balancing the Benefits and Costs of Skilled Migration in the Asia-Pacific Region”.

19. This is true even of those governments with reportedly successful HIV and AIDS policies, such as Uganda and Thailand.
related to HIV and AIDS provide some useful lessons, among them that interventions for AIDS prevention must be rights-based, i.e. based on the principle that the right to information and protection applies to all. This can help reduce the stigmatization of particular individuals or groups for ‘spreading AIDS’. It can also increase empowerment, self-esteem and confidence in health systems, leading more people to seek and receive information on HIV prevention, as well as counselling and care.

Active outreach with HIV and AIDS prevention information is important, but policy changes to reduce risk and vulnerability in the first place are even more important. Such changes may include straightforward measures to protect the safety of women and girls in refugee camps, or more complex ones such as modifying policies concerning single sex labour migration, improving access to education and housing, and supporting income generation. More fundamentally, they could address the root causes of risk and vulnerability, or help control the ‘worst forms’ of migration – such as trafficking and forced migration – that create situations where individuals are highly vulnerable to acquiring HIV, and unable to adopt safe behaviours.

One policy option that attracts expert consensus concerns blocking the virus from entering a country by barring access to people who are HIV-infected: WHO and UNAIDS have strongly advised in a number of UN fora and documents that HIV/AIDS-related travel restrictions have no public health justification.20 The potential health consequences of purely control-oriented approaches are negative: they are highly unlikely to effectively exclude all HIV-infected travellers, they undermine public health efforts at HIV prevention and care by driving people underground where their clandestine status excludes them from accessing services, they encourage nationals to see HIV and AIDS as ‘foreign problems’, and they divert funds that could more efficiently be allocated to prevention and care programmes.

Finally, there is the critical issue of migrant access to care and treatment for HIV. World economic imbalances and inequalities create differences in access to ARV therapy, which means that death rates for HIV-infected adults in low- and middle-income countries are now up to 20 times higher than in industrialized countries. The reasons for addressing inequalities between developed and developing countries may well be ethical, but they are also practical. With easy access to information, it would be natural for those who can do so to migrate in search of the life-saving treatment they know is available elsewhere.

Migration to developed countries for access to care is a poor solution, since it can add to xenophobia, as migrants are seen as a burden on health resources. In developing countries, it can perpetuate inequalities, since it is beyond the means of most people requiring treatment. From a public health perspective such migration is even potentially dangerous, as migrants without regular status are likely to receive non-mainstream treatment that is irregular, inadequate and haphazard, ultimately leading to new strains of HIV that become resistant to ARV. These new pathogens will in turn travel, affecting more people in other places. Mobile populations, including refugees, must be included in strategies to make HIV and AIDS treatment available globally. In the words of the authors cited at the beginning of this chapter, “Health and well-being are not individual concerns: they are global issues... [they] are human rights; they are also public goods... like the road networks, clean air and clean water...(…). President Franklin Roosevelt said: “We have always known that heedless self-interest was bad morals; we now know that it is also bad economics.”21