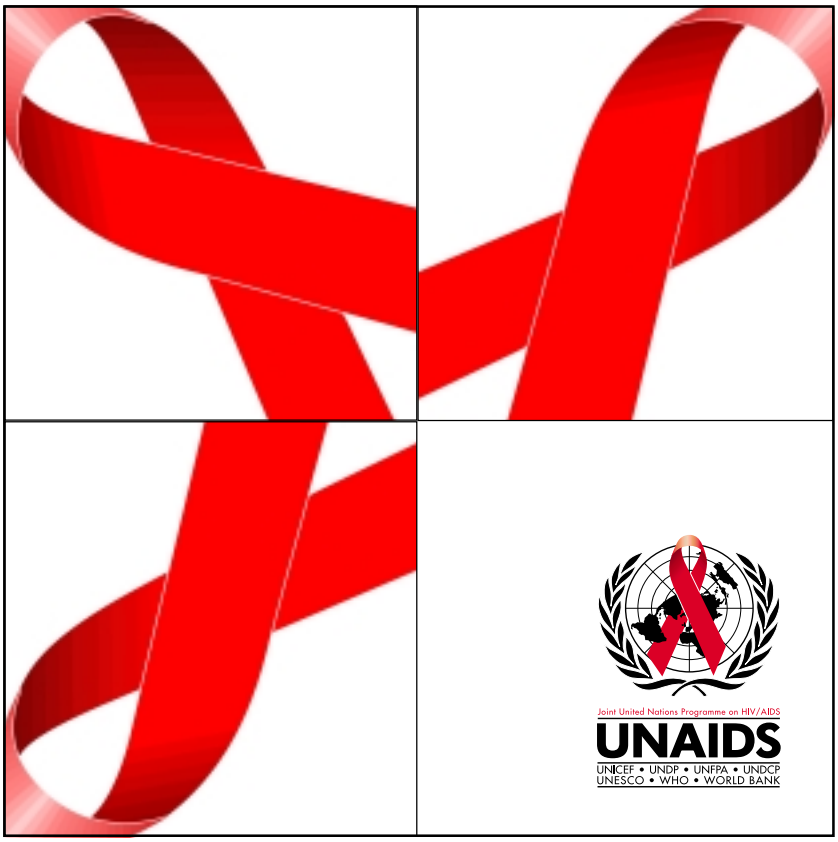
Population Mobility and AIDS



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At a Glance

Migration, mobility, and HIV/AIDS are major global phenomena at the beginning of the new millennium. Since the start of the HIV/AIDS epidemic, a concern of governments has been that people moving between countries might be spreading HIV. Today, however, there is increasing recognition that migrants and mobile people may be more vulnerable to HIV/AIDS than are populations that do not move. They may acquire HIV while on the move, and take the infection back with them when they return home, often without even knowing it. They also face greater obstacles in accessing care and support if living with HIV or AIDS.

Given the millions of migrants and mobile people in today's world, there is an urgent need for responses that address their particular vulnerabilities to HIV/AIDS. Such responses are critical to the effectiveness of national AIDS programmes in the many countries that experience significant migration and population mobility. They are also critical to the effectiveness of regional and international efforts to combat HIV/AIDS.

Responses for migrants and mobile people must address HIV/AIDS prevention, care and support throughout their journey – before they leave, as they travel, in communities and countries where they stay, and after they return home. These responses must be based on the social and contextual realities faced by migrants and mobile people and should be part of an empowerment that improves their legal, social, economic, and health status.

At a glance: suggested action for migrants and mobile people

- Put migrants and mobile people into HIV/AIDS strategic planning, and into national and community AIDS plans.
- Establish culturally and linguistically appropriate outreach in HIV/AIDS programmes targeted to migrants and mobile people. Establish peer counselling.
- Support associations of migrants, and help them integrate HIV/AIDS into their work.
- Focus HIV/AIDS prevention efforts in zones where there is increased likelihood that risk behaviours will occur and HIV will be encountered, e.g. truck stops, bus and train stations, harbours, markets.
- Implement programmes that cross national borders.
- Develop and implement pre-departure briefings, post-arrival and reintegration programmes, and use the experience of those going back and forth across borders.
- Improve the legal status of, and legal support for, migrants and mobile people and their families.
- Work with those who employ migrants to improve their living and health conditions.
- Make local health care facilities more accessible and 'user-friendly' to migrants and mobile people.
- Conduct operational research on the links between migration, mobility and HIV/AIDS.

This document was prepared in collaboration with the International Organization for Migration

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Background

Who are migrants and mobile people?

Some 150 million migrants currently live - and often work - outside their country of citizenship, and between two and four million people migrate permanently each year[1]. A small but significant percentage of people who move across borders have been forced to seek refuge outside their countries of origin: at the end of 1999 over fifteen million people were refugees and asylum-seekers[2]. Hundreds of millions more people move within their countries each year. Of these, some 20 to 30 million have been displaced because of wars, ethnic tensions, and human rights abuse[3]. Others move within countries in order to seek employment, to seek better living or working conditions, to seek markets or education, or to join family members. This document addresses the response to HIV/AIDS for migrant and mobile people. In doing so, it focuses on a wide range of situations. **Mobile people** can be described broadly as **people who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons**[5]. Key employment groups involving mobility include truckers, seafarers, transport workers, agricultural workers, itinerant traders, mobile employees of large industries (e.g. mining, oil companies), and sex workers[6].

Migration and mobility have increased over the past several years, and are likely to continue to increase, because:

- Land and air transport is more readily available.
- Economic imbalances between communities push people to move in search of better lives or in order to survive. Media and communications widely disseminate images of places of opportunity and/or safety.
- Closed societies and borders have opened, e.g. in Eastern Europe and the Commonwealth of Independent States, South Africa, and in China and Southeast Asia.
- Wars and ethnic tensions displace thousands of people, as they did recently in the Balkans or in the Great Lakes region in Africa.
- 'Organized' migration, and trafficking, increasingly move people between countries[4].

Migrants are mobile people who **take up residence or who remain for an extended stay in a foreign country**. Women comprise some 47 per cent of migrants, and dominate migration in some regions. For example more than 60 per cent of migrants from Sri Lanka are now women, employed primarily in domestic service[7].

The process of migration and mobility

Migration and population mobility are not static phenomena. According to the International Organization for Migration they are best seen as a **process** with stages comprising:

- **source** – where people come from, why they leave, what relationships they maintain at home while they are away
- **transit** – the places people pass through, how they travel and how they maintain themselves while they travel
- **destination** – where people go, the attitudes they meet when they get there, and their living and working conditions in the new place
- **return** - the communities to which people return, their families, their resources or lack thereof.

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[1] *See Martin S, An Era of International Migration, World Migration Report, Geneva: International Organization for Migration, 2000.*

[2] *For statistics on refugees, see http://www.unhcr.ch/ (United Nations High Commissioner for Refugees)*

[3] *For statistics on internally displaced persons, see: http://www.idpproject.org/ (Norwegian Refugee Council)*

[4] *Such migration is 'organized' in the sense that private individuals organize the movement of people within and between countries for profit. This often involves exploitation, e.g. high prices, bribery, confiscation or destruction of documents, dangerous transportation, sexual exploitation. Trafficking of human beings for sex and/or slavery is also increasingly documented.*

[5] *Reasons may include family reunion, professional or economic opportunity, poverty, war, human rights abuse, ethnic tension, violence, famine, persecution, medical or health care needs. See also UNAIDS Technical Update, Refugees and AIDS, 1997.*

[6] *The military, including peace-keepers, can also be a mobile population. For more information on the military, see AIDS and the Military: UNAIDS Point of View, May 1998.*

[7] *Martin, International Organization for Migration, 2000.*

Background

Much population movement is **highly fluid,** with people moving back and forth through these stages frequently – often over a course of days, weeks or months. To be effective, HIV/AIDS responses must address the particular needs and vulnerabilities of mobile people at each stage of the mobility process.

Why migration, mobility and HIV/AIDS?

HIV/AIDS is also a well-established global phenomenon. More than 15 years after HIV was first identified, the virus is present in every region in the world. By the year 2000, it was estimated that almost 34 million people across the world were living with HIV.[8] More than 95% of these infections have occurred in developing countries, where poverty, poor education and health systems, and limited resources for prevention and care fuel the spread of the epidemic, and where economic hardship and violence displace large numbers of people.

Studies on certain highly mobile groups (e.g. truck drivers, itinerant traders of both sexes, military, seafarers) have identified travel or migration as a factor related to infection. In many countries, regions reporting higher seasonal and long-term mobility also have higher rates of HIV infection, and higher rates of infection can also be found along transport routes and in border regions[9]. In addition, epidemiological studies focusing on more stationary migrant populations in several countries show that non-nationals are disproportionately affected by HIV and AIDS[10].

Such studies indicate that migration and mobility increase vulnerability to HIV/AIDS – both for those who are mobile and for their partners back home. Given the large numbers of migrants and mobile people, this vulnerability has far-reaching and tragic consequences. Yet governments have not yet done enough to address HIV/AIDS among those who are mobile.

A response early in the epidemic was to try to keep HIV-positive people out of a country by laws that restrict their entry or stay. Some 60 countries have such restrictions, most of which are applied to long-stay visitors, seasonal workers, migrant workers, and foreign students[11]. However, according to the World Health Organization, UNAIDS and the Office of the High Commissioner for Human Rights, these restrictions have no public health justification[12]. Such restrictions may in fact increase migrants' vulnerability to HIV/AIDS by driving them underground and discouraging them from coming forward for prevention information, testing, counselling and support – in both source and destination countries.

There is an urgent need to develop and implement more effective responses to HIV/AIDS for migrants and mobile populations. Such responses should empower migrants and mobile people to protect themselves against infection, reduce onward transmission of HIV, and provide care and support. This document briefly describes both the challenges involved and some possible effective responses.

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[8] *See Report on the Global HIV/AIDS Epidemic, December 1999, and the Epidemic Update, June, 2000, available from UNAIDS, Geneva.*

[9] *For a review, see International migration, 36/4, 1998.*

[10] *See, for example: Anderson J, Melville R, Jeffries DJ et al. (1996) Ethnic differences in women with HIV infection in Britain and Ireland: the study group for the MRC collaborative study of HIV infection in women. AIDS 10, 89-93. And Savignoni A, Lot F, Pillonel J, Laporte A. Situation du Sida dans la population étrangère domiciliée en France, Paris: Institut de veille sanitaire, Avril 1999.*

[11] *Lists and descriptions of HIV-related restrictions are kept, for example, by the Swiss Federal Department of Foreign Affairs (http://www.hivnet.ch), and the United States Department of State (http://travel.state.gov/HIVtestingregs.html).*

[12] *Global Programme on AIDS. Statement on Screening of International Travellers for Infection with Immunodeficiency Virus (WHO/GPA/INF/88.3), HIV/AIDS and Human Rights, International Guidelines, United Nations, New York and Geneva, 1998, HR/PUB/98/1.*

Being mobile in and of itself is not a risk factor for HIV/AIDS; it is the situations encountered and the behaviours possibly engaged in during mobility or migration that increase vulnerability and risk regarding HIV/AIDS.

Increased vulnerability

Migrants and mobile people may be highly marginalized while in transit, at destination, or on their return home. They may be subject to discrimination, xenophobia, exploitation and harassment, and have little or no legal or social protection in the host community. Such marginalisation increases vulnerability to HIV infection and also the difficulties of living with HIV/AIDS[13].

Migrants and mobile people may have little or no access to HIV information, health services, and means of AIDS prevention (condoms, treatment for sexually transmitted infections [STIs]). Cultural and linguistic barriers heighten their lack of access, as do unfamiliarity with the community, and the instability of mobility.

Migrants and mobile people may avoid attention from authorities, even if that attention is meant to provide health services, or to help improve their living conditions. They may also be uncomfortable and inexperienced in relating to the non-governmental or community-based organizations that might be there to help them.

Poverty and lack of resources may force those moving from one place to another to increase their risk of HIV by trading or selling unprotected sex for goods, services and cash in order to survive and/or continue their travel.

Migrants in some countries face the possibility of involuntary testing for HIV, and deportation, if found to be positive[14]. Their HIV status may be revealed to authorities in their destination or source countries, or to their communities and families. Such breaches of confidentiality give rise to stigma, discrimination and rejection. Deportation from a country in which advanced HIV care is available to one in which such care is not available may mean greater suffering and an earlier death.

The most vulnerable

The most vulnerable mobile people are refugees, those without legal status in the country in which they are living, and women.

Refugees and internally displaced people – People displaced by conflict and other emergencies live through chaotic conditions, during which HIV/AIDS is not likely to be seen as a priority. Yet HIV spreads fastest in conditions of poverty, powerlessness and social instability, the conditions that are at their extreme in complex emergencies. Physical, financial and social insecurity erode the caring and coping strategies of individuals and households. This often results in forced high-risk sexual behaviour and sexual abuse. Women and girls find themselves coerced into sex to gain access to basic needs such as food, shelter, and security, and are also especially vulnerable to rape[15].

Legal status – Whether a person is in a country legally or illegally has a powerful influence on his or her vulnerability to HIV/AIDS. Undocumented migrants live on the margin, trying to avoid contacts with authorities that may result in imprisonment and deportation. They have virtually no rights in the place where they live, including no legal access to social and health care services and to prevention and care for STIs and HIV/AIDS. They may be forced by their precarious circumstances into unsafe working conditions and accommodations, and be exploited for meagre wages. Women and children may also be subject to sexual violence, thereby increasing their risk of HIV and other STIs.

Women and girls – Employment opportunities are usually more limited for women migrants, who may find themselves confined to a parallel economy, working under inferior conditions, subject to discrimination both as women and as migrants, and unable to claim the rights that are their due. They may have very little or no access to reproductive health services. They may also have little or no bargaining power to prevent unwanted and unsafe sex during travel and at destination. Large numbers of women move

[13] *For a discussion of the link between marginalized populations, vulnerability and HIV, see Report on the Global HIV/AIDS epidemic, June, 2000, UNAIDS, Geneva.*

[14] *c.f. Verghis S. Promoting and protecting human rights to reduce the HIV vulnerability of migrant workers. UNDP (Editor). Population mobility in Asia: Implications for HIV/AIDS action programmes. Bangkok: UNDP, 2000, p. 87-103.*

[15] *Piot P. HIV/AIDS in complex emergencies – a call for action. World Health Organization, Health in Emergencies, 7 (September 2000).*

to take up work as domestic employees. Often their rights are not respected, nor are they protected by local laws or customs. They may be sexually exploited by their employers. Some women migrate to take up occupations that involve increased risk of encountering HIV, such as sex work[16]. Other women and girls (and boys as well) are deceived, coerced or trafficked into sex work[17]. Still other women end up in precarious and vulnerable situations after they have entered countries clandestinely to join husbands or partners who had migrated. Finally, some women become vulnerable without ever having left their homes when their partner has gone abroad to work, and comes home with HIV[18].

Increased risk-taking

Migrants and mobile people are exposed to unique pressures, constraints, and living environments. Many are separated from their families and spouses or regular partners. They may feel anonymous. They may also feel freed from the social norms that guided their behaviour in their family, community and culture. Lonely people away from home may be especially susceptible to peer pressure. These factors may provoke people to take risks and engage in behaviours they would not have engaged in at home.

In some settings, living and recreational environments for migrants and mobile workers are almost exclusively male. This leads to the development of commercial sex services and the pressure to use them. It may also lead to increased sex among men.

> *'If you wanted to spread a sexually transmitted disease, you'd take thousands of young men away from their families, isolate them in single-sex hostels, and give them easy access to alcohol and commercial sex. Then, to spread the disease around the country, you'd send them home every once in a while to their wives and girlfriends.'* [19]

Lack of attention and resources

Financial, human and institutional resources in many countries are extremely limited for HIV/AIDS prevention and care programs. The resources that *are* available are most often targeted to local populations, with little or no resources going to the needs of migrants and people moving through the community.

The projects on HIV/AIDS and mobility established in some developing countries by international agencies and non-governmental organizations (NGOs) have generally been limited in social and geographical coverage, and also in time.

Few national AIDS plans deal with population mobility in ways that take into account its importance to the epidemic. The challenge is thus for governments to acknowledge the need to address HIV/AIDS among migrants and mobile people.

[16] *For more information on sex work see UNAIDS Technical Update on sex work.*

[17] *For examples of work being done with trafficked women and girls, see IOM website http://www.iom.int*

[18] *c.f. Salgado de Snyder V, Perez M and Maldonado M. AIDS - risk behaviors among rural Mexican women married to migrant workers in the United States, AIDS Education & Prevention, 8, 1996, 134-142.*

[19] *Quote by Mark Lurie, South Africa Medical Research Council, speaking about mines in South Africa, in Schoofs M. All the Glitters: How HIV Caught Fire in South Africa, The Village Voice, 28 April-4 May, 1999.*

Responses

Responses to HIV/AIDS for migrants and mobile people start with creating an enabling environment. An enabling environment has three components:

- the ability to protect oneself by making informed choices and being supported in these choices
- specific prevention programmes grounded in the psychological, social and cultural constraints and opportunities of migrants and mobile people
- access to 'migrant/mobile-friendly' care and support for those living with HIV/AIDS.

Several strategies are necessary in order to establish such an environment. These involve:

'Migrant and mobile-friendly' interventions

A basic rule is that interventions for HIV/AIDS prevention and care for migrants and mobile people must be offered in the appropriate language and tailored to the cultural context of the target group. It is often possible to share materials and messages between source and destination communities. Members of the migrant or mobile community should be involved to help design and implement the interventions. Such community input will ensure that the interventions are relevant, and they will also help find ways to overcome barriers to HIV/AIDS prevention.

Effective approaches include making sure that condoms are available. Reproductive health services, including treatment for STIs, should also be made available. Culturally and linguistically appropriate HIV/AIDS information may be provided through media campaigns, street theatre, small group education sessions, and peer education. To ensure sustainability, intervention strategies should be linked to migrant associations, to local authorities, and to local NGOs. Links between sending and receiving communities should also be made.

Interventions should also address factors that may marginalize the migrant and mobile person. These would include poverty, discrimination, segregation and lack of legal status. They would also include mobility itself: special interventions must be designed for people who are more or less always 'on the move', such as itinerant traders, truckers, seafarers, or transport workers. Interventions for highly mobile populations involve outreach to individuals and groups, working with specially trained and highly flexible staff, use of mobile facilities, and working with local police and community authorities to increase access.

STI/HIV/AIDS Prevention along migration routes in West Africa

In 1998, USAID's regional project, Santé Familiale et Prévention du SIDA (Family Health and AIDS Prevention) initiated a cross-border initiative to address the issue of migration and AIDS in West Africa. Launched along the heavily travelled corridor between Abidjan in the Ivory Coast, and Ouagadougou in Burkina Faso, the initiative, called Prévention du SIDA sur les Axes Migratoires de l'Afrique de l'Ouest (PSAMAO), now spans four countries, including those with the highest rates of HIV prevalence in the region.

A host of complementary strategies are employed by Population Services International (PSI), the NGO which coordinates the project, from social marketing to mass media and interpersonal communication. Of particular interest is the use of peer-education among the target groups to convey adapted prevention messages. Truck drivers, sex workers and seasonal migrant workers in plantations are trained in STI/HIV/AIDS and communication techniques so that they can then organise small discussion groups with their peers. Topics covered include transmission and prevention methods, risk assessment and correct condom use. A question and answer period is featured at the end to allow the peer-educator to verify whether the information has been properly understood. One-on-one sessions are also conducted to allow the beneficiaries to ask more sensitive questions. On-going evaluations suggest that positive behavioural changes have taken place since the beginning of the interventions. Comparing data from studies conducted in Burkina Faso in 1997 and 2000, reported condom use among truckers during the last sex act with an occasional partner has increased from 69% to 90%. With a regular partner, the proportion went from 49% to 67%. Intention to use a condom in the future increased from 53% to 73% [20].

[20] *Devine J. Prévention du sida sur les axes migratoires de l'Afrique de l'ouest (PSAMAO). Paper presented at the Regional Workshop on Migration and HIV/AIDS in West and Central Africa. Bamako, Mali, 30 May – 1 June 2000. For more on this project, see the website of Population Services International : http://www.psi.org*

Responses

West Africa Initiative

The West Africa Initiative for a response to the HIV/AIDS epidemic has carried out research-action entitled '*Migration and AIDS*' in 5 African countries – Burkino Faso, Cote d'Ivoire, Mali, Niger and Senegal. This initiative has comprised a wide range of interventions in sites such as car stations, railway stations, trains, marketplaces, and neighbourhoods with a high concentration of migrants or mobile people. It has also utilized networks of mobile people, such as associations of migrants, of itinerant vendors, and of sex workers. Interventions often initially focus on a core, or nucleus, of a particular group in a particular area and expand outward, through trained contacts in the core, to other relevant groups for condom promotion and sensitization[21].

Focusing on risk zones

A promising approach is one that focuses not on groups or individuals, but on the sites or areas where risks may occur. This 'risk zone' approach targets interventions in places through which a large number of mobile people pass. Examples might be truck stops, autogares, train and bus stations, marketplaces, harbours, and customs zones. The advantage of the approach is to focus on more than one or two specific groups (such as truck drivers and sex workers), to cover everyone potentially at risk in the area (such as bar and hostel workers, traders, or simply local young people coming to where the excitement is).

Focusing on destination communities

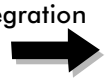
Some industries depend on workers who will migrate to a specific place for a term or season. Examples are agriculture, logging, mines and construction sites. The conditions in these destinations, and how these conditions may contribute to HIV/STI vulnerability, should be assessed and improved with the participation of private and public sectors, including relevant local NGOs and trade unions. Responses should take into account the needs of the local population, as well as the impact of in-migration on that population. In the best of cases interventions should benefit both migrant and local populations.

Another level of intervention is to work on policies that affect such migrant workers, such as that of single sex labour migration. Allowing migrant workers to live with their families if they so wished would reduce the HIV risks that occur when large numbers of lonely people live in single sex barracks. Living, working and health conditions can often be significantly influenced by the employer. For example, employers can ensure that decent housing is available, and that there is access to basic health care services, including HIV prevention and care services and condoms.

The Mothusimpilo Project

The Mothusimpilo project has been running since the beginning of 1998 in Carletonville, South Africa, the biggest gold mining complex in the world. The gold mines in Carletonville employ about 70,000 men who migrate to the mines from rural areas within South Africa and the surrounding countries. They live in single sex hostels, without their wives or families. Women are drawn to Carletonville from many countries in the region to make a living selling sex and alcohol.

Data collected early in the project showed very high rates not only of HIV infection but also of curable STIs including syphilis, gonorrhoea and chlamydia – among mineworkers and sex workers, but also among young women in the communities surrounding the mines. Drawing on the experiences of other projects, particularly those in Southern Africa, the organizers of the Mothusimpilo project implemented a community based intervention focusing on ensuring good treatment of STIs, peer education and condom distribution. From the beginning the project was fully integrated into the local health care systems provided by the mines, the state, private practitioners and traditional healers. Such integration



[21] *For full discussion, see UNAIDS Inter-country Team for West and Central Africa, Findings of the Research-Action 'Migration and AIDS' Project, available from UNAIDS, Geneva and Abidjan, and from the World Bank, Washington.*

ensured that there was good coordination across all sectors involved in providing health care services. The project was also integrated with a local home-based care programme supported by the Provincial Department of Health. Much of the success of the project has been due to the way in which all stakeholders – the mines, the trades unions, scientific organizations, national, provincial and local governments, and most importantly a wide range of community organizations – have worked together to ensure effective implementation and to deal with the problems that have inevitably arisen[22].

Focusing on cross-border and regional responses

Migration - movement across borders - can involve even greater challenges with regard to HIV/AIDS interventions than does internal mobility. In the destination country such migration usually involves increased linguistic, cultural, and legal barriers. Migrant communities are usually segregated and marginalized.

Reintegration back to home countries may also be difficult, when migrants return to families and communities that have changed during their absence.

Creative cross-border approaches are ones that link opportunities in source and destination countries. They provide information on HIV prevention and care services to people moving between these countries. Such approaches may involve efforts between respective governments to establish and harmonize contacts, policies and programmes for migrant groups. They may also involve international and regional NGOs forming alliances across borders for certain groups, and/or the establishment of self-help and support associations efforts by migrant communities themselves on both sides of the border.

CARAM Asia

An interesting example of a cross-border response has evolved during the work of **CARAM (Coordination of Action Research on AIDS and Mobility)**. CARAM is a partnership of seven NGOs from Bangladesh, Cambodia, Indonesia, Malaysia, Philippines, Thailand and Vietnam. Here are some examples of cross-border approaches: CARAM Bangladesh carries out pre-departure briefing and training of migrant workers going to Malaysia. They rely on migrants who have already returned from working in Malaysia to help in the training. Women attending the sessions are given orientation on where they can go in Malaysia if they have difficulties. Upon arrival, CARAM Malaysia takes over handling their cases and offers them support in protecting their reproductive health. CARAM Malaysia encourages Bangladeshi migrants to participate in the post orientation programmes. CARAM Bangladesh, in turn, involves return migrants in reintegration programmes they carry out in Bangladesh.

There are similar exchanges between CARAM Cambodia and CARAM Vietnam regarding the many Vietnamese who go to Cambodia. This 'cyclical' use of the experience of mobile people, as well as the exchange of information in the network, makes the programmes effective [23].

[22] *For further information and a list of publications see the Mothusimpilo project website at www.csir.co.za/aidsproject.*

[23] *For more on the activities and research of CARAM, see the regular newsletter 'CARAM News' and: http://www.geocities.com/ResearchTriangle/Facility/7747.*

Responses

Some other important cross-border initiatives are being carried out by regional and international organisations.

The UN Regional Task Force on Mobile Populations and HIV Vulnerability

The UN regional Task Force on Mobile Populations and HIV Vulnerability, convened by the UNDP South East Asia HIV and Development Project, is composed of UN agencies, international NGOs, governmental AIDS authorities, and academic researchers active in AIDS mobility issues in South East Asia. It is currently involved in a number of projects.

In the Irrawaddy River Love Boat Project, for example, AIDS prevention activities are carried out from a boat making its way along a major river in Myanmar. Music and entertainment draw visitors during stops on shore. Condoms and information are distributed to the audience.

In another series of activities, rapid situation assessments have been carried out in order to develop action plans for seafarers and their source and host communities in Cambodia, Thailand and Vietnam. One study united researchers from CARE, Family Health International, The Thailand Business Coalition on AIDS, and World Vision Thailand to profile the maritime industry in the Port of Ranong in Thailand. The researchers were able to define a number of risk practices for HIV and for substance abuse. They also identified numerous opportunities for intervention, specific to different fishing industries, routes and type of vessel[24].

Mobilizing communities of migrants and mobile people

HIV/AIDS prevention and care activities are most effective when undertaken by those for whom they are intended. It is members of the target community who will best be able to assess their own particular vulnerabilities, and propose effective solutions. Experience shows that migrant communities, like any other communities, will contain individuals and associations willing to make significant contributions to prevent HIV/AIDS and to assure access to care among their own. Given the necessary tools and resources, community members can provide peer education – and support for behaviour change and health needs – that will be more effective than that coming from 'outsiders.' In collaboration with partners from host countries migrant communities can also mobilise to influence the policies that affect them.

African community lobbying in the United Kingdom

Among proposed policies concerning people seeking asylum in the United Kingdom are some that would be harmful to asylum seekers living with HIV.

Africans are the second largest group affected by HIV in the UK, after gay men. More than 80% of infected women are African, as are the vast majority of HIV-infected babies. Most of the Africans in the UK live in London, and it is in London that almost all African-sensitive HIV services have developed. These include clinical experience treating children, women, and heterosexual families, and also interpretation, advocacy, and support networks. Policies of dispersal of asylum seekers throughout the country mean that those with HIV may be settled far away from such appropriate treatment. Travelling to London for treatment causes administrative problems and extra stress. Another policy that causes difficulties is one of giving support in the form of food vouchers. Such vouchers can only be used in specified supermarkets, but culturally appropriate foods are not available in these stores.

Various groups within African communities in the UK have come together to lobby for change in such policies. For the past several years, and in partnership with local groups such as the Terrence Higgins Trust and the National AIDS Trust, the African HIV Policy Network has been gathering data to document problems, advocate, and lobby national authorities for policy change[25].

[24] *For a more complete description of task force membership, terms of reference, and activities, see http://www.hivundp.apdip.net*

[25] *Sesay M. Immigration Legislation, HIV and Migrant Communities: Insights from the African Experience in the UK. MoOrE218. XIII International AIDS Conference, Durban, South Africa, 9-14 July 2000.*

Increasing care and support

Much remains to be done to improve the situation of migrants and mobile people living with HIV and AIDS. In destination communities efforts should be made to increase legal and actual access to local HIV/AIDS health and support services. This may involve developing and implementing specialized health services for migrants and mobile people, or it may involve adapting existing health services. In either case services for people living with HIV/AIDS should address cultural and linguistic barriers, as well as barriers caused by mobility and lack of legal status.

Migrants and mobile people living with HIV who return home often do not know they are infected. People who are aware of their HIV status are in a better position to seek support and care, and also to further protect themselves and their partners. In reintegration and receiving programmes, returning migrants should thus be provided with HIV voluntary counselling and testing services[27]. If found to be HIV positive, they should be referred to available community HIV care and support. Efforts should also be made to protect those returning with HIV or with AIDS from stigma and discrimination. At a very minimum, confidentiality about HIV status on return should be strictly maintained. Associations of people living with HIV/AIDS and other community care and support efforts in countries of destination and of return should be encouraged to reach out to and include migrants and mobile people affected by HIV/AIDS.

Comprehension difficulties between doctors and patients

Even when mobile people have legal access to care in a community, many difficulties remain, as this description of the situation of Brazilians living with HIV/AIDS in London indicates: 'There are also those Brazilians whose access to health care stops short in the doctor's office. They may be handed a bag full of pills by a doctor who may be nice and kind, but they don't understand what s/he is talking about. They may understand all of the medicalized words that the doctor is using, but not their meaning. They may be so grateful to have the doctor's attention that they don't challenge his/her orders. They can be people filled with doubts and questions; people who don't know their rights, are full of fears, feel isolated, confused, stressed and have a whole range of problems that have a direct influence on the management of their health care, quality of life and treatment[26].

Improving laws and regulations

Human rights law and some international and regional laws protect the rights of migrants and mobile people. National and local laws may also contain protective provisions. However, national laws and regulations should be reviewed to ensure that the rights of migrants and mobile people are protected in the following areas:

- protection of family unity including the ability to bring spouses and children to the destination country
- legal access to local health care services
- protection against discrimination
- application of local labour protection to migrants and mobile populations, including minimum wage and the right to organize
- availability of legal process and legal support, including in the context of deportation
- protection of confidentiality of HIV status
- access to basic social security during transit and at destination
- ratification of the International Convention on the Protection of All Migrant Workers and Members of their Families, as well as other international instruments that protect migrants and seasonal workers[28].

[26] *Santoro-Gomez L. The user's point of view - Self-help group 'Pau Brasil' / NAZ Latina, AIDS and Mobility (Ed), Access to new treatments for migrants living with HIV and AIDS, Conference report, 25 – 27 June, 1999.*

[27] *See UNAIDS Technical update on voluntary counselling and testing, May 2000.*

[28] *The Convention was adopted by General Assembly Resolution 45/158 of 18 December 1990. For further information on international protection of migrants, see websites of the Office of the High Commissioner for Human Rights – http://www.unhchr.ch/ - and of the International Labour Organisation - http://www.ilo.org.*

Responses

With regard to HIV-related restrictions on entry and stay, such restrictions can have such negative consequences as discriminatory denial of entry; deportation without legal process; promotion of a false sense of security in host countries; fostering of racism and xenophobia; and diversion of funds from more effective interventions. They 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 UNAIDS. 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 by 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'[29].

Including migrants and mobile people in strategic planning and AIDS plans

Almost all countries are affected by migration and by population mobility – as sending or receiving countries and/or because of population movement within their borders. This population mobility could be a major factor driving the HIV epidemic in a country, and yet neither the mobility itself nor the migrants and mobile people involved are usually addressed in strategic planning or in national AIDS plans. In national and community strategic planning, any mapping of the epidemic and the factors driving it should include attention to migrants and mobile people, their realities, and their vulnerabilities. Where relevant, national AIDS programmes should give population mobility, migrants and mobile people special attention in national and community AIDS responses, and allocate sufficient funds to address the needs involved.

At the same time, regional and international bodies must use their institutional advantages to promote effective responses to migration, mobility and HIV/AIDS[30]. Finally, resources must be increased and/or shifted to deal more strategically with the issues involved. Communication and sharing of knowledge must occur between regions and between programmes.

[29] *HIV/AIDS and Human Rights, International Guidelines, United Nations, New York and Geneva, 1998, HR/PUB/98/1, para 105 and 106.*

[30] *For example IOM and UNAIDS have signed a cooperation agreement that among other things seeks to promote strategic responses to HIV/AIDS among migrants and mobile people.*

Evaluation of AIDS prevention for migrants in Switzerland

In 1990, Switzerland's Federal Public Health Office began an AIDS prevention programme designed especially for the almost 20 percent of the population living and working in the country who were non-nationals. The programme took place as one element of an overall national HIV/AIDS prevention strategy, along with programmes for the general population and for several other specific groups.

Exploratory studies had shown that the most marginal among the migrants in the country, seasonal workers in the hotel and construction industries, were already well aware of AIDS by 1989, but that their information was not always correct. They used condoms for sexual relations with casual partners less often than did the local population.

Process evaluation during the programme's first 18 months taught valuable lessons. For example there was a frustratingly long latency period before target communities showed active interest in the programme. This initial period was followed by rapidly accelerating demands that later strained the programme's resources.

Outcome evaluation after some three to four years showed that when such efforts are placed within an overall national HIV/AIDS prevention strategy for everyone living in the country, a government-sponsored HIV/AIDS prevention programme can mobilise considerable engagement within migrant communities. A very wide range of institutions in the target communities had been sensitised to AIDS issues, and a large number of peer educators and other community 'mediators' were actively carrying out HIV/AIDS prevention activities. Stigmatisation had been avoided, and levels of protective behaviour during risk activities had become the same as those of the local Swiss population [31].

Supporting action-oriented, operational research and evaluation

Though a correlation between HIV incidence and prevalence and population mobility has been established in many areas, the situation is different from region to region or even within a given region. Some mobile populations may in fact be less affected by HIV than are non-mobile people. Definitive epidemiological reviews need to be carried out concerning specific regions and specific mobile groups.

Even more important is to gain greater knowledge of the risk factors involved in the mobility process, of the determinants of the risk-taking behaviour that result in infection. Gaining such knowledge is essential if effective HIV/AIDS prevention programmes are to be developed.

Broader health issues that affect mobile populations need to be better understood. Such issues include the linkages between HIV and other important public health issues such as tuberculosis, or the barriers to treatment, care and support. They also include understanding the resources and strengths on which migrants and mobile people might draw to help them overcome the health challenges they face.

Finally, the descriptions – and especially the evaluations – concerning existing HIV/AIDS prevention and care programmes for migrants and mobile people need to be widely disseminated. Knowledge concerning effective programmes – what works and what does not work – should be widely and proactively shared by electronic and written means, among field workers, researchers, migrant associations, and programme planners and policy makers.

[31] *Haour-Knipe M, Fleury F, Dubois-Arber F. HIV/AIDS prevention for migrants and ethnic minorities: three phases of evaluation. Social Science and Medicine, 49, 1357-72, 1999.*

Selected Key Materials

Bronfman, Mario; Sejenovich, Gisela; Uribe, Patricia. *Migración y sida en México y América Central: Une revision de la literatura*. CONASIDA, Mexico, 1998.

Review of the literature concerning HIV/AIDS and migration in Central America and Mexico: migration legislation; epidemiological data; migrants' STI/HIV/AIDS knowledge, risk behaviours and situations; AIDS prevention and assistance programmes. The authors stress that risk conditions are created by extreme poverty and by violation of migrants' rights.

De Putter, Jeanette (Ed). *AIDS & STDs and Migrants, Ethnic Minorities and other Mobile groups: The State of Affairs in Europe*. Woerden, The Netherlands. AIDS & Mobility, 1998.

Country reports for Belgium, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and the United Kingdom: major mobile groups; epidemiological data; laws and regulations; major risk factors; national health policies as they concern mobile groups, HIV/AIDS projects for migrants.

Haour-Knipe, Mary and Rector Richard (Eds) *Crossing Borders: Migration, Ethnicity and AIDS*. London: Taylor and Francis, 1996.

Focuses on Europe, applicable on other continents: migration theory; migration policy and HIV/AIDS; legal, human rights, moral and ethical dimensions; migrants vulnerability and resistance resources; stigma and racism; HIV/AIDS prevention for migrant 'general populations', irregular migrants, sex workers; care issues; international networking; evaluation.

West African Initiative for a Response to the HIV/AIDS epidemic. Results of the Research-action 'Migration and AIDS' Project: Burkina Faso, Côte d'Ivoire, Mali, Niger and Senegal. UNAIDS Inter-Country team for West and Central Africa, 2000.

Research-action project taking place in railway and road stations, hotels, markets. Special attention paid to sex work, and other situations of particular risk and vulnerability. Trust and partnerships created with health care services and volunteers. Now to be translated into more sustainable interventions for mobile populations in the countries covered.

Shtarkshall, Ronny and Soskolne, Varda. *Migrant Populations and HIV/AIDS*. UNESCO/UNAIDS, 2000.

Developed on the basis of experience with Ethiopian and Russian migrants to Israel: background, theories, and principles underlying HIV/AIDS programmes for migrant populations; methods and steps to be taken in developing interventions; examples demonstrating methodology and variations under different conditions.

Skeldon, Ronald. Population Mobility and HIV Vulnerability in South East Asia: An Assessment and Analysis. UNDP, Bangkok, 2000.

Focuses on Southeast Asia: argues that migration itself is less important for HIV risk than is migrants' behaviour; that tourists and other short-term movers within regions also engage in high-risk behaviour; that individuals who are moving are thrust into high-risk situations they may not otherwise experience at home.

Special issue on Migration and HIV/AIDS. *International migration*. 36/4, 1998.

Commissioned reviews for West and Central Africa; Eastern and Southern Africa; South-East Asia; Eastern Europe and the Community of Independent States; and Mexico and Central America. Issues in need of urgent action: health services and HIV prevention, assuring that HIV testing is truly voluntary, limiting vulnerability, legal protection of migrants and their rights.

UNAIDS APICT Taskforce on Migrant Populations and HIV Vulnerability. *Guidelines For Rapid Applied Research on Mobile Populations for Planning and Implementing STD/HIV/AIDS Prevention and Care*. FHI, Ford Foundation, UNAIDS APICT and UNICEF EAPRO: Bangkok, 1998.

Structured questionnaires administered at repeated intervals to population subgroups in specific areas can provide advance warning of an impending HIV epidemic. The guidelines discussed concern key activities, research activities at different phases, links with programme planning, and human rights issues.

United Nations Development Programme South East Asia HIV Development Project (Ed). *Population mobility in Asia: Implications for HIV/AIDS action programmes*. Bangkok: UNDP, 2000.

Papers cover: population movement, development and HIV/AIDS; reaching migrant workers with prevention programmes; risk exposure among HIV positive workers; undocumented workers' access to health care; risk practices; vulnerability of women workers; national identity among sex workers; human rights; programme evaluation.

Notes

Joint United Nations Programme on HIV/AIDS

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