

HIV and “People on the Move”: Six Strategies to Reduce Risk and Vulnerability During the Migration Process

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ABSTRACT

Mobile, migrant and displaced people require specific attention with regard to HIV vulnerability, including information and services tailored to their social, cultural and economic backgrounds and to the phase of mobility. Too few studies have systematically documented the needs of people on the move in this regard or evaluated the existing responses to meeting these needs. Most studies and programme descriptions focus on specific populations at country or community levels. Few compare and contrast different population groups, and few are regional or cross-continental in scope. Most are purely descriptive, and lack a theoretical framework. The aim of this article is to precipitate more structured international comparisons – and questions – that will fill some of the evidence and programming gaps defined.

INTRODUCTION AND BACKGROUND

This article makes use of unique material gathered during a 2009 session on “people on the move” organized by the United Nations Joint Programme on HIV/AIDS. Using an established framework for the mobility process, HIV vulnerability associated with population mobility is sketched through various phases: during transit, in destination communities, and in communities of departure and return. The focus is world-wide. Vulnerability is reviewed independently of the type of or reasons for migration, following the often-repeated observation that it is not migration itself that drives HIV risk, but the conditions under which mobility takes place.

The second half of the review goes beyond description of the problem, to sketch some of what has been done about it. Six complementary policy and programme approaches are outlined for reducing HIV vulnerability and risk – and for ensuring that migrants, refugees, and people whose jobs require them to move from place to place are covered by programmes that claim to assure “universal access” to HIV prevention, treatment, care and support. Examples are given.

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It is increasingly pointed out that although people who migrate may be in better health than their non-migrant peers before they set off, mobility can raise a number of risks to health (Gushulak and MacPherson, 2006), including accidents, health problems due to unsatisfactory working and living conditions, and mental health problems. Mobility can also increase the risk of acquiring the human immunodeficiency virus (HIV). Such risks have long been attributed to the social disruption that characterizes certain types of migration (Decosas et al., 1995): indeed, a key axiom in discussing the relation between migration and HIV is that it is not moving *per se*, but the conditions under which people move, that determine vulnerability. Epidemiological conditions, sexual and drug use patterns, and access to health information and services further define their risk of exposure to or transmission of HIV. Typologies of migration, displacement, and movement are complex, and sometimes contentious. Zimmerman, Kiss and Hossain (11), for example, have listed eleven types of mobile groups: international migrants; internal migrants; irregular migrants; trafficked persons; international labour migrants; internally displaced persons (IDPs); refugees; asylum-seekers; stateless persons; tourists; and international students. This article does not aim to address the differences among such groups, but rather to summarize progress in understanding how a broad range of “people on the move” can be addressed in national and international efforts to control and reverse HIV and to achieve the Millennium Development Goals (United Nations, 2012). We use the term “mobile, migrant and displaced populations” as the most general term for people on the move. International tourists and students deserve reviews of their own: here we focus on HIV vulnerability and risk among the first eight of the above categories, and identify strategies for ensuring that they are included and well served in HIV and broader health policies and programmes.

The enormous numbers of people involved in population mobility world wide make it both a matter of equity (UNAIDS, 2011) and a practical concern to ensure that their needs and contributions are understood and featured in HIV and other health and development policies and programmes. The need has been widely recognized: one important step was an unprecedented General Assembly Special Session (UNGASS) in 2001, during which United Nations member states unanimously committed to providing access to HIV prevention, treatment, care and support for all people who need it, including people on the move (United Nations, 2001). These commitments have been twice reaffirmed, most recently in 2011, with specific commitments to include migrants and people affected by humanitarian emergencies in HIV strategies and programmes (United Nations, 2011, paras 60 & 84).¹

There is, however, a need for greater clarity on the social, economic, legal and health experiences and needs of mobile, migrant and displaced populations, as well as on policies and programmes developed to meet those needs. After a brief description of the methods and the key concepts used, this review discusses HIV risk and vulnerability as they occur across the phases of population mobility. It then outlines six complementary strategies for reducing such vulnerability and for improving access to prevention, treatment, care and support.

METHODS AND KEY CONCEPTS

In June 2009 the biannual meeting of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS (UNAIDS) convened a full day session to examine the state of the art in programmes and policies regarding HIV and “People on the Move.” The heading was deliberately chosen to encompass diverse types of intra- and inter-national movement addressed by UNAIDS’ co-sponsoring agencies and partners. The session, and the background paper prepared for it, were developed collaboratively, through a series of iterative consultations among UNAIDS stakeholders (UN member states and civil society including networks of people living with HIV), academic and service organizations working with migrant, mobile and displaced populations,

recognized experts in the field of HIV and mobility, and by the UNAIDS Secretariat, WHO, ILO, UNHCR, UNDP, UNFPA IOM, and other relevant international organizations. An online search was conducted for published and grey literature regarding health, HIV and people on the move. Additional references and programme examples were brought forward by the experts involved in developing the session, then more still by meeting participants from all over the world. This review originates from the background paper prepared for that meeting (UNAIDS, 2009), but has been extensively revised. In particular, the review of the literature was updated to include more recent material. The document also integrates some of the unpublished programme descriptions presented during the session, as well as reflections from the discussions.

Key Concepts

Several premises are important to this review. A first is that much population mobility occurs for mixed reasons. For example, women may migrate to find employment – but also to “become modern” (Hew, 2003); men who have sex with men may leave home for reasons of employment – but also to escape local stigma and discrimination based on their sexual orientation (Carrillo, 2010); or health workers from countries in conflict may migrate to better working conditions in wealthier countries – but also to escape oppression (Rogerson, 2007). A second premise is that official categories for migrants in receiving countries change, for example when labour migrants’ or asylum seekers’ permits expire and they stay on as irregular migrants. A third premise is that the migration process is in constant flux, for example when migrants shuttle between countries of origin and of destination, when people move through several countries in their quest for refuge, or when people who intend to migrate are “intercepted”.

As for risk and vulnerability, in the context of HIV programming, *risk* is defined as the probability that a person may acquire infection with HIV. Such risk is highly influenced by epidemiological conditions, as well as by individual behaviour. The concept of *vulnerability* is broader. Vulnerability hinges upon structural conditions that reduce people’s ability to avoid or to control their risks. Such factors may be personal (e.g. fear, loneliness, separation from the social norms that control behaviours in home communities), societal (e.g. poverty, exclusion from legal protection, gender and power inequalities), or programmatic (e.g. lack of access to appropriate prevention and treatment). Multiple causes of vulnerability may be experienced by entire communities (UNAIDS, 1998).

Stigma is another key concept for discussing HIV and people on the move. HIV-related stigma is: “Prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV infection and at the individuals, groups, and communities with which they are associated” (Herek, 1999). Fear of AIDS interacts with social judgements associated with some of the behaviours related to HIV transmission, such as non-marital sex and illegal drug use, making HIV-related stigma – including self-stigma – widespread (Parker and Aggleton, 2003). HIV related stigma compounds the vulnerability and marginalization of people who also face stigma based on their mobility, migration or displacement.

HIV RISK AND VULNERABILITY DURING THE MOBILITY PROCESS

HIV risk is a complex function of personal characteristics and behaviours, access to information and services, societal conditions, and the prevalence of HIV among sexual partners and among those who share paraphernalia for injecting drugs. Mobility, migration and displacement affect risk indirectly when they create conditions in which people are more likely to engage in unsafe sexual or drug use behaviour, and/or are unable to protect themselves. They also affect HIV risk directly, by linking populations with different HIV prevalence.

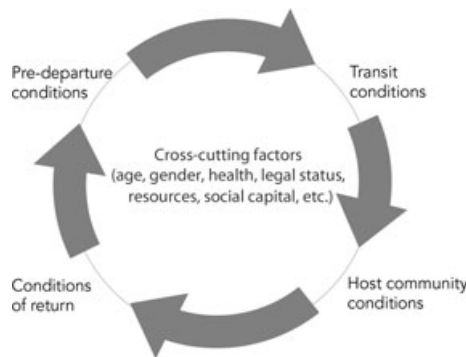
The process sketched in Figure 1 provides a useful framework for discussing HIV vulnerability for mobile populations, although with some provisos. The phases of the mobility process are by no means one-way or inevitable in sequence, and the same factors that drive departure may also drive HIV risk and vulnerability throughout the migration process. Risk and vulnerability factors pre-departure and upon return to communities of origin, in particular, are largely mirror images of each other, and will be discussed together. We thus start the mobility process with the transit phase.

In transit

Although most journeys take place without incident, HIV risk and vulnerability during the transit phase can become acute, especially if the journey takes place under difficult circumstances or is prolonged. Vulnerability in transit is significantly affected by the extent to which an individual has been able to prepare for the journey, by the degree of control over its conditions, and by the resources available. For example, people fleeing disasters or conflict may find themselves with little choice about leaving, little time to prepare, few material resources, and in dangerous or violent conditions. Women, but also men, may suffer sexual violence during conflict, and may be forced to exchange sex for their passage as they flee (Global Coalition on Women and AIDS, 2004). Women who migrate voluntarily may also be subjected to non-consensual sex at borders, or have little recourse but to turn to commercial sex to continue their journey if their funds run out during transit (Bronfman et al., 2002). Such dangers and risks may become more significant in a climate of repression, where both men and women are likely to experience threats, assaults, and sexual violations (Infante et al., 2011).

People who are repeatedly mobile or in “transit” because of their professions have been relatively well studied. Examples are transport personnel such as truckers and fishermen, and military personnel, as well as market women and mobile sex workers. The former, in particular, are usually sexually active men whose work requires long absences from their homes and regular partners. Their professional activities often involve periods of monotony interspersed with highly stressful moments, peer pressure that promotes risky behaviours and a culture of risk taking, and may extend to fatalism regarding death. In addition, they often carry significant sums of cash relative to the communities through which they travel; that cash attracts the creation of a range of specific services to serve them, including sexual services (see Feldbaum et al., 2006 for military personnel; Mojola, 2011 for fishermen; and Stratford et al., 2000 for truckers). The vulnerability of mobile

FIGURE 1
PHASES OF MOBILITY INFLUENCING HIV VULNERABILITY.



Source: IOM, 2004b

sex workers – females, males and transgender people – is heightened by their marginalization. Such workers receive minimal social or legal protection, and are thus particularly vulnerable to such abuses as robbery and violence. Perpetrators assume that their abuse will not be reported and, indeed, mobile sex workers – especially those who are undocumented – may avoid the police in fear of arrest, detention and deportation (Choi, 2011).

At destination

In their destination communities, migrants' ability to make healthy choices may be limited by the same factors that pushed them to migrate in the first place. Economic deprivation is one example. Although highly skilled and well paid migrant workers can usually relocate to a safe and fully serviced neighbourhood, those who are unskilled often have little power over the conditions in which they work and live. Their wages are typically lower than those of local workers; they may receive no health or other social benefits; and they have little recourse if they fail to receive their pay or lose their jobs (Benach et al., 2011). These problems tend to be intensified for female unskilled migrant workers, who also can face sexual harassment and violence, especially when they work in informal and unregulated jobs (Peberdy and Dinat, 2005). Some cross-border migrants will have paid substantial sums to employment brokers and others who facilitate their journey, and find themselves burdened with significant debts after they arrive. A study of women migrating from Asia, for example, pointed out that the combination of large debts, low wages, and exploitative employers contributes to a financial burden that can motivate high-risk behaviour such as sexual-economic exchange (UNDP, 2008).

Many people who have migrated – whether for work or to flee unsafe conditions - find themselves clustered in neighbourhoods that concentrate structural disadvantages, such as poverty, poor housing and low access to security, information and services (Parrado et al., 2010). Employers frequently house migrant workers, sometimes in crowded dormitories or housing that is inadequate, a situation that can also foster risk. With little contact with home, little comfort, and little opportunity for healthy recreation, there are abundant opportunities for HIV risk behaviours (see CARAM Asia, 2004 for Asia Pacific; IOM and Southern African Migration Project, 2005 for Southern Africa; Ondimu, 2010 for Kenya; Wardlow, 2010 for Papua New Guinea). Migrant women's vulnerability may be increased by the need to exchange sex to meet their basic needs. A classic study of HIV among Haitian women working in sugar cane plantations in the Dominican Republic, for example, revealed that single women were not eligible to receive housing: taking up union with a male cane worker was the "safest" way to secure accommodation and protection (Brewer et al., 1998). A more recent study from the border between South Africa and Mozambique made similar observations, and further noted that a female farm worker who refuses to grant sexual favours to an insistent foreman can lose her job (IOM, 2004a).

Migrants' access to health and support services is often limited in destination communities. In some cases such services simply do not exist. In others, services may be available, but are not accessible due to language barriers, cost, or lack of information. Fear and stigma can also hinder access, including stigmatizing attitudes of employers and service providers, and self-stigma. A study of legally-admitted immigrants attending language classes in Sweden, for example, found that fear of deportation was an important determinant of reluctance to seek medical care – even though Sweden does not deport migrants on the basis of HIV status (Nkulu Kalengayi et al., 2011). Indeed, studies in Asia (CARAM Asia: 2007), Europe (Prost, 2005), and the United States (Foley, 2005) have shown that even migrants who have all the necessary permits may hide their HIV status and medications for fear of stigma, of losing their jobs, or of deportation. Undocumented migrants, in particular, may not know how to gain access to medical care in destination communities, and, among these, those who have been trafficked may be practically helpless.

As for conflict settings, assessments have shown that access to HIV prevention services is extremely limited, especially at the outset, as may also be the case for natural disasters (Samuels and Spraos, 2008). When the response to an emergency is fast, well-designed and fully funded, on the other hand, refugees may experience the paradox of receiving better HIV-related services in camps than in their community of origin (Spiegel et al., 2007).

In communities of return/origin

Although the stereotype often encountered at the beginning of the epidemic – that migrants or people seeking refuge would “bring HIV” to destination countries – has repeatedly been challenged (Araujo et al., 2010 for migrants; Spiegel et al., 2007 for conflict-affected populations), the fact that the groups discussed here travel between populations of different HIV prevalence means that mobility can have a significant impact on communities of origin and of return. Communities of transit can also be affected: a study in Malawi, for example, showed that living close to a major road – where sexual relations with travellers are more likely – is directly and significantly associated with increasing odds of HIV (Feldacker et al., 2011). In humanitarian situations, HIV risk for the non-displaced may rise in the post-conflict phase when people begin to return to communities that had been protected by their isolation during the crisis (Mock et al., 2004).

The factors just discussed mean that a certain number of people who are mobile, migrant or displaced will acquire HIV while they are living abroad. Many of these will eventually return to their home countries. For many years the predominant model was that a male migrant worker would acquire HIV from unprotected sex with partners while abroad, and transmit the virus to his wife or other partners at home when he returned. Indeed this pattern has been observed in numerous studies, for example in South Africa (Campbell, 1997) and in India (Saggurti et al., 2011). In every population, condom use for HIV and STI protection is more contentious and less frequent among intimate partners (e.g. married couples) than with casual partners or sex workers (Gardner et al., 1999). As for migrants, a classic study from rural Mexico showed that although wives of men temporarily working in the United States were aware of the risks, traditional gender roles prevented them from using condoms when their husbands returned home to visit (Salgado de Snyder et al., 1996). Some 15 years later, and on a different continent, researchers came to much the same finding: Tajik wives of men working in Moscow never used condoms, never suggested doing so, and found it shameful to discuss such things (Golobof et al., 2011). Indeed, such gender norms around employment and around intimate partner relations interact with mobility to increase HIV vulnerability and risk in communities of origin across a wide range of other countries and cultures (see Ghosh and Kalipeni, 2005 for Malawi; Jordan Smith, 2010 for Nigeria; Yang and Xia, 2006 for China).

However, this longstanding and widespread pattern is by no means the only model of mobility and HIV risk upon return. First, women are increasingly the primary labour migrants in their families (UNFPA, 2006). Some studies from Asia examine the impact on families and communities of origin when women who have acquired HIV while working abroad return. Such workers face a potentially devastating series of economic, social and emotional difficulties, ranging from loss of income and difficulties in finding new employment to stigma, discrimination, and isolation (CARAM Asia, 2004; UNDP, 2008). The issues have been particularly well examined for South Africa, where population movements were found to have influenced the development of the epidemic throughout the country. Hunter (2007) and Lurie (2006), for example, explore how such significant social changes as decreases in marriage rates and rising unemployment are influencing women’s entry into the labour force. Many women are moving back and forth between rural homes and peri-urban settlements. The latter provide opportunities to eke out a living in the informal economy, but they also mean that inhabitants are much more likely to encounter HIV, since rates are far

higher in the settlements than in either rural or urban areas. Second, in a couple in which one member is a migrant worker, it is no longer obvious which partner may acquire HIV first. Work from both South Africa (Lurie et al., 2003) and Nepal (Smith-Estelle and Gruskin, 2003) suggests that the affected partner may be the economically dependent women who has remained at home while her husband works abroad, and who, if he fails to send remittances, may engage in unprotected transactional sex while he is away.

Finally, some studies have examined the effects on families and communities when former migrant workers with AIDS "return home to die" (see Clark et al., 2007 for South Africa; Knodel and Saengtienchai, 2005 for Thailand). In contrast to their situation a decade ago, returnees with HIV may live for many productive years if they can obtain access to AIDS treatment. Nevertheless, the phenomenon creates strains on communities and on the need for services. For the families involved, the effects may last for generations, as they cope with the eventual loss of some of their members, and specifically, loss of members upon whom they had especially relied (Ssengonzi, 2007).

In sum

As can be seen from the examples sketched, many individual and collective risk and vulnerability factors apply across different forms of mobility, migration and displacement, and in different phases. These include personal factors, such as sexual risk behaviour; loneliness, fear and alienation; and fear and denial due to HIV-related stigma. Societal vulnerability factors include the exclusion, communication barriers, increased risk of exploitation, and inadequate physical and legal protection that reduce social support for healthy choices. Programmatic vulnerability factors include deficient or poorly adapted HIV services, and exclusion from mainstream health, education and social services. Mitigating each of these are the social and financial resources available to the person on the move, and the levels of HIV-related and migration-related stigma they encounter before, during and after their move.

TOWARDS UNIVERSAL ACCESS: POLICIES AND PROGRAMMES

The basic principles of "Universal Access" emphasize that services must be equitable, accessible, affordable, comprehensive, and sustainable over the long term (UNAIDS, 2008b). As the UNAIDS Executive Director, Michel Sidibé, has stressed, "Universal means no-one in need is excluded" (United Nations, 2011). A variety of promising local, national, regional and global programmes, projects and services have emerged to extend access to HIV prevention, treatment, care, and support to mobile, migrant and displaced populations. During the session on HIV and "people on the move" described at the beginning of this review, six such inter-related approaches were identified. These are sketched in Figure 2, and described with examples. For this necessarily brief overview, the policies and programmes sketched are far from being either exhaustive or complete in their descriptions. They are simply examples.

Policy dialogue across national boundaries and within countries

Policy dialogue across national borders, among key ministries within countries, and with civil society, is key to promoting the human rights of mobile, migrant and displaced populations, and to instigating coherent and consistent access to HIV prevention and care.

- In Southeast Asia, the Philippines, Indonesia and Myanmar are estimated to send over twelve million workers abroad, and Thailand and Malaysia to receive some eight million (UN

FIGURE 2

SIX COMPLEMENTARY APPROACHES TO PROMOTE UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR MIGRANT, MOBILE AND DISPLACED POPULATIONS



Source: UNAIDS

Regional Task Force, 2008). The Association of Southeast Asian Nations has been hosting a platform that unites sending and receiving countries to promote universal access to HIV prevention and treatment for such workers. The platform has endorsed important policy recommendations over the years. For example, Governments are strongly encouraged: to ensure that testing HIV testing of migrant workers adheres to international standards of informed consent, confidentiality and counselling; to review laws, policies and practices so that migrants living with HIV are no longer excluded, detained or deported on the basis of HIV status;² and to strengthen discussions in pre-departure and post-arrival orientation for migrant workers on HIV vulnerability, and on how to obtain services (ASEAN Secretariat, 2009).

- An initiative for the ports of the Red Sea and the Gulf of Aden is bringing together national governments and international organizations around mobility, migration and HIV risk and vulnerability. With a particular emphasis on human rights, experts and leaders have agreed to strengthen advocacy and leadership on HIV and mobility, to pool human and technical resources, to build inter-country referral systems and to build capacities to address HIV among people on the move (UNAIDS, 10).

Documenting needs, programme evaluation and dissemination of information

Up-to-date information is essential for tracking needs in rapidly evolving mobility contexts, and also to help avoid incorrect or stigmatizing generalizations about HIV in the populations of concern here. This is especially true since the stigma frequently experienced by migrant, mobile and displaced populations is compounded when questions about HIV are raised. The UNAIDS review emphasized the paucity of rigorous evaluations of HIV programmes for such populations, a lack that reflects the challenges of designing and conducting ethically sound research involving extremely vulnerable people. It also showed that these challenges can be met.

- The “Partnership on HIV and Mobility in Southern Africa” (PHAMSA) was implemented in five countries in Southern Africa to reduce the incidence and impact of AIDS among the region’s mobile workers and their families. The programme involved advocacy for policy development, technical cooperation, and pilot projects in sectors with high population mobility, such as transport, informal cross-border trade, construction, mines, and fisheries. Each

programme component included formative research, generating a rare and rich knowledge base. As just one example, a baseline, unlinked, anonymous biological and behavioural survey conducted among employees on 23 farms in two South African provinces revealed high rates of multiple sexual partners, low rates of condom use, and HIV prevalence among farm workers approximately double that of the general population (IOM, 2010). Behavioural and social change communication pilot projects were carried out as a result of the survey, and systematically assessed against a regional framework defining good practice. The survey, and assessments of the projects, informed recommendations to scale up health promotion and service delivery in the agriculture sector in the region, and established baselines for future evaluation studies.

- In 2009 the European Centre for Disease Control commissioned a review of the literature and expert consultations with which to propose recommendations for improving data quality and comparability concerning HIV and migrants in the European region. The report recommended, *inter alia* clearly defining target groups, numerators, denominators, and indicators; and collecting data only if it can be used for improving public health information and action. It discussed a number of potential ethical and practical problems in gathering data about such populations and proposed such measures as making sure that research is guided by members of the target groups (ECDC, 2011).

Catalysing joint planning, mobilizing support

Analysing HIV vulnerability and mapping unmet needs must be followed by joint planning amongst partners from different sectors and institutions. Resources must be mobilized if appropriate policies are to be formulated and programmes implemented, thus donors are among the key stakeholders, along with government policy makers and actors from civil society.

- Acknowledging that in emergency situations those displaced often lack access to HIV prevention, testing, treatment and care, the UK Department for International Development launched a three year UN-system wide work programme in 2006 to scale-up HIV services for populations of humanitarian concern. The programme encouraged joint planning among humanitarian and development agencies, and defined the gaps that hamper access to existing services. It raised awareness, and stimulated national and international agencies to collaborate in advocacy, policy development, technical support, public awareness, and service delivery. In Colombia, for example, where high levels of sexual and gender-based violence towards internally displaced women and girls had been documented, the programme enabled agencies to work together to implement a broad range of interventions addressing the root causes of such violence. A handbook and toolkit were developed, networks of trainers were trained (including government and community leaders) and community reference points were established to coordinate activities. Partners became more proactive and effective in addressing the sexual violence and HIV vulnerabilities and concerns of displaced women (Molesworth and Lescornec, 2009).

Facilitating access to HIV prevention, treatment, care and support

A large number of HIV prevention programmes have been established for migrants, refugees, and other mobile and displaced populations on all continents. Programmes facilitating their access to HIV treatment, care and support are increasingly being established.

- Private transport companies increasingly acknowledge that in areas of high HIV prevalence the costs of absences, and of replacing and training employees, are creating a significant

financial burden, and even threatening commercial sustainability. A study of a transport company in Zimbabwe, for example, estimated that total HIV-related employee costs equalled 20 per cent of profits (Stover and Bollinger, 2009). The North Star Alliance (a public/private partnership founded in 2006 between the international haulage company TNT, the International Transport Workers' Federation, the World Food Programme, and other partners) has established a network of drop-in health clinics at transport hubs, truck stops and border crossings where large numbers of transport operatives and sex workers congregate. Known as "Wellness Centres" the low-cost clinics are geared to the schedules and realities of transport workers' lives. They offer highly accessible but confidential sexual health information, counselling, condoms, and HIV testing, as well as treatment for STIs and common work-related ailments, services for tuberculosis and malaria, and referrals to specialists. There were eight wellness centres in seven countries in Africa in 2008, and 22 planned for 2011 (Disney, 2009). The centres are connected via computerized systems, and clients are issued an electronic "health passport" to facilitate their access to services throughout the network.

Evidence-informed advocacy and combating stigma and discrimination

Going a step beyond facilitating access to prevention and care, the next approach involves active advocacy, raising awareness of – and challenging – stereotypes, stigma and discrimination against migrant, mobile and displaced populations and against HIV among these groups. This involves documenting problems and abuses, using documented cases as a basis for advocacy or legal action, informing mobile populations of their rights, and helping them claim their rights – in other words, empowerment.

- CARAM Asia (Coordination of Action Research on AIDS and Mobility) is a regional network that advocates for migrant workers, their rights and their health. The NGO's membership reflects regional migration routes, and extends across North- and South-East Asia, the Gulf States and the Middle East. CARAM studies have shown that existing health initiatives and policies tend to exclude migrant workers and to disregard their rights. They also highlight the health and HIV vulnerability of mobile people during the transit phase, and document barriers to accessing health services in host communities. These gaps have been addressed by informing and engaging with migrants and the organisations that advocate for them. For example, CARAM has advocated for the sexual and reproductive health and rights of foreign domestic workers, and developed a simple comic book to inform such workers of their rights and of how to assert them. It has also designed and operated regional initiatives to tackle discrimination and stigmatisation of migrants living with HIV, in collaboration with HIV-affected migrant workers (ACHIEVE and CARAM, 2005).

Working upstream: reducing vulnerability in situations and at places known to create it

There is a growing awareness of the power of structural interventions to improve the effectiveness of encouraging individual behaviour change to reduce HIV risk (Auerbach et al., 2011). The literature on HIV and population mobility has long stressed the importance of addressing the "upstream" sources of HIV vulnerability and risk (Decosas et al., 1995).

- In the late 1990s the Asian Development Bank (ADB) developed toolkits for HIV prevention among mobile groups in the Greater Mekong sub-region – such as construction workers, truck drivers, fishermen and migrant sex workers – to increase HIV knowledge, encourage protective behaviours, and build resilience by fostering environments that support

- HIV risk reduction (Asian Development Bank, 1999). The toolkits were subsequently used to guide prevention and mitigation interventions in construction projects funded by ADB loans in other areas as well. For example, the Government of the People's Republic of China recognized that the ADB-assisted Western Yunnan Roads Development Project would not only improve access between rural and urban areas, but could also accelerate diffusion of HIV and other STIs. It thus requested the Bank's technical assistance to prevent and mitigate the potential social risks associated with the project (Asian Development Bank, 2003).
- Also in the 1990s, analysis of the explosive spread of HIV in Southern Africa identified a number of strategies for altering the "upstream" conditions that create HIV vulnerability among migrant workers. The approaches proposed range from linking bank loans for major development projects to the obligation to carry out "AIDS impact studies" (analogous to the aforementioned example from Asia, and to environmental impact studies) – to such changes as replacing all-male barracks with housing suitable for families, or reducing waiting times for trucks at international border crossings – thus reducing the amount of time truck-drivers spend in "hot spots" known for risk behaviours (IOM and Southern African Migration Project, 2005).
 - If HIV-related stigma was an enigma in the 1990s, its causes are well understood today (Parker and Aggleton, 2003). A variety of remedial strategies are available, ranging from documenting and discussing levels of stigma and discrimination experienced by migrants, refugees, or people living with HIV, to reviewing and removing stigmatizing policies. An example of the latter that directly affects mobile, migrant and displaced populations is an effort to change the HIV-related travel restrictions that effectively stigmatize the populations, while doing nothing to effectively protect public health. In 2008, UNAIDS convened an International Task Team on HIV-related Travel Restrictions, comprised of representatives of governments, international organizations and civil society. The Task Team's report recognized countries' right to define who is eligible to enter their borders, but also pointed out that international human rights law constrains countries in how they do this. It reiterated previous recommendations that HIV-related travel restrictions would be ineffective, impractical, and wasteful, and recommended that countries replace them with access to HIV prevention, treatment, care and support for all mobile people, citizens and non-citizens alike (UNAIDS, 2008a). Subsequent to this initiative, HIV-related travel restrictions have been lifted in a number of countries, including China, Fiji, Namibia and the United States (<http://www.hivtravel.org/>).

DISCUSSION AND CONCLUSIONS

This article pursues themes that were addressed in a ground-breaking set of articles published in *International Migration* in 1998, including one of the initial reviews of knowledge concerning "migration and AIDS". That special issue of the journal was commissioned by UNAIDS, as was the 2009 session that precipitated the current article. Both efforts were aimed at practitioners and policy-makers in the field of HIV, but especially at the diverse audience of policy specialists and researchers in both fields, to raise their awareness as to aspects of the relation between migration and HIV.

The scope of this article is deliberately very wide, and it intentionally addresses diverse populations and regions. While the policy issues concerning truck drivers, refugees and second generation migrants, to take just some examples, are clearly quite different, and differ according to geographic locale, the various mobile populations have numerous vulnerability and programme issues in common, from which instructive ideas and lessons can be extrapolated. The focus, however, is limited to HIV. For a variety of reasons, ranging from concern for the public health to xenophobia and fear

of the “other”, HIV and AIDS in relation to mobile populations have received a great deal of attention ever since AIDS was defined over 30 years ago. The interest has been far greater than that in other health issues concerning mobile populations. Here, too, some extrapolation is in order, to apply some of the lessons learned in relation to HIV to other migrant health issues.

Population mobility and migration will continue for as long as environmental changes, conflict, and economic inequalities – or simply a desire for travel and adventure – push and pull people away from one place and towards new ones. Mobility benefits individuals, communities and nations, yet the conditions under which people move often increase their vulnerability to HIV. Calls have been made to reduce such vulnerability, and to assure that people on the move have access to relevant information and services so that they can reduce their HIV risk. A wide range of policies and programmes have been developed, at first focusing on HIV prevention, then more recently on providing treatment, care, and support.

Serious gaps nevertheless exist. These include insufficient attention, and often distorted views, of the importance of population mobility in relation to HIV; limited application of up-to-date research and programming strategies that avoid stigmatizing groups that are already marginalized; imprecise and diverse definitions of target populations that make rigorous comparisons impossible; inadequate programme monitoring and evaluation; the slow pace of inter-regional knowledge sharing and policy development; and a fragmented approach that retards sustained improvement in the lives of the people on the move. Among the major hindrances is the tendency for countries’ HIV strategies to leave out people who are present only temporarily, pushed by an emergency, or without regular legal status: scarce resources tend to be allocated first and foremost to citizens. Another challenge is that dialogue and collaboration across sectors, organizations and nations is often practically difficult, and may be uncomfortable: cross-sectoral conversations tend to fall between the cracks unless they are specifically planned for and driven by leadership of the interested parties, with good management and accountability for results.

The reasons for which people on the move miss out on HIV-related health and social services can be complex, yet promising approaches have been pioneered by local, national, regional, and inter-regional actors. Often the rate-limiting factors are awareness of these tested approaches, and political will to adopt, adapt and implement them. Field experience shared during this review would argue that all six of the identified strategies should be adopted, and implemented in a coordinated manner. These include policy dialogue to build bridges between partners; generating and using data to document needs and evaluate policies and programmes; reaching out and programming together – rather than stapling together disconnected sectoral strategies or projects; delivering on national commitments to provide universal access to needed HIV services; abolishing stereotypes, to recognize the contribution made by people on the move – assuring that they are included in comprehensive national AIDS strategy development and programming; and implementing structural interventions that work “up-stream” to reduce underlying social, economic and political causes of HIV vulnerability and risk. More documentation and evaluation using rigorous and ethically sound study methods is required, along with more integrated policy and programmatic actions. So too, is more evidence-informed advocacy to dispel persistent and sometimes pernicious myths about migration, mobility and forced displacement. It is only when rights-based and evidence-informed policies are implemented, and when people on the move have access to prevention, treatment, care, and support, that “universal access” will truly become universal, and equitable.

ACKNOWLEDGEMENTS

It is impossible to individually thank the large number of people who helped prepare this document. Among them are the staff members of UNAIDS, its co-sponsors, and other international

organizations, as well as representatives of member states, and civil society organizations who went far beyond the call of duty in preparing the sessions for the Programme Coordinating Board meeting. They include the participants in its lively discussions, many of whom also contributed written material. Nina Allen, Andrea Miller, Emma Fowlds, David Trees, Kiran Dhanapala, Marion Schilperood, Susan Timberlake, Allehone Mulugeta, Monique Middelhoff, Emir Salim Yüksel, Kourosh Ahmadi, and Christine Harmston were exceptionally supportive in the preparations, and Tonie Jaquez, Robert Carr, Sissel Hodne Steen, and Wangari Tharao served as rapporteurs on the discussions. An advisory group accompanied the entire process, from the initial conceptualization of the session to guiding the background documents produced: in addition to two of the authors of the present document [MH-K and KM] these included Mina Mauerstein-Bail, Laura Agustón, Peter Wiessner, Lee-Nah Hsu, and Michaela Clayton. Further assistance with the background paper was provided by Robin Jackson, Annmarie Isler, Robin Landis, Sara Simon, Caitlin Wiesen, Marta Vallejo, Jenny Butler, Ann Pawliczko, Rosilyne Borland, Camilla Gendolla, Riku Lehtuvuori, Alasdair Reid, Nwe Nwe Aye, Mumtaz Osman and Iris Semini. Finally, the authors would like to thank anonymous reviewers for their helpful comments on previous versions of the paper.

NOTES

1. "Universal access" does not imply that there will be – or even should be –100% coverage of all HIV services everywhere. Different countries and settings have distinctly different HIV epidemics and different needs, which change over time (UNAIDS, 2008b); therefore it would be unrealistic to attempt to prescribe a uniform or static package of HIV responses, including for people on the move.
2. A small number of countries may deport migrant workers discovered to be living with HIV (see www.hiv-travel.org). The issue, and the related issue of HIV-related restrictions on entry, stay and residence, has been the object of intensive policy discussion practically since the beginning of the AIDS epidemic.

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