



MIGRANTS

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{ MIGRANTS

I am a migrant. I face these issues.



WHY MIGRANTS ARE BEING LEFT BEHIND

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HIV burden

Social, economic and political factors in both the country of origin and destination countries influence migrants' risk of HIV infection. HIV prevalence can be higher among migrants, especially for people originating from countries where the primary contributor to the scale of the epidemic is heterosexual transmission and the unequal vulnerability and risk of adolescent girls and young women to HIV, or among migrants in a key population, such as sex workers, gay men and other men who have sex with men and people who inject drugs. Migrants may acquire HIV in their country of destination or while in transit and often face a specific vulnerability to HIV related to their status as a migrant.

In KwaZulu-Natal, South Africa, where migration is common, studies found that HIV prevalence among migrant women aged 25–29 was as high as 63% (10).

In South-East Asia, HIV prevalence among migrants to Thailand from neighbouring countries is up to four times the rate of HIV prevalence found among the general population.

In India, HIV prevalence among people who have migrated from rural to urban areas is estimated at 0.9%, almost four times the national prevalence.

Whatever their diverse reasons for travel, migrants often find themselves separated from their spouses, families and familiar social and cultural norms. They may experience language barriers, substandard living conditions, exploitative working conditions and a lack of social protection, such as health insurance and other social security benefits. The resulting isolation and stress may lead migrant workers to engage in risky behaviours, such as unsafe sex or drug use, and they may face sexual violence and other human rights abuses. This increased HIV risk and vulnerability is exacerbated by inadequate access to HIV prevention, treatment and care services and the fear of being stigmatized for seeking HIV-related information or support (6,7).

THE TOP 4 REASONS

01

Restrictive laws and policies

02

Limited access to health information and services

03

Vulnerability to exploitation

04

Stigma and discrimination

In 2011, around 37% of new HIV diagnoses among heterosexual people in the European Union and European Economic Area occurred among people originating from countries where the primary contributor to the scale of the epidemic is heterosexual transmission and the unequal vulnerability and risk of adolescent girls and young women to HIV, primarily sub-Saharan African countries (8). Rates ranged from very low levels in parts of eastern Europe to approximately 60% in Belgium and approximately 50% in Sweden and the United Kingdom.

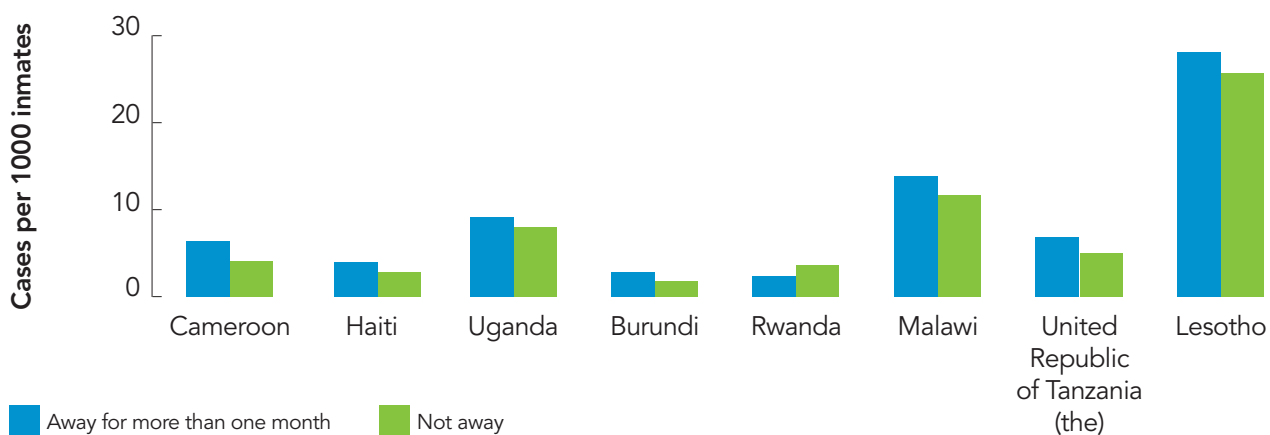
In South-East Asia, HIV prevalence among migrants to Thailand from Cambodia, Myanmar, southern China and Viet Nam is up to four times the HIV prevalence among the general population. The highest prevalence among migrants in Thailand was found in the fishing industry, with rates of 2% among fishermen and 2.3% among fishery workers, versus HIV prevalence of 1.1% and 0.74% among factory workers and farm workers, respectively (9).

Internal migrants and their families are also vulnerable. In urban settings, migration was identified as an independent risk factor for HIV infection, with female migrants 1.6 times more likely to be HIV-positive than non-migrants in certain cities in South Africa (11). In Kenya, urban HIV prevalence is 8% in formal settlements and 12% in informal settlements (12).

In Thailand, the vast majority of sex workers are migrants from villages, who use the income from sex work to support families in their home communities.

In India, HIV prevalence among people who have migrated from rural to urban areas is estimated at 0.9%, almost four times the national prevalence of 0.27% (13). Significantly higher HIV prevalence were found among Chinese male migrant workers and Chinese male miners compared to the general population in surveys conducted in Yunnan, China (14).

HIV prevalence in women by migrant status in selected countries



Source: Demographic and Health Surveys, 2009–2012.

Workers in the transportation sector, particularly long-distance truck drivers, have also been identified in different parts of the world as associated with an increased risk of acquiring HIV. HIV prevalence is higher among transport workers and in communities along transportation routes than among the general population. Studies of sex workers and their truck driver clients along a South African trucking route found that up to 56% of both were HIV-positive (15). In Paraguay, the majority of HIV cases among transport workers are concentrated in the capital city of Asunción, the Central Region and in regions bordering Argentina and Brazil (16).

Data show that the highest prevalence occurred in locations where goods are loaded and unloaded or where truckers have long waits associated with the processing of documentation (17). Significantly higher rates of HIV have been found among workers in the fishing industry in various parts of the world, particularly in western Africa (17,18).

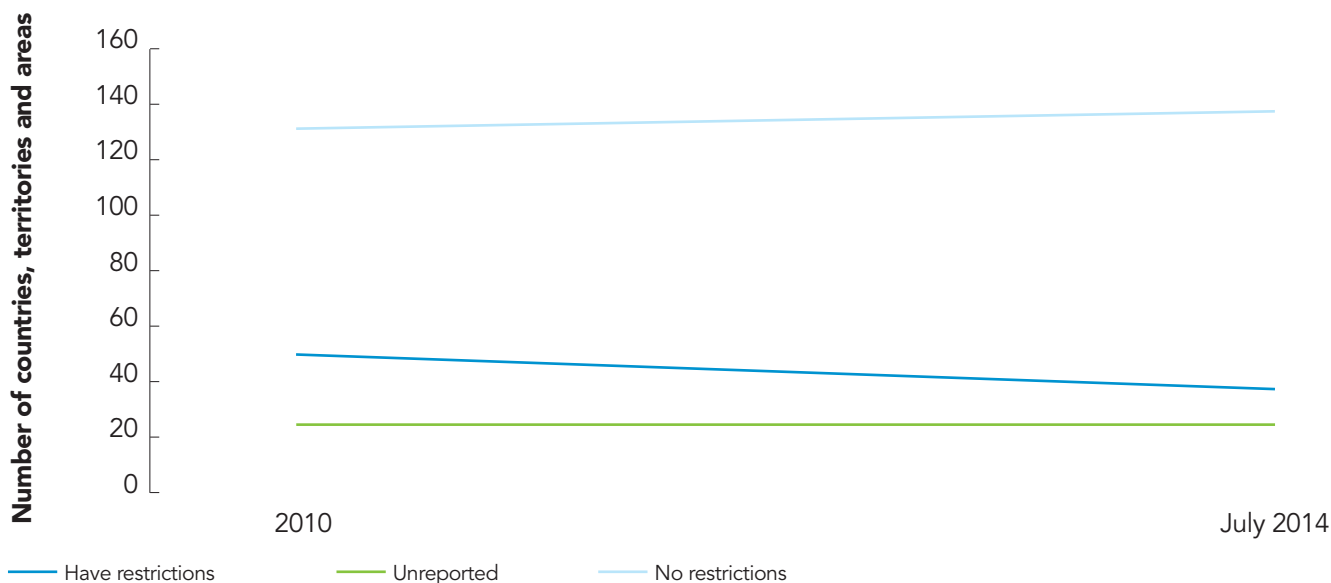
Studies indicate that women who have been internationally trafficked and forced into sexual exploitation also have significantly higher HIV prevalence as well as an increased vulnerability and exposure to violence (19). In Mumbai, India, almost a quarter (22.9%) of sex-trafficked women and girls were HIV-positive (20). HIV prevalence was 38% among sex-trafficked women and girls returning from India to Nepal (21). In Indonesia, one in five women trafficked internationally was HIV-positive in 2011 (19).

Restrictive laws and policies

While the majority of countries worldwide have no restrictions on the entry, stay and residence of people living with HIV, 38 countries, territories and areas still have such restrictions (22). Of these, five countries maintain a blanket ban on entry by people living with HIV, five require proof of an HIV-negative status for those seeking to stay for 10–90 days and at least 18 countries authorize the deportation of individuals found to be living with HIV (23).

Restrictions on entry, stay and residence based on HIV status exist in all of the Gulf Cooperation Council (GCC) countries, which are an important destination for migrants from the Asia and the Pacific region. Thus, the largest numbers of migrants affected are those seeking entry, stay and residence in countries in the Middle East and North Africa, where migration increased by 3% between 2000 and 2010 (1).

HIV-specific restrictions on entry, stay or residence, 2010–2014



Source: UNAIDS human rights and laws database. Geneva, UNAIDS, 2014.

Mandatory HIV testing and deportation is also an issue (24,25). All GCC countries require HIV testing for the renewal of migrant visas. Despite repeated calls by international migrant rights organizations, mandatory HIV testing is ongoing in contravention of internationally agreed standards related to informed consent, confidentiality and counselling. Those who test positive for HIV are often put in detention and deported. Moreover, their status is shared with testing clinics throughout the region, where they are designated as permanently unfit for employment.

Migrants often face conditions in their host country that make them vulnerable to acquiring HIV. Further violating their rights, through compulsory testing and treating them as criminals with detention and deportation, is traumatic. This experience is compounded by the stigma and financial consequences of being deported due to an HIV-positive status.

There is no evidence that HIV-related restrictions protect the public health or help prevent HIV transmission. Restrictive policies such as these not only violate individuals' right but also limit the uptake of voluntary HIV testing and hinder adherence to antiretroviral therapy. Countries should end these punitive, discriminatory approaches and have committed to doing so as signatories to the 2011 United Nations Political Declaration on HIV and AIDS (26).

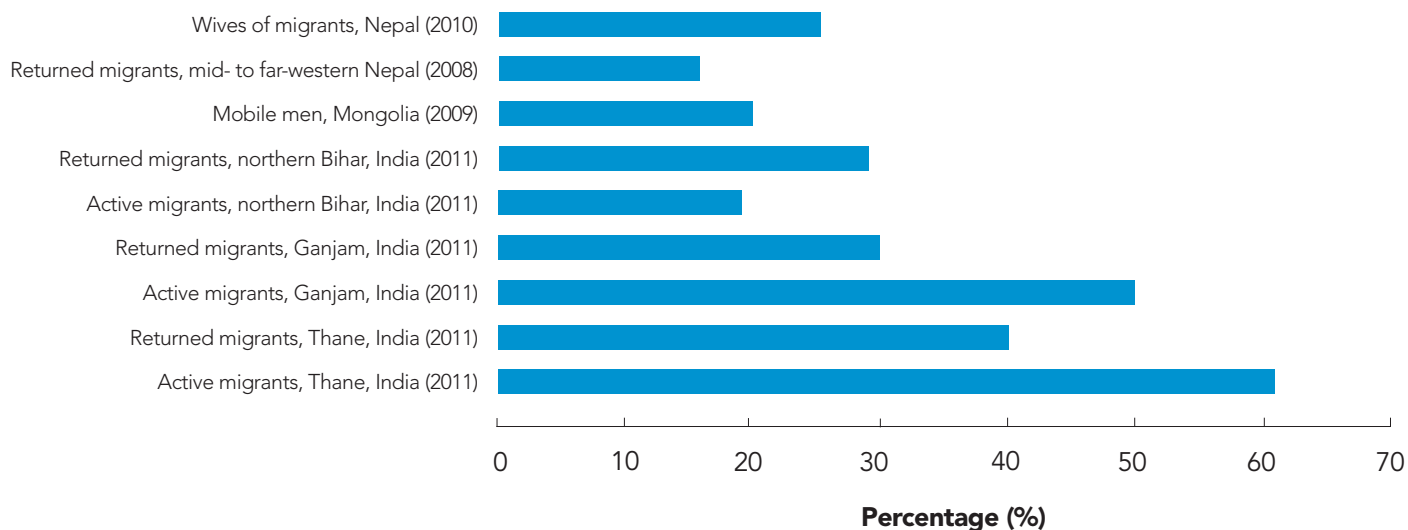
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Culturally appropriate health and HIV services in languages migrants are comfortable with may be scarce. Migrant workers living at construction, plantation or mining sites with little provision of health services struggle to adhere to treatment. Employers may also exercise considerable power over their migrant employees. They can refuse sick leave and enforce long work shifts, making it extremely challenging to access HIV services. Health clinics often require patients to be registered in a local residential area, which migrants often cannot do. Additional medical treatment costs, transportation costs to reach health-care facilities and the fear of the loss of income further hamper their access to services. Other barriers include the fear of being arrested or harassed by the police when travelling, which may force migrants to pay bribes.

Migrants rarely have the same entitlements as citizens to insurance schemes that make health care affordable, particularly if they are undocumented.

Knowledge of antiretroviral therapy and how one can benefit from treatment tends to be low among migrant populations, further highlighting the need to increase outreach activities. One study found that only 10% of Nepalese migrants in India were aware of the availability of treatment for HIV (28). These low rates of antiretroviral therapy knowledge were found across the region: just 14% of spouses in Nepal had heard of antiretroviral therapy, while just 20% of respondents had heard of antiretroviral drugs in Bangladesh. These rates are much lower than those found among other key populations at higher risk of HIV exposure (29).

Proportion of migrants with comprehensive knowledge on HIV in India, Mongolia and Nepal (2008–2011)



Source: HIV and AIDS Data Hub for Asia Pacific (www.aidsdatahub.org).

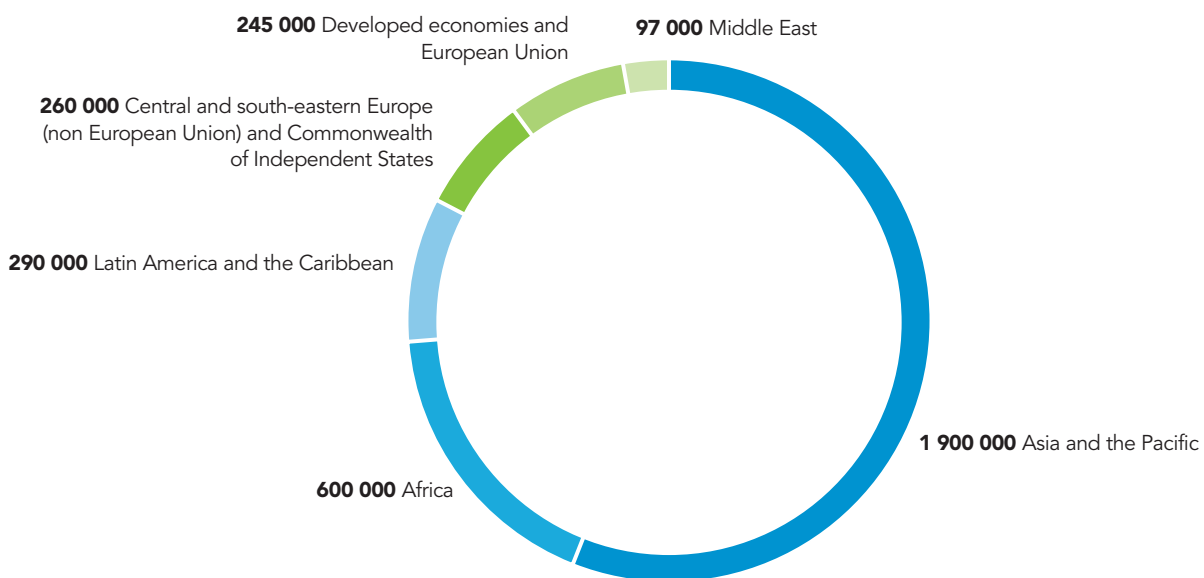
Some countries—for example, Ethiopia, Kenya and Nepal—have recognized the increased vulnerability of migrants to acquire HIV. National AIDS strategies include programmes aimed at reaching out further to mobile populations so that they receive effective HIV prevention, treatment, care and support services. The Philippines has developed pre-departure briefings for migrants related to HIV, health care and similar issues, much of which is carried out by civil society.

Vulnerability to exploitation

Female migrants employed in lower skilled jobs within the manufacturing, domestic service or entertainment sectors are often undocumented and have little access to health services. This leaves them particularly vulnerable to HIV. They are susceptible to exploitation and/or physical and sexual violence, in some cases perpetrated by their employer.

Female migrants in transit may be forced to engage in transactional and unprotected sex to facilitate their border crossing. Once in the destination country, they may face huge debts owed to recruiting agents and for transportation costs combined with high interest rates, which puts them in a particularly vulnerable position. Sexual harassment, abuse and rape are experiences commonly reported by female migrants (30).

Total number of victims of cross-border sexual exploitation by region



Source: Recalculated from ILO global estimates of forced labour: results and methodology. Geneva, ILO, 2012.

In 2008, the United Nations estimated that approximately 2.5 million people from 127 countries had been trafficked to 137 countries (9). More than half of the victims of forced labour—primarily associated with domestic service and sexual exploitation—were women and girls (31). Sexual exploitation is shown to significantly increase risk of exposure to HIV. Data collected from interviews in India indicate that women forced into prostitution are nearly three times as likely to be HIV-positive (32). Among trafficked women who also report physical or sexual violence, the risk of exposure to HIV is more than 10 times that found in other populations at higher risk, such as female sex workers (19).

Sexual exploitation is commonly associated with high numbers of clients, violent sex, unprotected sex, poor hygiene both in the venue and among the clientele, voluntary or induced drug use, including unsafe injecting practices, and inadequate screening and treatment for common sexually transmitted infections. Women and girls are at higher risk, but so, too, are young boys (19).

Sexual harassment, abuse and rape are experiences commonly reported by female migrants.

Economic and social vulnerability

Spouses separated for longer periods of time for economic and social reasons can find themselves in situations of increased vulnerability. For women who stay behind when their spouses migrate, the economic challenges and food insecurity that precipitated their husband's migration may continue. Thus, they may be forced to exchange sex for food or money. They may also be at risk if their husband returns home having become HIV-positive. In certain states in India, nearly 90% of newly diagnosed HIV infections were among wives with a migrant husband (33).

The mining sector is one industry in which migrants are shown to have an increased risk of acquiring HIV. The mining industry in southern Africa is overwhelmingly staffed by migrant men aged 18–49 with lower levels of education. They are referred to as oscillating workers, individuals who spend 11 months of the year in their place of work and return to their family home for one month each year. Migrant miners between Lesotho, South Africa and Swaziland aged 30–44 are 15% more likely to be HIV-positive (4). Having a migrant miner as a partner increases a woman's probability of becoming HIV-positive by 8% (4). By way of comparison, non-migrant miners in Zimbabwe do not appear to experience a similar added comparative risk (4).

The danger and risk involved in their daily work may mean that miners have a different perspective on HIV risk. The likelihood that these workers will engage in risky sexual behaviour may be influenced by the separation from their family, their higher income in relation to the surrounding communities and the presence of brothels. Once infected, they may risk transmitting HIV to their partners upon returning home.

Stigma and discrimination

Stigma, discrimination and social exclusion have made it more difficult to provide health services to migrants. Migrants who are living with HIV endure a double stigma: for being migrants and for being HIV-positive. This hinders their access to HIV prevention, care and treatment services. Furthermore, migrants—whether documented or not—may face significant challenges in accessing mechanisms of redress in relation to discrimination or abuse.

Migrants who are living with HIV endure a double stigma: for being migrants and for being HIV-positive.

Case studies from South Africa and Thailand illustrate the difficulties undocumented migrants may face in accessing treatment due to stigma and discrimination directed at them from health-care workers and employers (35). These barriers exist despite quite protective legislation that guarantees the right to basic health care for migrants.

Undocumented migrants have reported being turned away from public health clinics when unable to present citizenship papers. Mine workers—including miners living with HIV and multidrug-resistant tuberculosis—have been expelled from the destination country and left at the border of their home country without access to treatment or a referral to local health services so that they may access treatment (35).

Without a multifaceted, rights-based approach to addressing the HIV and health needs of migrant populations within their specific contexts, interventions run the risk of missing key groups of this mobile population (3).

CLOSING THE GAP

Because migrants have difficulties in accessing HIV-related services and face significant human rights challenges, countries—along with their neighbours—must address some of the structural factors causing harm. Constraints often include a lack of effective cross-border mechanisms to address the needs of migrants in a comprehensive way and respect for their human rights. In addition, too little is being done to address the stigma and discrimination that people face when they are both a migrant and HIV-positive. Better understanding of the depth of these issues is needed.

Providing treatment to people living with HIV brings economic gains to a society through a person's improved health and productivity. It also has a preventive effect by reducing the individual's viral load, thereby reducing the likelihood of transmitting the virus. Coupled with the falling costs for treatment, it is increasingly difficult to argue that people living with HIV incur greater costs to the destination country compared to the benefits they could contribute over a long-term stay while they are healthy. Perhaps recognizing these factors, the United Kingdom makes antiretroviral therapy available to all people living with HIV in the country at no cost regardless of their immigration status.

Cross-border coordination is key to an effective treatment strategy, which should include cooperation between the countries of destination and origin to improve adherence after migrants return home.

For example, Thai and Cambodian authorities have collaborated on a scheme that allows Cambodian migrants living with HIV to return to their home country to obtain a three-month supply of antiretroviral medicines. Cross-border tuberculosis treatment systems were effectively developed between

HOW TO CLOSE THE GAP

01

End restrictions and ensure rights

02

Provide access to health services, including cross-border initiatives

03

Protection from sexual and labour exploitation

04

Non-discrimination laws and strengthened civil society leadership

the United States and Mexico and may serve as an example for enabling care for mobile individuals elsewhere (35).

The danger and risks involved with daily work may mean that workers have a different perspective on their risk of contracting HIV. The likelihood that migrant workers will engage in higher risk sexual behaviour may be influenced by the separation from their family, their higher income in relation to the surrounding communities and the presence of brothels. Once infected, they may risk transmitting HIV to their partners upon returning home. To address such issues, the South African National AIDS Council is establishing a multistakeholder advisory committee on mobile men and migrant populations to provide advice on a comprehensive and strong programme aimed at reducing the risk of HIV transmission and other infectious diseases among migrants.

Anonymous and free-of-charge HIV testing and counselling has helped many migrants and other key populations to know their HIV status and, if HIV-negative, reduce their risk of exposure to the virus. Antenatal testing for all pregnant women is often seen as an effective strategy for achieving good coverage of HIV testing in migrant populations and ethnic minorities. HIV testing uptake in antenatal settings among migrants has been shown to be high and similar to that for non-migrant women (36).

Despite the documented economic benefits related to migration, in times of limited public spending the needs of international migrants are too often considered a lower priority than services for citizens, even in high-income countries. A climate of austerity can fuel attitudes whereby migrants are viewed suspiciously and resented as a drain on scarce resources. Furthermore, since they usually are not entitled to vote, politicians rarely make migrants an investment priority.

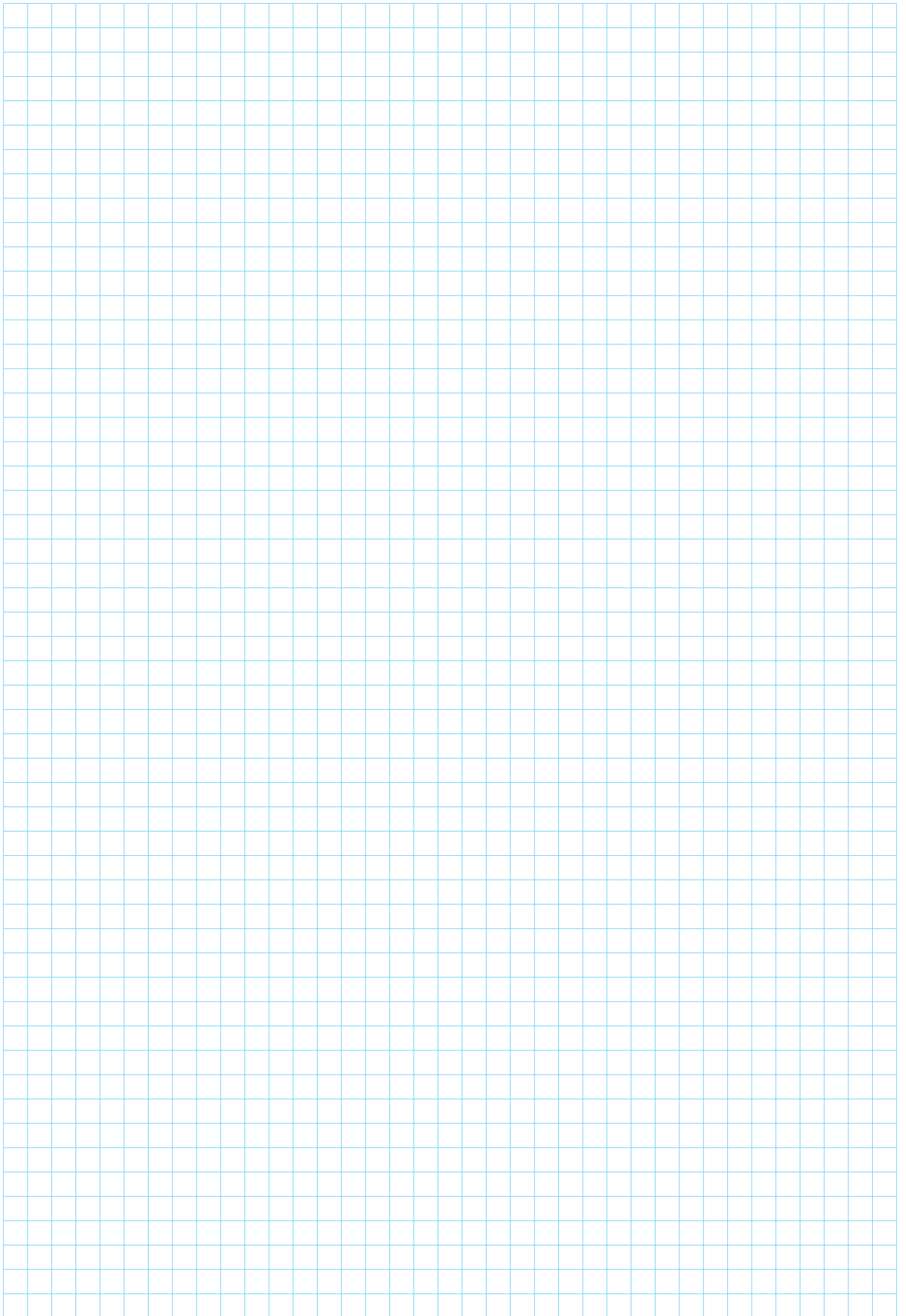
Civil society can play a greater role as advocates and providers of HIV-related services to people on the move. In Asia, one network is bringing together nongovernmental organizations working on migration and health issues spanning across South-East Asia, North-East Asia, the Gulf and the Middle East. It engages in national and regional advocacy, partnering with and supporting the capacity of local groups working with migrants to protect their health and rights. Based on its research on the impact of mandatory health and HIV testing, it has issued a call for the removal of such mandatory approaches (37). In eastern and southern Africa, a network has brought together more than 70 public, private and nongovernmental partners to deliver health services to truck drivers, sex workers and communities with limited access to medical facilities. Since 2007, it has expanded from one clinic with 5 000 visitors to a network of clinics in 13 countries that is reaching more than 250 000 people (38).

Business leaders are encouraging countries to repeal HIV-related entry, stay and residence restrictions based on economic grounds. They argue that, in a globalized world, companies require flexibility in the recruitment and deployment of workers to where they are most needed. More than 40 chief executive officers have signed a pledge opposing HIV-related travel restrictions (39).

Countries can make a difference to migrants by:

- Ending all restrictions on the entry, stay and residence of people living with HIV.
- Ending all mandatory HIV testing practices and, instead, offer routine HIV counselling and testing without the potential for negative consequences related to migration decisions.
- Ensuring that all people on the move—citizens and non-citizens alike—have access to essential HIV services.
- Enforcing national non-discrimination laws and frameworks that specify protections for people living with HIV and guarantee access to health and other services.
- Expanding access to HIV treatment and other health services to migrants, ensuring that services are delivered through a rights-based approach.
- Recognizing the increased vulnerability of migrants in national AIDS strategies and including programmes to reach mobile populations with effective HIV prevention, treatment, care and support services.
- Ensuring that resources are directed to those migrant populations and communities that are most vulnerable to HIV.
- Designing programmes that are responsive to migrants' different backgrounds and needs.
- Designing HIV information in the languages that migrants feel most at ease with when making decisions about their health and personal behaviour.
- Implementing and coordinating cross-border initiatives for issues with an impact that transects borders, including HIV treatment.
- Mobilizing communities by engaging people from within migrant and ethnic minority populations in order to ensure that their needs are being met and that programmes are culturally appropriate.
- Protecting all people from sexual and labour exploitation.
- Strengthening civil society leadership to counter stigma and social exclusion.
- Meaningfully including migrants, as well as members of their families, in community health programmes at the local level.
- Ensure consultations on health and development frameworks and programmes at the national level.

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