COMPENDIUM OF

MIGRATION AND

HIV and AIDS -

INTERVENTIONS

2009

IOM works to help ensure the orderly and humane management of migration, to promote international cooperation on migration issues, to assist in the search for practical solutions to migration problems and to provide humanitarian assistance to migrants in need, including refugees and internally displaced people.

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HIV and Mobility: Compendium of Migration and HIV and Aids Interventions.
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COMPENDIUM OF MIGRATION AND HIV AND AIDS - INTERVENTIONS

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Compendium of Migration and HIV and Aids - Interventions

Foreword

In an era of rapid globalisation, human migration has evolved into a dynamic phenomenon. with respect to the multitude of factors contributing to migration of unparalleled numbers of migrants across immense geographical trajectories. Evidence of the relationship between mobile populations and HIV and AIDS is increasingly being seen as significant. While this continues to be an important and debated issue, there is greater acknowledgement that mobile populations are more vulnerable to infection by HIV when compared with local populations. AIDS and migration are two of the crucial social issues facing today's changing world. At the end of 2008, UNAIDS and the World Health Organisation estimated that almost 33 million people were living with the human immunodeficiency virus (HIV). More than 90% of these infections have occurred in developing countries, where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus.

With interstate and international travel becoming easier and more common, the increase in population mobility is bringing about discussions on several public issues such as public health, climate change and poverty.In this context, the linkages between HIV and AIDS & mobility need to be seriously debated and understood. Migrant populations have a greater risk for poor health in general and HIV infection in particular. This is due to the impact of socio-cultural patterns of the migrant situation on health, their economic transitions, reduced availability and accessibility of health services, and the difficulty of the host community health care systems to cope with the traditions and practices of the migrants. The otherness of migrants creates often xenophobia, isolation and hostility by the host community. In addition, as with other people living with HIV and AIDS, migrants who are HIV positive are subject of stigmatisation and discrimination, and therefore, they hide their HIV status as long as possible, thus making support services unavailable for them.

Women and children, particularly girls, are disproportionately vulnerable. They are more susceptible to violence and abuse, which increases the likelihood of becoming infected. The responsibility for caring for orphaned children or ill family members falls primarily on women and girls, also often limiting their access to education. Even if health and social services would be prepared to assist migrant populations, they often encounter great difficulties to reach out to them. Due to their powerlessness, they are frequently subject to all kinds of exploitation, including sexual exploitation. To provide migrant populations with services to prevent HIV infection and care for those living with HIV and AIDS requires innovative and culturally sensitive approaches, some of which are described in this document.

Stigma and discrimination is also a key challenge to mobility and HIV. While host communities has been increasingly perceived migration as something negative, and xenophobia is increasingly becoming more common, people living with HIV are particularly vulnerable to stigma and discrimination in this context. Cultural misperceptions regarding HIV infection combine with existing power imbalances and gender inequalities to create a scenario of social

exclusion that can further limit migrants' access to health, education and basic needs. Stigmatising and discriminatory measures are expressed in several forms, such as compulsory screening and testing, restrictions of the right to anonymity, prohibition of people living with HIV to perform in certain occupations, or even isolation, detention and compulsory treatment of infected persons in extreme cases. Despite the efforts of international organisations and civil society and the firm steps towards unveiling some discriminatory practices against people living with HIV throughout the globe, much work remains to be done to provide PLHIV with the highest levels of human dignity.

Understanding the reality and developing appropriate interventions to provide required support to the migrant communities to protect themselves from the threat of HIV and AIDS is the need of the hour. This document compiled by International Organization for Migration (IOM) examines various dimensions related to migration and HIV and AIDS, experiences and lessons from different parts of the globe, laws and regulations related to migration and HIV and AIDS, national and global responses, projects in addressing HIV and AIDS linked with movement of population. This document is a modest attempt to bring in global experiences and knowledge in addressing/managing migration and HIV and AIDS. Various projects and programs being designed and implemented in different parts of the world is discussed in this document. We hope that this humble attempt will help the readers to have a glimpse on migration, HIV and AIDS issues and programs that have been taken up in different parts of the globe.
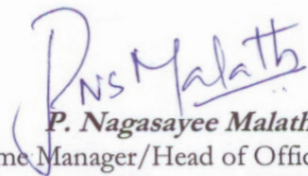
Prof. Charles Gilks
Country Coordinator
UNAIDS India

ACKNOWLEDGEMENT

INTRODUCTION TO THE DOCUMENT

It should be noted that the special interest in working with migrant populations and developing documents related to migration, HIV and AIDS stems from the perceived increase in vulnerability of migrants and their special needs, and not in viewing them as posing risk or threat to the host communities.

This document, best practice collection, is the product of an intensive search using available literatures of all forms. About 650 documents and reports on migration, mobility, HIV and AIDS in various parts of the world were referred and analysed and the information synthesised together in a manner that could help the reader to have a first hand understanding on different types of interventions that had been carried out by various organisations in different parts of the globe.

The best practice document is divided into three main parts – Part A look into interstate migration, HIV and AIDS issues of migrants, interventions and experiments in India in addressing mobility of people, HIV and AIDS. Part B deals with information/knowledge on migration, migrants issues, projects and programs implemented in various South Asian countries and the final part, i.e., Part C provides an abridged version of interventions and projects implemented in various parts of the world, except in south Asian countries on migration, mobility and HIV and AIDS.

The document essentially deals with migration, HIV and AIDS trends, migration, HIV and AIDS related policies, legislations and rules, major programs and projects that have been taken up by different stakeholders to address migration, HIV and AIDS issues at global, regional, national and sub-national level. The document will provide a list of available projects, programs and documents related to migration, HIV and AIDS. This is only a small attempt, a lot more need to be done to include ideas, concepts, programs and projects being taken up in all corners of the world. Some of the tools and instruments used in developing programmes and projects, training courses, implementation of activities, and monitoring and evaluation are provided as examples in tables and text boxes. Interested readers are encouraged to contact the authors directly for more detailed information on those tools and instruments.

Part A
Indian Scenario

Introduction

The latest data on migration released by the Government of India (GoI 2005) based on the Census of 2001, show that migration has increased: 30 per cent of the population or 307 million people were classified as migrants compared with 27.4 per cent of the population or 232 million people out of the total population of 838 million people in India in 1991. Of these, nearly one-third had migrated in the previous decade. However of the total, nearly 44 per cent had moved for marriage (mainly women) and only 14.7 per cent had moved for employment. Rural–rural migration continued to account for the bulk of movements (54.7 per cent) but had reduced during the previous decade. Movements from one urban area to another accounted for 14.7 per cent and the rest were urban–rural migrants. Rural–rural movements are mainly over short distances, while rural–urban migrants cover greater distances, often travelling to different states. While there are no official estimates of temporary migration, there is an informal estimate of 30 million, which is 10 million up from the informal estimate of Deshingkar (2005). Labour-sending areas are typically agriculturally backward and poor and emerging destinations are towns and cities, industrial zones, coastal areas for fish processing and salt panning. High productivity agricultural areas ('green revolution areas') continue to be important but more migrants are opting for non-farm employment because of greater returns. Migration rates are high among the most and least educated. Unlike East and South-east Asia, illiterates appear to dominate seasonal labour migration (Rogaly et al. 2001; Haberfeld et al. 1999).

If we focus only on migrant workers as defined by the ILO, it carries the risk of leaving out a substantial part of mobile populations: on the one hand, internal migrants, including seasonal agricultural workers, and on the other mobile workers such as trucks drivers, itinerant traders, border workers, and commercial sex workers who are among high-risk behavioural groups and important from an HIV and AIDS intervention point of view. Therefore, we have to broaden our definitions to include these groups if we are to deal adequately with the issues of mobile and migrant workers and HIV and AIDS. Most existing studies and programmes on migration and HIV and AIDS have in fact focused on mobile workers.

Migration, HIV and AIDS and India: Migration dates back to even before the British rule in India. During the time of the British, Indians moved to other colonies of the British for work. India is both a source and a destination at the same time. While men and women both skilled and unskilled migrate out from the country in search of better employment opportunities, there is an influx of labour into the country. The government is making efforts to regulate out-migration from the country. The 1983 Emigration Act facilitates employment on a contractual basis and also safeguards their rights and welfare. Migration being as widespread as it is needs more attention for a complete development perspective to emerge.

India is not just a source country but also a destination for workers from Nepal, Bangladesh and other countries. There are a sizeable number of migrants from Nepal and Bangladesh primarily in India but adequate provision for support is not made available to the migrants. Workers from neighbouring countries come voluntarily but there is forced and illegal migration too, and under such exploitative conditions, health, and especially HIV, vulnerability increases. India is still to sign the 1990 UN Convention on Migrant Workers and their Families. Also, there is need for dialogue and agreement on the movement of labour between the source and destination countries in order to protect the rights of the migrants.

Setu Project: Ganjam and Gajapati

A project of CRS and LEPRA Society was jointly implemented from April 2005 through the local partner NGOs (ARUNA, Berhampur and SWAD, Rayagada) in Ganjam District of Orissa. The project aims to improve the quality of life of people in the operational areas through an integrated approach by promoting safe and informed migration and safe sexual health. During the period, the major focus was on IEC campaign for the migrants and their families, PRIs, CBOs, school teachers, NGOs, SHGs, Peer educators, Members of the village development committee and general people etc.

In addition to this, a series of capacity building programmes were organised for the local community members, PRI representatives, project personnel and other stakeholders for reducing stigma, providing adequate information on HIV and AIDS, care and support , community mobilisation and encouraging the community support. Further, regular clinical supports were provided to the people through the referral services and organisation of health camps. With the active co-operation of the Panchayats, the migrant registration process also stated at the Panchayats. The project also developed an information kit for the migrants. Similarly the migrant committee was formed in the target areas. The project efforts were continuing for identifying the suspected and HIV positive cases and referring them to VCCTC as well as providing them and their families with care and support, including counselling, nutritional supplements, nutritional advice and treatment for opportunistic infections.

http://www.lepraindia.org/newevents.htm

Nepal-Vulnerability of Migrant Workers: The opportunities for employment in Nepal are primarily in the agrarian sector. Nepal has not moved significantly towards a more industrial set up and therefore there is a high unemployment and under employment. To promote employment opportunities, the Government has taken measures to establish relations with neighbouring countries and make inroads for Nepali citizens in their workforce. A large number of Nepali migrants move to India and Bangladesh in search of employment. The legislations available to Nepali migrants are: the Foreign Employment Act 1985 and the Foreign Employment Regulation 1999. Most Nepali migrants are young men who travel in search of employment. Lack of information exposes them to a greater risk, making them vulnerable to contracting HIV and AIDS. There is need to promote awareness programmes in Nepal to ensure the safety of the migrants.

Types of Internal Migration

Population movements of the scale currently experienced by developing countries have significant implications for the spread of sexually transmitted diseases (STDs), HIV and AIDS. Initially it was only migration across border that worried governments in countries experiencing heavy migration from other countries with concern that incoming migrants might bring HIV with them. While

> **Migration and HIV transmission in rural South India: An ethnographic study**
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> *There is a widespread assumption in Northern Karnataka, India that HIV transmission is due to the large volume of male seasonal labour out-migration. In order to examine this issue, an ethnographic study was conducted in one of the Northern Karnataka districts using a combination of quantitative and qualitative methods. Findings indicate that migration does not seem to be a key factor affecting sexual behaviour among married men. Nearly 35% of married migrant men reported being involved in extramarital sex and 40% of unmarried migrant men were involved in premarital sex. While earlier in the epidemic there was a strong correlation between HIV infection and migration, more recently the correlation seems to be getting weaker. More innovative HIV prevention programmes which take into account the social and cultural characteristics of this region are urgently needed to curtail the rapid development of the epidemic.*

Types of Migration	Characteristics	Comments
1. Rural to Rural	Movement from one rural area to another. Consists of both short- and long- distance movements of traders, pastoralists, and agricultural workers.	
2. Rural to Urban	2. Rural to Urban Movement from rural to urban areas driven by poverty, low agricultural productivity, population growth, shortages, fragmentation and inequitable distribution of land, environmental degradation, and lack of economic opportunities in rural areas (Oberai 1987 cited in IOM 1995).	The most common form of internal migration. By 2020, the populations of urban areas of the developing world are expected to increase by nearly 1 billion people (UN Secretariat 1994 cited in IOM 1995).
3. Urban to Urban	Movement from one urban area to another, usually for employment.	A dominant form of migration in countries that are highly urbanized, e.g., countries in North America and Europe.
4. Urban to Rural	Movement from cities to rural areas, often as part of a "new settlement" plan; some return to their rural homes after having migrated to cities.	

this scenario still persists, there is increasing recognition that migrants may be more vulnerable than local populations to acquiring the infection during migration, and they may spread the infection upon return to their respective homes. In addition to international migration, economic hardships related large volume of internal migration streams have also become matter of serious concern in the dynamics of spread of STDs and HIV and AIDS. The concern arises from the fact that volume of internal migration within countries is much larger compared to volume of international migration, signifying the enormity of the volume of people at risk. Besides, internal migration of people may be much faster and migrants may move to several places within a short span of time thus extending the territorial spread of these diseases. The increasing movement of people, with associated age and sex selectivity in terms of dominance of single male migration, has great potential in spreading the sexually transmitted health risks. In addition to age and sex selectivity, in case of developing countries majority of the migrants are poor and illiterate migrants from rural areas. Majority of them work as labourers on construction sites, factory workers or in other informal activities in cities and earn too little to have formal housing in the cities. Most of these migrants live in slums in sub-human living conditions. It is well known that vulnerability to STDs and HIV is often greatest when people find themselves living and working in conditions of poverty, powerlessness and social instability, conditions which apply to most of the migrants. Separation from family and socio- cultural norms, isolation/ loneliness, a sense of anonymity that offers more sexual freedom, and availability of some disposal income in hand, make migrants more vulnerable to adopting high-risk behaviour such as alcohol and drug-use and unprotected sex with the person with unknown sexual history, making them vulnerable groups for HIV infection (UNAIDS and IOM, 1998).

They move single leaving their families in the villages, thus nobody to fall upon in case of need. They often feel insecure and isolated at the place of destination. The resulting isolation may increase vulnerability to HIV (Bronfman and Minello, 1995). However, migrants being social human beings create their own social networks and relationship, which are often non familial and of short duration particularly among single migrants. This kind of social networking and relationships may also make them more vulnerable to peer group pressures and acts. In addition to individual risk-factors of HIV and AIDS infections, migrant labour is also exposed to various environmental risk-factors, such as availability of recreational outlets like beer bar, discotheque, easy availability of commercial sex workers, exposure to pornographic materials, etc. that may increase the vulnerability to HIV infection. The cultural heterogeneity of people from different areas may keep the anonymity of the relationships with realistic possibility of unsafe sex due to drunkenness, drug-use that are known to weaken self control. The problem gets multiplied if these migrants have poor or no access to health care as well poor information about the health care facilities at the place of destination.

The threat of extensive spread of HIV is looming large in India. The estimates show that 3.2 million people in India are infected with HIV and more than 125,000 cases of AIDS already have occurred in the country. The most rapid and well-documented spread of HIV has occurred in Mumbai city and the state of

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SAHAS project – Surat

The organisation has undertaken work with men employed in the diamond cutting and polishing industry in the city which is reputed to be the largest in the world for supply of polished diamonds. Majority of the men were migrant labour from rural parts of Gujarat and other states of India and the special concern was their vulnerability to HIV and AIDS while in the city. Their single status, peer influences, disposable income , easy availability of sexual partners and low awareness regarding transmission of HIV were some of the factors which put the men at considerable risk of acquiring HIV infection. Of further concern was the possibility of transmission of the virus and other sexually transmitted diseases to the spouse/ regular partner during annual/biannual visits home by the men who are already infected.

To address these concerns, the team of outreach educators provide HIV and AIDS and sexual health education to the workers at the worksites , promote safe sex to workers at risk and link them to counselling, testing and treatment facilities at the clinic set up by the project.

The clinic was very popular with the patients. The aim of the clinic was to provide general health care, counselling, treatment of sexually transmitted diseases, testing for HIV, early detection and treatment of opportunistic infections, counselling on nutrition and referrals for detection of tuberculosis, referrals for treatment of AIDS and hospital care when needed. Involvement of people living with HIV as peer counsellors had added value to the services provided.

Within a year, the project was successful in reaching 12187 migrant workers with sexual health education and identification of 2505 men at risk of contracting HIV infection. The men were offered counselling, diagnosis and treatment for sexually transmitted diseases and HIV testing facilities. 824 men received treatment for sexually transmitted diseases, 372 men volunteered for HIV testing after counselling and 107 men who tested positive were given care and support facilities.

The project planned to spread awareness on HIV and AIDS in the rural populations who are highly vulnerable due to migration of men from their villages.

Tamil Nadu. In Mumbai HIV prevalence has reached the level of 50 percent in sex workers, 36 percent in STD patients and 2.5 percent in women attending antenatal clinics. Contrary to traditional belief, studies show that sexually transmitted diseases and sex with multiple partners are common in the country, both in urban and rural areas. It is felt that HIV is spreading fast to rural areas through migrant workers and truck drivers. Surveys show that 5 to 10 percent of some truck drivers in the country are infected with HIV. These studies on certain highly mobile groups such as truck drivers, commercial sex workers and itinerant traders though have helped in drawing inferences about linkages between migration and HIV Spread, there is a paucity of credible information on the actual role of migration in the spread of HIV.

There is an urgent need to develop and implement more effective responses to HIV and 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.

Targeting Populations at Source

Given the association between HIV and mobility of population, new models of interventions address mobility specifically. Certain adaptations to the traditional prevention models have been made to take into account the different stakeholders involved and associated with mobility and the dynamic nature of the population movement. The effective design and implementation of these approaches depend on good information on the dynamics and behaviour of the population(s) and the epidemiology of the disease, appropriate programs including language and culturally sensitive programs and capacity for monitoring, evaluation and coordination of all partners – local, regional, private and public.

At the source community, programs might include income generation or literacy programs in order to reduce the propensity to move or, in the latter case, ensure that those that move are better educated on HIV and AIDS. These types of programs are likely to lead to reduce risk of infection but also reduced vulnerability if a mobile member of the community who is providing remittances to the community falls sick. Examples of interventions within source, transit and destination communities include: firms involved in the recruitment of mobile workers working with local NGOs to provide reproductive and sexual health programs or facilitate the movement of an employee's family with the migrant labourer.

The program will be implemented through using community-based interventions strategies. The programme would be implemented in identified communities with the support of local NGOs and migrants' organisations. The NGOs will increase their reach by mobilising community associations, such as youth groups and migrant wives groups, in the fight against AIDS. The main focus of the programme would be on behaviour change through massive awareness creation and increasing the accessibility of condoms at the community level. In order to sustain activities, emphasis will be given in building organisational capacity through technical assistance to local NGOs, district health offices and PHCs in close coordination with district, block and Gram Panchayats.

Comprehensive HIV and AIDS Programme among Nepali Migrants and their families in Delhi

Initially they had identified 14 sites for interventions. Later on added more sites where Nepali migrants were found in large numbers. There were around 25 intervention sites.

The project started the work by concentrating on rapport building with the Nepali migrants, through giving information about the facilities and services available in the Drop-in-Centre (DIC). The project also provided information on HIV and AIDS, and STIs by conducting one to one sessions, group sessions, street corner meetings, film shows, and mass sessions through street plays and Magic shows on HIV and AIDS and STIs.

Developed Special Tool Kits in Nepali, Training of the Field Animators (Nepali Peer Educators), Drop in Centres, "Gaudhuli"- A trip to Nepal, Clinics, Pre-test counselling & referrals to VCTC, sensitisation meeting with the health care providers, sensitisation meeting with the stakeholders, condom outlets, respondents drive approach, health camps, satellite radio 'Desh Pradesh' programme, care and support services

1. *Conducted 8033 one-to-one sessions on STIs/ HIV and AIDS with Nepali migrants and 3652 sessions in GB Road. Other subjects covered were health, hygiene, correct condom use and safer sex practices.*

2. *One to group meetings - Here we covered the same subjects as mentioned above and gave referrals to our DICs and informed them about HIV testing facilities available at our centres.*

AIDS AWARENESS GROUP, Delhi

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ICHAP Project

One major initiat ive was to design, implement and demonstrate a replicable programme model for HIV prevention and care for migrant men and their sexual partners from two states - Rajasthan and Karnataka. The Rajasth an HAMARA project works in the Shekhawati region of Rajasthan (place of origin) and in Ahmedabad, Gujarat (place of transit) and Mumbai, Maharashtra (place of destination). The primary target groups are the spouses of migrants including the return migrants and potential migrants. The ICHAP collaborated with the State AIDS Control Society and partnered with four organisations for designing and implementing the programme- Bhoruka Charitable trust, M.R. Morarka GDC Rural Research Foundation, Saral and Jyoti Sangh.

(i)   Needs assessments: A situation needs assessment was done in all blocks of three districts of Rajasthan - Churu, Jhunjhunu and Sikar in October December 2002. At the same time, a needs assessment was done in Mumbai (place of destination).

(ii)   Baseline study: A baseline study was done during January-March 2003 in those blocks that showed high out migration and cases of HIV were identified.

(iii)   NGOs identified: Identified the grass root level agencies to implement the programme at place of origin, transit and destination.

(iv)   Training: Capacity building exercises were done for the partnering implementing agencies and HAMARA designated staff to work in the area of Sexually transmitted Infections (STI), HIV and AIDS and public health approaches.

(v)   Cluster offices opened: In the areas of operation, the implementing partners opened cluster offices for every 18,000-20,000 population and for each cluster recruited one male and one female health worker. Other staff involved in implementation included one project coordinator, two assistant project coordinators and 5 administrative staff for the whole project.

(vi)   Links formed: The project established linkages with the Government-run Primary Health Centres (PHC). This included training 50 PHC doctors on syndromic management of STI/Reproductive Tract Infections (RTI) and care to people living with HIV and AIDS and involving them in holding STI camps in villages. Medicines were procured and distributed to PHC doctors for management of STI cases. The partnering agencies mobilised community support by partnering with smaller partner non-government organisations in the area of operation. Village Health Committees (VHCs) were formed in every village and the platform was used for HAMARA programmes.

(vii)   Condom depots: The project established condom depots at strategic locations within the villages. In Rajasthan, each village is divided into mohalla (locality) and in each mohalla a meeting was organised to identify condom depot holders. In keeping with the culture of the area, the meeting was arranged separately for men and women.

(viii) Peer educators: Male and female Peer Educators (PE) were selected from the villages. They used to report to health workers of HAMARA project. About 1,200 volunteers were selected and trained to carry out household surveys, identify potential migrants and refer cases from the community to PHCs run by government and NGOs.

(ix)   Publicity: The project developed a lot of communication material on HIV in Hindi such as flip STD cards, stickers, pamphlets, snake and ladder games related to HIV, booklet etc.

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(i) Monitoring: The project prepared a household register consisting of household characteristics including migration status. The PE updated the register regularly for identify potential migrants and arrange one to one or one to group meetings.

(ii) Destination: Hamara had been working with Rajasthani migrants in Piplaj, Ahmedabad and in Kherwari, Mumbai. In Ahmedabad, local resource agency, SARAL, and an NGO, Jyothi Sangh. In Mumbai, ICHAP was undertaking direct implementation with Rajasthani staff recruited through one of the Hamara partner NGOs in Rajasthan, BCT. In Ahmedabad, through a partner NGO, an outreach team of six was reaching almost 3,500 Rajasthani migrants. This outreach team distributes free condoms, conducts VCT and STI referrals, and organizes popular IEC cultural events. A team of 15 trained Shekhawati peer educators was in place to support community outreach. In addition, 17 condom depots had been established. In Mumbai, 6 person outreach team distributes free condoms and provides VCT and STI referrals, and reaches 2,200 Shekhawati migrants. Seven peer educators had been trained and support program outreach. The Rajasthan States AIDS Control Society (RSACS) was involved from the very beginning of the HAMARA project i.e., in the design, training and monitoring of the project. At the destination level (in Ahmedabad and Mumbai) there was also a technical agency monitoring the project and providing all the technical support. Overall project management responsibility was with the Project Officer who reports to the State Coordinator.

(iii) Results: The project covered 30,000 Migrants, 24,000 migrants' wives and 6,000 "potential" migrants. The key achievements of the project were as follows:

a. Condoms were promoted through condom depot holders, separately for men and women in all villages.

b. An enhanced STI management system with quality referral service was operational in all sites. Over 70 government doctors had been trained in syndromic case management.

c. The capacities of 2 Non-Governmental Organisations (NGO) - Borukha Charitable Trust and Morarka Foundation had been strengthened for effective programme implementation. The two agencies, in turn, were partnering with 8 grass root level NGOs.

d. During the project period in 133 villages spread across Sikar, Jhunjhunu and Churu, the project was able to identify 4,609 STI cases and 3,735 cases were treated.

e. The condom use at the beginning of the project was almost negligible in the project area. The available statistics culled from monthly progress report of the project shows that by the end of February 2006, the cumulative condom distribution figure was 1,319,513 at district of origin in Rajasthan.

f. Awareness on STI/HIV has increased. The number of one-to-one contacts and one-to-group contacts was 62,537 and 1,19,249 respectively. After the completion of the project in March 2006, the activities undertaken in HAMARA would be up-scaled by Rajasthan State AIDS Control society. Till this happens, a trust namely, India Health Action Trust has been formed to oversee the project activities.

Source:http://cbhi-hsprod.nic.in/listdetails.asp?roid=200

The programme will mainly target migrant men and their wives. The migrant workers will be given orientation on HIV and AIDS and STIs, which includes education on how to prevent infection. The men will be approached on an individual and group basis by peer educators trained under the programme before leaving for work. Attempts will be made to follow up through education at their transits and destination sites also. Drop-in centres (DICs) at different locations, entry points to and out of identified villages will be established as a part of the programme activities. This will be a better instrument to reach out the migrants. These centres will be used as centres to provide education, condom promotion, and distribution of IEC materials regularly. From the DIC functionaries can approach the migrant men/women who are moving out to a different destination and those who emerge from the destination and before they proceed home.

Partners at the Source to make the interventions effective

All the payers in the society need to be included in the process of implementing a project to address migrants at the source to prevent the spread of HIV and AIDS and provide care and support. Some of the main partners would be:

- Local government and hospitals
- Local religious institutions
- Civil society organisations like, NGOs, CBOs, etc.
- Youth and women groups
- Local recruiters (contractors, etc.)
- Panchayat Raj Institutions
- Police and other law enforcement wings
- Self Help Groups, etc.
- Other ongoing HIV and AIDS programs in and around the locality.

Strategies that work

Responses to HIV and 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 programs 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 and AIDS.

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

A basic rule is that interventions for HIV and AIDS prevention and care for migrants and mobile people at source 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 mobile or migrant 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 and AIDS prevention.

Provide information on condom usages before travel. Information availability of condoms at various locations while on travel. Effective approaches include making sure that condoms are available. Information on reproductive health services, including treatment for STIs. Also different locations with details, where, these facilities are available. Culturally and linguistically appropriate HIV and AIDS information may be provided through media campaigns, street theatre, small group discussions sessions and peer education (those who returned from destination). To ensure sustainability, intervention strategies should be linked to migrant association at destination, to local authorities and to local NGOs. Links between sending and receiving communities should also be made.

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

HIV and 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 purpose effective solutions. Experience shows that migrant communities, like nay other communities, will contain individuals and associations willing to make significant contributions to prevent HIV and AIDS and to assure access to care among their own. Given the necessary tools and resources, community members can provide peer education, at different stages, – and support for behaviour change and health needs – that will be more effective than that of coming from "outsiders". In collaboration with partners from source and host societies can also mobilise influence the policies that affect them.

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

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 programs, returning migrants should thus be provided with HIV vulnerability counselling and testing services. If found to be HIV positive, they should be referred to available community HIV care and support centres. Effort 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 and AIDS and other community care and support efforts in destination societies and of return should be encouraged to reach out to and include migrants and mobile people affected by HIV and AIDS.

National and state laws have protective provisions to a certain extent. However, these should be reviewed to ensure that the rights of migrants and mobile people are protected:

• Protection of family unity through adequate support provisions.

• Protection against stigma and discrimination

• Application of labour protection to migrants and mobile populations including minimum wage and right to organise.

• Availability of legal process and legal support in the context of labour issues.

• Protection of confidentiality of HIV status.

• Access to basic social security during transit and at destination.

• Socio-economic support provisions on return.

Suggested Interventions

Available data indicate that HIV and AIDS is escalating among migrants and mobile people and could have a devastating impact among these populations and their families unless immediate steps are taken. Prevention of HIV transmission, and providing continuous, comprehensive care and support for migrants and mobile people who are HIV infected are important and should be part of any comprehensive plan.

• Establishing trust, cultural competence and addressing HIV stigma and discrimination

- HIV prevention, testing and linkage to care

- Access to comprehensive care, case management and enabling services

- Treatment adherence

- Quality of care and services

- Coordinating care across geographic boundaries

- Data, research and planning

- Policy issues relating to improving overall health status of migrants and mobile people

There are now a number of HIV and AIDS prevention programmes for migrant and ethnic minority communities throughout the world, both 'top down' programmes organised, for example, by governments and large NGOs, and 'bottom up' programmes, organised by migrant groups themselves. Evaluation of such programmes, however, is in most cases sorely lacking. The overall assessment have highlighted the need for culturally and linguistically appropriate prevention efforts which use already-existing community structures, as well as the need to identify and train people from within communities to carry out local prevention efforts. Programs need to be initiated to address potential migrants, families of migrants, especially the spouses, developing provisions to provide services at the source, transit and at the destination. A triangular approach through with the migrants will be addressed at all the three important stages of migration. An enabling environment will be created for the migrants to develop knowledge of HIV and AIDS, condom usage, linking with service providers and accessing services. A reporting and referral system needs to be developed to link the migrant with all three stages of migration and when s/he returned to his/her family.   All these are possible when a close collaboration and linkage develop with different players and service providers in all these areas. A government sponsored HIV and AIDS prevention programme can meet with acceptance by migrant communities; considerable engagement in prevention activities can be mobilised; and AIDS prevention among such communities can be effective. Such efforts can create levels of sensitivity to HIV issues and of protective behaviour that are equal to those of the host community. The key elements are to avoid potential for stigmatising by:

(1) Placing HIV and AIDS prevention efforts for migrant populations within an overall national HIV and AIDS prevention strategy

(2) Informing and sensitising general populations within migrant communities before initiating more targeted prevention with migrant IDUs, MSM, and CSWs;

(3) Encouraging, facilitating and guiding health promotion efforts which emerge from within migrant communities themselves.

In short the intervention package should like:

- Outreach and communication at the source

Peer (returned migrants)-led, NGO-supported outreach and behaviour change communication (BCC):

1. Addressing the potential migrants, their families, especially spouses.

2. Addressing migrants' families, especially their spouses.

3. Returned migrants and their families

4. Migrants who infected with HIV and AIDS.

5. Massive campaigns like (e.g. street theatre, games, etc.)

6. Interpersonal behaviour change communication (IPC)

- **Services at Source**

  1. access to condom - promotion of condoms

  2. Linkages to STI (sexually transmitted infection) services and other health services (e.g. ICTC, ART, drug/alcohol de-addiction)

- **Enabling environment**

  1. Advocacy with key stakeholders/power structures

  2. With different migrants organisations

  3. Linkages with other programmes and entitlements

- Liking with Source, transit and destination

- Referral systems

  1. Developing referral cards to link with source, transit and destination.

  - Community Mobilisation

  - Developing and strengthening migrants (CBOs) groups to assume ownership of the programme

    1. Development of Drop in centres

POLICIES AND LAWS IN INDIA

Existing Policy and legal framework to assist migrants between states

India has ratified many ILO conventions but is neither a signatory or ratified the CMW. The Indian Constitution contains basic provisions relating to the conditions of employment, non-discrimination, right to work etc. (for example, Article 23 (1), Article 39, Article 42, Article 43) which are applicable for all workers including migrant workers within the country. Migrant labourers are covered under almost all labourers laws and policies. These laws include the Minimum Wages Act, 1948; the Contract Labour (Regulation and Abolition) Act, 1970; the Equal Remuneration Act, 1976; the Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996; the Workmen's Compensation Act 1923; the Payment of Wages Act 1936; the Child Labour (Prohibition & Regulation) Act, 1986; the Bonded Labour Act, 1976; the Employees State Insurance Act, 1952; and Maternity Benefit Act, 1961.The last two Acts cover only organized sector workers and exclude temporary migrants.

Existing Labour Laws in India Relevant for Migrant Workers

All workers

- Workmen's Compensation Act 1923

- Payment of Wages Act 1936

- Minimum Wages Act, 1948

- Contract Labour (Regulation and Abolition) Act, 1970

- Bonded Labour Act, 1976

- Equal Remuneration Act, 1976

- Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act 1996

- Child Labour (Prohibition & Regulation) Act, 1986

Workers in Organised Sector

- Employee's State Insurance Act, 1952

- Maternity Benefit Act, 1961

In addition to the these laws, Parliament passed the Inter State Migrant Workmen (Regulation and Conditions of Service) Act 1979, specifically to deal with malpractices associated with the recruitment and employment of workers who migrate across state boundaries. The Act followed the recommendations of a committee set up by the Labour Minister's Conference in 1976. The Act only covers interstate migrants recruited through contractors or middlemen and those establishments that employ five or more such workers on any given day. The Inter-State Migration Workmen Act, 1979, defines a migrant workman as one who is recruited by the contractor in the workman's home state. It clearly states that migrant workers are entitled to equitable money to dependent family payable by employers along with their travel expenses when they migrate.

In India, in the case of internal migration among the poor labourers, the migrant's rights have remained elusive. Available studies clearly show that human rights are generally not well protected in informal sector employment. Most of the migrant workers cannot avail themselves of the existing schemes under the national policy on migrant workers as the casualisation of work and the subsequent absorption in the informal sector beats the actual number of migrants working in the informal sector. The Inter State Migrant Workmen Act has largely remained on paper and proved to be futile in the backdrop of helplessness, ignorance and desperation of the prospective migrants.

In the case of the 1979 Act, few contractors have taken licenses and very few enterprises employing interstate migrant workers have registered under the Act. The record of prosecutions and dispute has been very weak. Migrant workers do not posses pass books, prescribed by the law, and forming the basic record of their identity and their transactions with the contractor and employers (National Commission of Rural Labour 1991).[1]

Several studies conducted on the migrant workers working in the unorganized sector in several states point out the violations of the Child Labour (Prohibition & Regulation Act 1986), the Minimum Wages Act (1948), the Contract Labour Act (1970), the Inter State Migrant Workmen Act (1979) and the Equal Remuneration Act (1976) (Breman, 1996; Biswas 2003; Gamber & Kulkarni 2003).[2] A recent tragedy of workers losing their lives due to lack of safety conditions during work, in the month of December, 2005 in Delhi, exposed once again the abysmal working conditions prevailing in the unorganized sector and raised the issue of safety of the workers in the unorganized sectors. In the first case, fire broke out in a garments factory in East Delhi, and in the second case 12 workers buried under the debris at a construction site in South Delhi. The commonality between two isolated incidents within the same month is that the workers who lost their lives were migrants from mostly West Bengal and Bihar. Living in shanty accommodations, these migrant workers were employed on a casual basis by the employer.[3] The rights of IDPs are even more neglected as there is lack of systematic information of the accurate estimate of people displaced due to conflicts, development projects and natural disaster.[4]

> **Interstate Migrants Act**
>
> - Contractors and establishments are required to be licensed and registered by a notified registering authority.
>
> - The Contractor is required to issue a passbook to every worker, giving details about the worker, including payments and advances, and pay each worker a displacement allowance and a journey allowance.
>
> - Contractors must pay timely wages equal to or higher than the minimum wage; prescribed medical facilities and protective clothing; and notify accidents and Causalities to specified authorities and kin.

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1. The Unorganized Sector Workers Bill, 2003 has been drafted by the Central Government following the recommendations of the Second National Commission of Labour 2002, to identify workers employed in the unorganized sector and to provide them with basic social security.
2. This is more present among migrant workers in the brick kilns factories, construction industry, sugarcane plantation, etc. Different kinds of harassment are meted out to migrant workers by the employers, labour contractors, police during their journey, etc. Migrant labour is recruited from various parts of a particular state through contractors or agents for work outside that state in large construction sites and sugarcane plantations. This system lends itself to abuses –working hours are not fixed and workers have to work under extremely harsh conditions. Employment in the unorganized sector compounds their vulnerability.
3. Basu Moushumi ,(2006), Delhi's Twin Tragedy, Commentary, Economic & Political Weekly, Vol. XLI No 9, March 4-10, pg. 784.
4. Would refer to workers moving for temporary employment under GATS Mode 4 agreements

SUGGESTED IMPLEMENTATION STRATEGIES

Implementing Cross-Border Prevention Projects
Listing cross-border locations

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Why?

With each bridge, paved road or port, opportunities for cross-border movement increase. Therefore, it is important to try to establish a working list of international border crossings to serve as the "universe" of possible sites for a project. This list need not be exhaustive. Indeed, listing some unofficial sites might jeopardise the welfare of migrants. It should, however, include the major cross-border junctions where a significant number of people engage in daily economic activity across borders.

How?

- First, list the sites that meet the criteria for a cross-border location. Try to categorise the basic nature of the site from information available from common knowledge (e.g., official/unofficial, land/sea/river crossing, large/medium/small size).

- Be creative about finding reliable sources of information. Include recent migrants, local government officials (particularly health officials) and representatives of nongovernmental organisations (NGOs) that may have development projects in border areas. Trips to the perimeter of the country are often useful and necessary. Look for published lists of cross-border sites (e.g., from the national immigration authority).

- Having an international airport should not be a criterion for selection because the higher priority sites are land or water crossings. (HIV is concentrated among the lower- and middle-income segments of society. Those who travel by air either have higher incomes or travel infrequently and are, therefore, at considerably lower risk of transmitting HIV to large numbers of people.)

- Cross-border sites are not only contiguous land borders; rivers or seas can connect "sister" port towns. Port cities that regularly receive international seafarers should always be included in a list. (However, "rest and recreation" sites that receive foreign navies a few times a year are not necessarily places where HIV flourishes and should not receive priority attention unless they meet other criteria described in this case study.)

Selecting sites for a formal assessment

Why?

Once a pool, or "universe," of cross-border sites is assembled, a subset needs to be selected for more in-depth assessment. The list of potential sites is usually too large to enable efficient assessment. Selecting the preferred sites requires making a judgment on the relative importance of each site for the regional HIV epidemic—current or future. Please note that this step occurs before the on-site assessment. Thus, the selection of priority sites should be made based on secondary information that can be obtained easily.

How?

In the absence of more specific data, sites with larger populations should be selected because they have greater potential for STI and HIV spread. This is because a local economy must reach a certain size in order to sustain overnight accommodations, commercial sex establishments and a wide selection of drinking establishments and to offer people some anonymity to engage in (usually) illegal activities—all hallmarks of cross-border HIV epidemics.

If existing data show that a particular site has a tradition of non-marital sex and a known STI or HIV problem, clearly that site is a priority for selection. Some of the key proxy information to look for is included in the following checklist:

- Do people cross the border for commercial sex?
- Is there a well-established nightlife or entertainment sector?
- Are drugs and alcohol available or traded?
- Is the site on a major truck route?
- Is the site a major port for deep-sea fishing vessels or sea transport?
- Is there evidence that women are welcomed aboard ships in port to engage in commercial sex (the "boat climber" format for commercial sex)?
- Do employers in the area want and employ migrant labour?
- Are there large numbers of soldiers or police in the area?
- Do men outnumber women?
- Are there legal differences between the two countries that stimulate cross-border movements (e.g., availability in one country of gambling, cheap alcohol, drugs, sexual services, pornography)?
- Is there a rapid change in the social environment that could create risk (e.g., sexual experimentation by youth, separation of families)?
- Are government welfare services or medical services weak?
- Is there significant trading of goods and services?
- Is the cross-border site a good-sized town and not just a "pass-through" point to another larger town?
- If a site has already been assessed within the past several years, reports of these assessments and their authors should be consulted as part of site selection and prioritization. Search for previously conducted studies about the sites that might be relevant (e.g., studies of drug use, trade, transportation, infrastructure development).
- A site that has some government or NGO HIV-prevention services may still be considered a priority if these services are weak or very limited in coverage. If a comprehensive prevention programme has already been mounted in a particular site, however, that site should be a low priority for new intervention.
- Sites that pose a security risk should be included and assigned relatively high priority in the list, because HIV tends to thrive in environments that encourage other forms of risk behaviour, such as gambling, organized crime, commercial sex and smuggling. Many of these activities occur in remote border areas because it is usually more difficult for authorities to police such sites. However, one must recognize the increased risk to project staff in such an environment and take this into account during design and implementation phases.

Conducting a preliminary rapid assessment and prioritisation

Why? There are few agencies delivering cross-border prevention activities in different parts and not enough comprehensive programmes to cover all sites adequately. Thus, prioritisation is particularly important in order to avoid wasted effort. More HIV infections will be prevented sooner if programmes strategically select locations with the greatest potential for HIV transmission. Some objective basis for this prioritisation is needed to ensure that resources are directed to the most important locations. The data collected to make these decisions also will help funding agencies understand the need for and goals of cross-border projects.

What? The term "rapid assessment" is frequently used to describe data collection in a number of sites before a final location is chosen for an HIV-prevention project. Such an assessment need not be a complex and expensive behavioural survey. Enough is known about the context of HIV epidemics to allow efficient collection of the relevant data from observation and interviews with a few key informants. The main difference between rapid assessments and larger, more formal surveys is time. Depending on the site, a rapid assessment can range from one to two weeks.

In a rapid assessment, a trained team uses a set of methodological tools to efficiently gather information about a site. The methods may be qualitative, quantitative or both, but are often mostly qualitative. They include in-depth interviews, mapping, observation, collection of secondary data, taking photographs, videotaping and focus group discussions.

How?

- The rapid assessment should provide data on the number of sexual-risk access points, contextual features that support risk, general volume of persons in the cross-border area, the dearth or abundance of HIV/STI prevention resources and political support for a prevention project.
- To the extent possible, use local people as data gatherers. This does not mean, however, that outside people cannot fully participate in the assessment.
- Training is particularly important when the local people have little or no experience in gathering data. Consider training needs when determining how long the rapid assessment will last.
- To the extent possible, conduct the assessment on both sides of the border.
- Consider what will happen in a cross-border site where you conduct a rapid assessment but do not decide to implement a project. How will it affect the people at the site? Can the information collected during the rapid assessment be used advantageously to serve that community?
- Prioritize among sites that have been assessed. From the assessment results, an informed decision can be made about where to begin action among several potential sites. Clearly the sites with greater risk environment and fewer HIV-prevention resources should be given top priority.

Preparing the intervention programme

Why? The rapid assessment may provide the data necessary for prioritising and selecting sites, but it will not yield enough in-depth information about the cross-border community to design a complete intervention programme. For this, a more involved pre-intervention technical assessment is needed.

What? Approaches designed to maximise the opportunity for community input include Participatory Rural Appraisal (PRA) and Participatory Learning and Action (PLA). Such approaches tend to be long term and in-depth. An agency that uses one of them should assume that it will start an intervention programme at the site—to justify the investment and also to be responsive to community expectations. Several shorter-term methods have been used to design cross-border HIV interventions in Asia, including assessments by multidisciplinary technical teams. These methods are focused, direct and rely on a small group of (usually outside) experts. Some of the advantages and disadvantages of these types of approaches to designing interventions are described briefly below. Implementing agencies must weigh the advantages and disadvantages and select one approach or a combination of both. Field experience to date is not sufficient to recommend one method over another.

How? (1) PLA: Participatory Learning and Action. PLA evolved out of the participatory rural appraisal approach developed for analyzing agro-ecosystems. Many of the PLA methods are derived from social anthropology and include visualized information exchange among members of a community. For example, members of a community draw maps showing where people meet, and stones or other objects are placed on the maps to indicate areas of high and low HIV risk. A variety of other tools are used to gather information, including time lines of influential community events, family lines and trend analysis. In the context of HIV, the PLA technique requires particularly skilled guidance from facilitators because of the myths and prejudices that surround HIV and AIDS. While a participatory approach allows more community input, it can also allow those with discriminatory tendencies to dominate group discussion. The facilitator needs to guard against these tendencies and try to ensure that false or bigoted information is exposed and rejected by the group. Despite this hazard, the final result of a successful PLA exercise should be a more profound understanding of the dynamics of HIV/STI risk in the cross-border community, more community investment in a solution and greater sustainability once external assistance ends.

(2) Multidisciplinary technical assessment. In this approach an outside group of technical specialists visits a series of communities and, by reviewing data and holding discussions with local key informants, makes some determination of the level of risk in the environment. If team members consider the site worthy of a prevention programme, they recommend certain general strategies. Then local implementing agencies are given funding to operationalise those strategies. While the factors that lead to HIV risk behaviour are many and complex, the mechanics of prevention can be basic and straightforward. Therefore, having outside technical experts design a plan that applies behaviour change and STI-care strategies that have proven effective in other border areas can save valuable time in mounting a prevention effort. Such early action may, in fact, be more important than long-term sustainability because of the explosive nature of HIV epidemics in Asia. The early period of very high infectivity (first three months after infection) followed by a long period of low infectivity means that a community can become saturated fairly rapidly unless the most susceptible sex networks are "immunized" by individual, group and structural interventions. On the other hand, if such immunization can be accomplished early in an epidemic, the result will be a rapid decline in new cases. Thus, if HIV prevention is the primary goal of a cross-border project, a technical planning team might be more efficient than PLA. However, if long-term community health development is the goal, PLA may provide a broader base for future programming.

Implementing the interventions

Why? It is reasonable to ask why this additional section on implementing interventions is needed— why not simply apply the current state-of-the-art in HIV prevention to cross-border settings? Because of the unique challenges of cross border programmes described earlier, unique adaptations to the intervention strategy are required. The experience of the cross-border programmes in Asia provides important guidance in many areas that other guidelines may not address. The next section lists some of these special attributes of interventions during the start-up phase of cross-border programmes. Since the implementation of these programmes in Asia is still nascent, it is premature to suggest lessons for successful (and unsuccessful) implementation.

How? (1) Forge local partnerships between agencies across borders. The most successful projects have started locally and gradually sought the support of national governments.

• Work with local agencies on both sides of the border.

• Initiate contact at the provincial or district level first; do not try to begin at the national level. Build relationships between local NGOs before forging government-to government collaboration.

• Plan to evolve toward a mixture of both government and NGO programme management.

• Include non-HIV programme areas of priority to local governments, such as assistance with repatriation of illegal aliens or orientation on immigration policies and differences in laws when crossing a border. Explore ways to incorporate these issues into the design of the intervention package. As projects mature, involve higher levels of governments.

• Inform and get approval from military/border police early.

(2) Identify and engage the key stakeholders in cross-border towns/ports.

- Once local cross-border partnerships have been formed, move beyond implementing agencies to link the following on both sides, as appropriate:
    – private sector (clinics, pharmacies, transport companies, fishing companies)
    – commercial sex establishments (with consistent condom-only policies)
    – local border officials (customs/police)
    – immigration officials
    – port health officials
    – branch offices of the Ministry of Defence (reaching men)
    – publicity/media channels (local radio, television, advertisers)
    – mass organisations (political support, connections)
    – UN agencies (expertise, resources)
    – political parties (funding)
    – universities (evaluation, capacity building)

(3) Establish a project advisory committee.

- Identify individuals on both sides of the border from the NGO, government and commercial sectors who can provide guidance and support to the implementing agencies.

- Include representative(s) from local organisations for migrant workers.

- Convene regular meetings of the advisory committee to review obstacles, progress and plans. (The advisory committee should be used as a "sounding board" to suggest what is realistically possible and what is not and to help interpret why activities do not proceed as planned.)

Evaluating the programme

Why? Evaluation is an essential component of all programmes, but it is particularly important for cross-border projects because of the special challenges they face. The high mobility of populations in border areas is perhaps the most formidable challenge, since effective behaviour change communication (BCC) requires repeated contacts. The many languages and dialects spoken in border areas may mean that BCC messages are not fully absorbed, or only by the full-time resident population. And the relative absence of social and legal controls in border areas means that risk is a way of life and that attempts to modify norms may have little impact on mobile populations. These examples are just some of the attributes that distinguish border areas from the average provincial or district capital or trade town. The implication is that what worked elsewhere in HIV prevention may not fully apply in cross-border settings.

Therefore, in this formative phase of cross-border programming, evaluation systems are needed to objectively monitor trends in self-risk perception and risk behaviour over many years. The information they provide will be useful to programme planners and implementers and to the funding agencies that are investing an increasing amount of resources in this strategy for regional HIV prevention.

What?

The following bimodal approach to evaluating cross-border HIV prevention programmes is recommended:

(1) Use quantitative data-collection tools to track risk behaviours over time among certain subgroups of the community.

(2)   Use qualitative methods to assess the environment of risk in the community at large. This approach is recommended because changes in risk behaviour have proved to be one of the more reliable indicators of prevention programme impact in Asia. While behaviour change itself does not necessarily protect one from HIV in all cases, there is a strong correlation between behaviour change and trends in STI and HIV in countries with extensive data. Process data from programme implementation, such as number of persons reached, condoms distributed and posters displayed, are important for monitoring implementation. However, these data do not always provide convincing evidence of programme impact.

How?

Monitoring changes in behaviour among a large population over time can provide reliable evidence that communities are changing in response to project interventions. Some of the recommended indicators include:

- self-reported number of sex partners in the previous six months

- self-reported patronage of commercial sex industry in the previous six months

- self-reported condom use with different types of partners

- self-reported STI symptoms and treatment seeking behaviour

- self-assessment and assessment of others' risk of contracting HIV

- ability to identify effective methods to prevent HIV transmission.

Data collection to measure these and other indicators should be conducted just before the prevention programme begins to establish a baseline and repeated once a year.

The behavioural surveillance survey (BSS) approach, created by Family Health International, has been applied in a variety of settings in Asia and may be an appropriate tool for sub-regional programme evaluation of cross-border projects. A core questionnaire and standard methodology already have been developed for the BSS and are described in several handbooks. While the BSS presents quantitative data on risk behaviour in the cross-border population, other evaluation data are needed on the context of risk in the community.

This is because some border towns have an "atmosphere" of risk that facilitates reckless behaviour and, possibly, HIV transmission. Some of the contextual dimensions that should be investigated (using qualitative data collection methods) include:

- Interaction between the resident population and the mobile populations who travel through a border town

- Self-perception when in or outside the border area (e.g., sense of anonymity, freedom from legal or social controls)

- Behaviours and attitudes of powerful authorities that may encourage or discourage risk behaviour

- Increase or decrease in institutions and policies that encourage or discourage risk behaviour.

Manuals for using qualitative methods to collect data for HIV-prevention programmes are available.

Leveraging Local Resources and Sustainability

Why?

Despite the increased attention to Asia as the area with potentially more future HIV infections than any other region, it is very likely that grant funding for HIV-prevention programmes will continue to decline indefinitely. While loan funds may increase for some time, these funds will be managed by national prevention programmes that may consider border sites a lower priority than large cities. Thus, agencies planning new cross-border interventions need to include plans for sustainability right from the start. As data are being collected during the pre-implementation phase, special attention needs to be given to the capability of the community to mobilize indigenous resources to eventually underwrite much of the prevention costs. If that capacity does not exist, it must be built as part of the intervention.

How?

To invest in, and then sustain, HIV prevention interventions can be particularly challenging in remote cross-border areas. Travel and communication costs are much higher on average for cross-border projects than for programmes in large cities and other more accessible areas. World Vision has attempted to address the sustainability challenge by integrating HIV prevention into its general development work along the border between Thailand and Myanmar. This integration achieves some economies of scale. Other programmes are considering a "prevention marketing" strategy to deliver prevention materials and supplies to at-risk mobile populations through social marketing. Cost-recovery is possible through the collection of modest clinic fees, as is done on the India-Nepal border. However, the most successful HIV-prevention work is achieved through sustained interpersonal communication with trained outreach workers, and this usually requires outside support.

While HIV has spread rapidly in some Asian countries, it appears that the pervasive urban and rural epidemics that many countries in sub-Saharan Africa are experiencing will not materialize in this region of the world. Nevertheless, for future decades HIV will continue to be a serious public health threat. Accordingly, regional prevention programmes need to concentrate their limited resources in the areas most vulnerable to HIV and AIDS epidemics. Analysis of the distribution of HIV in parts of the world suggests that areas with busy land border crossings and international fishing ports have higher levels of STI and HIV than other trade areas. Because of the volume of people who travel to and through these towns and ports, the implications for widespread transmission of HIV are enormous. Similarly, the implications for cost effective reductions in new HIV infections are also great. An increasing number of NGOs and funding agencies are recognizing this border-crossing epidemic-spread phenomenon and are steering resources to the geographical perimeter, instead of the centre, of societies. It is summed up in a few simple words: "Select carefully, start locally, plan broadly."

The experiences of numerous agencies in cross-border STI/HIV and AIDS prevention activities have produced the following program guidelines:

- Link prevention services on both sides of the border.

- Consider communities on opposite sides of the border as a single extended town with heavy interaction between border populations.

- Forewarn mobile populations that there is an unusually high risk for STI/HIV at cross-border areas and that they must anticipate the need for protection when travelling through.

- Produce communication materials in all of the major languages spoken at a border, usually two or more.

Implementing cross-border interventions requires:

Listing cross-border locations:-
Cross-border sites are not only contiguous land borders; water transportation can connect "sister" port towns. Compiling a complete list of cross-border crossings is impossible because sites change by the month. With the building or expansion of roads and bridges, new sites open while others may close or temporarily shut down. But it is important to try to establish a working list, mindful that including some unofficial sites may jeopardize refugees' welfare.

Selecting sites for format assessment:-

Based on the established list, selecting sites for further intervention requires making an informed judgment on the role of each site as a contributor or potential contributor to the regional HIV epidemic. This judgment is made after considering the population, the historical STI and HIV incidence, the commercial sex industry, the availability of drugs and alcohol, the presence of an established entertainment sector, the number of uniformed service personnel and migrant labourers, and existing coverage with medical and social services.

Conducting a preliminary rapid assessment and prioritisation:-

Because cross-border areas tend to be remote and receive less coverage than major cities, there are limited resources to support cross-border activities. Identifying priorities based on a quick data collection effort — a "rapid assessment" — is important. The methods used in rapid assessments are most often qualitative, including in-depth focus group discussions, but also can be quantitative. Rapid assessment guidelines can be found in the UNAIDS publication "APICT Task Force on Migrant Labour and HIV Vulnerability and Initiating Cross-Border HIV and AIDS Prevention Programmes: Practical Lessons from Asia."

Preparing the intervention program:-

While the rapid assessment will generate information needed for selecting and prioritizing intervention sites, designing an intervention program requires more detailed information about the cross-border community. Wherever bulk of cross-border HIV implementation activity has been occurring, two methods have been used. In one, the Participatory Rural Appraisal and the Participatory Learning and Action methodologies have been adapted to allow maximum community input. In the other, multi-disciplinary teams have performed technical assessments of communities, reviewing data with key local informants to design strategies that local groups will implement. In choosing between the two methods, the degree of urgency to implement prevention interventions must be weighed against long-term community development.

Implementing interventions:-

The special challenges of cross-border settings require adaptations of state-of-the-art interventions used elsewhere. The most successful projects started locally before gradually sought the support of national governments. As early as possible, identify and engage the key stakeholders in the cross-border areas and forge partnerships among agencies across borders. Establish a project advisory committee whose members -- from both sides of the border -- can guide and support the implementing agencies.

Evaluating the program:-

Evaluation, an essential component of all programs, is particularly difficult in cross-border programs because the populations' high mobility limits contact time for prevention activities. The great number of languages and dialects spoken in border areas is another complicating factor. And the relative absence of social and legal controls in border areas means that interventions designed to modify norms in migrant communities will be especially challenging. Evaluation efforts might be best focused on tracking risk behaviours and STI/HIV prevalence rates in certain community subgroups over time; qualitative methods could be used to assess the risk environment in the community as a whole.

International border trade towns and seaports consistently have the highest HIV prevalence among societies around the world. Epidemics tend to originate in these sites before progressing inland. If effective prevention programs are implemented in these locations, the return on investment (in terms of fewer new infections) should be one of the greatest in the field of prevention.

Programmes that need to be developed or integrated include:

- Training and sensitising border officials on the human rights of mobile populations, and steps to prevent sexual abuse and transactional sex between border officials and informal traders and CSWs;

- Implementing prevention and care programmes in the migrant-receiving and migrant- sending areas;

- Programmes that mobilize mobile populations to target their own communities, for example using peer education or drama performances. Community or peer theatre groups are often effective in putting across thought provoking messages in a memorable way. Peer educators (if possible PLHIVs) are often more effective educators on HIV and AIDS and STIs than outside educators;

- The integration of voluntary HIV counselling and testing (VCT) in formal and informal sectors, especially in the uniformed services where typically screening takes place upon recruitment and deployment;

- Especially in all-male work and living environments, programmes need to tackle gender stereotyping, promote women's rights and sensitize men against sexual violence;

- Develop and strengthen care and support programmes for mobile workers, especially at key migrant labour points such as border posts, mines, commercial farms, construction sites, etc. This could include extend to low-cost pre-packaged STI treatment kits, PEP STI treatment and VCT and also other aspects of care such as sup-port groups, spiritual care and information on nutrition to bolster immune systems;

- Set up counselling services and support groups to deal with work-related stress, in particular for those who face danger in their work, whether miners, truckers or soldiers. Stress, particularly when related to alcohol and drug abuse, increases the risk of unsafe sex;

- Provide entertainment and recreation facilities at key migrant routes such as border posts, mines, commercial farms, construction sites, etc. Recreational activities especially sport – enable workers to use spare time constructively and safely. Fostering a sense of belonging within the broader community (via church groups, youth clubs, etc.) can help build self-esteem and counter risky behaviour;

- Integrate compulsory HIV education in all training manuals and develop IEC/BCC programmes, which include education on sexual and reproductive health issues;

- Develop pilot projects on family housing or alternative housing that respects privacy and reduces vulnerability;

- Ensure condoms are available at every stage along migrants' journey (at places of origin, transit, destination and return).

Part B
South Asian Scenario

HIV and AIDS is likely to affect mobile populations in certain regions more intensively than others due to patterns of migration, development strategies, legal provisions, cultural norms and levels of poverty.

Both internal and internationals migration are widespread throughout the South Asian region. There has been an increase in levels of drug use, sex work, and STIs which suggests that South Asia could be vulnerable to rising HIV rates in the future[5]. Circular labour migration, mostly rural to urban and back again, is the main form of population mobility in the region. Millions in South Asia leave their families to travel to factories, construction sites and plantations inside the country and beyond. Although there is limited data on HIV and AIDS, it is suggested that the rapid spread of the disease is likely for this reason in particular[6]. Labour mobility and a range of changes associated with modernisation have contributed to the spread of HIV and AIDS in India. The transport sector is particularly at risk - some estimates suggest that the number of truck drivers contracting HIV increases at the rate of 1,000 truckers every week[7]. A study in Sri Lanka showed that almost 50% of those infected with HIV are returned migrant workers[8].

The Greater Mekong Sub-region, comprising Cambodia, Lao People's Democratic Republic, Myanmar, Vietnam, Thailand and Yunnan Province of China, includes a vast number of migrants and mobile people. Border crossing points are meeting places for many transport workers, traders, tourists, border police and military personnel. High levels of HIV prevalence are being detected among specific groups where surveillance is in place, for example, among fishermen and uniformed personnel in some countries of the sub-region[9].

Migration and HIV in South Asia

South Asia, which is burdened with the one of the lowest human development indicators and increasing socio-economic inequalities, is home to the world's second largest number of people on the move. Annually millions of people are migrating within and between countries in the region, in desperate search for a better life. This intense movement of people is accentuated by the growing mismatch between pockets of economic activity and deprivation brought about by the new global economic order.

> ### *SAHAS project – Surat*
> *HIV and AIDS Counselling and Education Program for Migrant Workers, Bangladesh*
> *Implemented by SHISUK-CARAM Bangladesh (Morshed 2002)*
> *In 1995, SHISUK-CARAM Bangladesh began focusing on migration issues, gathering information, identifying and mobilizing stakeholders, and advocating for policy changes. In 1997, SHISUK brought together repatriated migrants to a form self-help group, to organise themselves for advocacy and peer support of other migrant workers. This organisation, the Welfare Association of Repatriated Bangladeshi Employees (WARBE), had worked with SHISUK and other rights advocacy organisations, in different events, to establish migrant workers' rights. In December 1999, the organization began implementing a pre-departure program for migrant workers called "HIV and AIDS Counselling and Sexual Education Program for Documented Migrant Workers."*
> *In July 2000, SHISUK began implementing several pilot programs, including pre-departure briefings on HIV and AIDS for migrating workers with the leading overseas migrant worker recruiting agencies in Bangladesh; developing community based interventions for potential migrants and their spouses and family members; publishing a newsletter for migrant workers; and developing entrepreneurship for reintegration (Morshed 2001). Developing entrepreneurship merits some discussion, as it illustrates how a intervention acknowledges contextual factors and addresses multiple levels of a migrant's reality. Established effective follow up home community and receiving community and developed networks for effective referrals.*

To a large extent, migration is a beneficial process, not only for individuals, but also for communities and nations. While new economic opportunities meet the livelihood needs of migrating individuals and their families, their remittances play a crucial role in strengthening the economy of their countries and host communities. Migrant remittances are indeed a major source of national income for the countries of the region.

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5. UNDP South East Asia HIV and Development Project: Assessing population mobility and HIV vulnerability in Guangxi, People's Republic of China (Bangkok, 2001).
6. Hugo, G.: Population mobility and HIV and AIDs in Indonesia, ILO, (Jakarta, 2001).
7. DFID: Trucker Project, Project Memorandum, DFID (London, 1996).
8. From Sri Lankan Bureau of Health research study. Reported in the Daily News: http://www.lanka.net/lakehouse/2001/05/05/new14.html
9. Chantavanich, S.: Mobility and HIV and AIDS in the Greater Mekong Subregion, Asian Development Bank (Bangkok, 2000).

HIV and AIDS awareness for migrant communities in the rural hills – Nepal

In Nepal there is a high rate of migration, primarily among men (adolescents and adults), who leave their villages in search of jobs to support their families. At least one male migrating for work. A study on HIV/STI prevalence among selected villages in Doti District revealed that 10% of migrants were HIV-positive at random blood sampling. All of them had been to Mumbai for work.
Targeting men and their families
The project was to reduce HIV/STI-related risk behaviours among vulnerable population groups through community-based interventions. The programme implemented with the support of two local NGOs. These NGOs increase their reach by mobilising community associations, such as youth groups and migrant wives groups, in the fight against AIDS. The main focus of the programme is on behaviour change through massive awareness creation and increasing the accessibility of condoms at the community level.
"News from home"
The programme mainly targets migrant men and their wives. The migrant workers are given orientation on HIV and AIDS and STIs, which includes education on how to prevent infection. The men are approached on an individual and group basis by peer educators trained under the programme before leaving for work to India. A small cloth bag containing leaflets on HIV/STIs, along with personal messages from the organization and the migrants' wives, is sent by mail or given to other men going to the same place. The package, named Gaon ko Raiwar (News from Home), is meant to remind the men to take precautions while abroad. A drop-in centre (DIC) at a bus stop entry point to one village in Doti District was established as a part of the programme activities. The DIC operator provides education, does condom promotion, and distributes IEC materials regularly. From the DIC, a counsellor catches up with migrant men emerging from the bus and before they proceed home.
Women
The migrants' wives have formed 146 groups who have been trained in both project districts. Every group has a peer educator group leader, who is approached regularly by the community facilitators of the partner organizations. They encourage and update the women with information on IEC tools and impart skills for sharing the information with their fellow group members. They are also expected to discuss and negotiate safer sex with their husbands when they return home. Other activities of the community programme are:
HIV/STI education for school teachers, female community health volunteers, school-going adolescents, participants of non-formal education groups, members of Youth Action Groups (YAG), key stakeholders and leaders in the community.
Messages displayed in public places through wall paintings and billboards.
Celebrations on HIV and AIDS Day and Condom Day (AIDS rallies).
Community-based condom distribution centres (social marketing) in all project communities. These centres are functioning very well and there are clear indications that condom use is on the increase.
Training of health-care providers (government health centres/local NGOs) on STIs and case management through the syndromic approach, and on HIV and AIDS.
Training of traditional healers on referring patients to STI treatment facilities and other health services.
CARE-Nepal; P.O Box 1661, Kathmandu, Nepal; e-mail: nirmala@carenepal.org

Afghanistan:	Over 1,500,000 refugees living in Pakistan and Iran
Bangladesh:	200,000 documented migrants per year moving from the country
India:	200,000,000 persons not living in their place of birth
Nepal:	More than 250,000 migrants living in India
Pakistan:	2,790,221 persons in 1999 registered as living abroad
Sri Lanka:	788,000 persons living overseas; 60 percent of them women

Effective peer education program to address migration and HIV and AIDS

SHISUK (NGO), Dhaka, Bangladesh
Migrant workers in Bangladesh had little access to information and can be hardly reached for HIV and AIDS prevention. SHISUK's community based Peer Program experience in different communities and it reflects the effectiveness of different peer groups in HIV intervention for migrant workers. SHISUK with the support of UNAIDS, ILO, IOM and UNDP has been experimenting peer approach with three different groups; potential migrants, recruits for departure and returnees in three different communities. The objective of involving different groups was to identify more effective and appropriate intervention strategy. The focus was to develop peer volunteers for sustainable knowledge in the community. The observation and participatory activities constituted the basis of this action research. Effectiveness of peer educator was not depending on the target category rather than the skill building and scopes. Involvement of different group as peer educators was more effective than to use one particular group.

http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102254067.html

Push Factors include:

- Low and variable agriculture productivity
- Lack of local employment or opportunities for advancement
- Landlessness
- Marginalisation
- Population pressure
- Domestic or community conflict
- War, political unrest, natural calamities

Pull Factors include:

- Rapid urbanisation and industrialisation
- Consumerism and increased access to information
- Better opportunities for livelihood, education, etc.
- Improved system of mobility
- Spirit of exploitation

South Asia is also the home to the one of the fastest rates of HIV infection in the world. Though the HIV prevalence rates are still reportedly low, the huge population of the region translate them to large numbers, there are over 7.6 million people living with HIV in South and South East Asia. In India alone accounted for 3.1 million infections in 2008. All over South Asia there are concentrated epidemics among the vulnerable groups such as sex workers, injecting drug users and MSM (Men having Sex with Men). The infection is steadily spreading to the general population, closing fast the window of opportunity for prevention. Experience from the region and other parts of the world clearly show that the apparent low prevalence does not offer any room for complacence.

As the epidemic spreads wider, the link between migration and HIV is emerging stronger than ever before. A recent study by UNDP, in partnership with PLHIV groups in the Asia Pacific region, irrefutably demonstrates this reality. Nearly 67 percent of the people living with HIV and AIDS, who participated in the study, said that migration was the main factor that led to their HIV vulnerability and better access to information and services could have helped to protect them.

HIV and migration do not have a linear, cause and effect relationship, but are laterally linked. HIV is a manifestation of the inequalities and deprivation faced by migrants. Hostile and lonely environments, separation from families, lack of access to information and services and social support systems can lead to social and sexual practices that make them more susceptible to HIV exposure. However, it may be noted that migration in itself is not a vulnerability factor for HIV, but it is the unsafe process of migration that creates conditions of vulnerability.

The Prevention to Care Continuum Project, HIV and AIDS IMPACT Mitigation through Mobilizing Affected Communities Project in Kanchanpur. Reducing the susceptibility and vulnerability of children and families to HIV and AIDS in communities where male migration occurs to India. - Save the Children

"The HIV and AIDS Impact Mitigation through Mobilising Affected Communities Project" in Kanchanpur district was funded by USAID/ Nepal for two years (June 14, 2001 to June 13, 2003) in response to its Annual Program Statement of "Supplemental Funds for Children Affected by HIV and AIDS" to reduce the susceptibility and vulnerability of children and families to HIV and AIDS in communities from where male migration to India was endemic. The overall Goal of the Project was to "to protect the health of Nepali families in Kanchanpur District of the Far Western Developmental Region of Nepal that were vulnerable to HIV and AIDS". The key strategies adopted largely were awareness raising, capacity building, community participation and mobilisation, development of community program options, creation of referral and linkage systems, and the initiation of care and support activities including advocacy on the emerging needs of care and support to PLHIVs. During the project period, a wide range of activities had been accomplished to yield better impacts. Awareness raising of HIV and AIDS through community mobilisation had been very effective in terms of increasing community capacity to facilitate and support local efforts to provide care and support for PLHIVs both at family and community levels. Moreover, inclusion of participatory approach in facilitation, planning, implementation, and, monitoring and evaluation has made community based HIV and AIDS initiative more effective and result-oriented.

Migration - the movement of people across the nation for employment - is an increasingly important aspect of national economy. There is a need to focus on the HIV related needs and rights of domestic labour migrants, regardless of their status as regular or irregular, or the duration of their migration. Social, economic and political factors in origin and destination sites influence the risk of HIV infection of labour migrants. These include separation from spouses, families and familiar social and cultural norms, language barriers, substandard living conditions, and exploitative working conditions, including sexual violence. The resulting isolation and stress may lead migrant workers to engage in behaviours, e.g. unsafe casual or commercial sex, which increase HIV risk. This risk is exacerbated by inadequate access to HIV services and fear of being stigmatised for seeking HIV-related information or support. Female migrant workers may be particularly vulnerable to HIV. Many are employed in relatively unskilled jobs within the manufacturing, domestic service or entertainment sectors, often without legal status and little access to health services. They are often susceptible to exploitation and/or physical and sexual violence, in some cases by their employer, and have few alternative employment opportunities. Women left behind by their spouses, faced with the same economic challenges, and other challenges besides (e.g. food insecurity) that contributed to their husband's migration, may be forced to exchange sex for food or money and thus become vulnerable to HIV. They may also be at risk if their husband returns infected with HIV.

HIV and AIDS/STDs Prevention, Care and Support Program in Bajhang and Doti District

A Rapid Community Assessment (RCA) Conducted by CARE Nepal in Bajhang and Doti Districts in 2002

Target Populations

- Primary: Migrant workers (males), their wives and potential migrants

- Secondary: Female sex workers and their clients

Strategies

- Partnership through local NGOs- Nepal Red Cross Society, District Chapter, Bajhang and Group for Social Development (GSD) in Bajhang and Nepal Red Cross Society, District Chapter Doti in Doti district.

- Social Mobilisation- approaching different groups such as women's group, migrants wives groups, Junior Red Cross Circle (JRC), Peer Education

- Right-based approaches throughout the programming

Major Accomplishments

- Awareness created to 9314 people on various aspects of HIV and AIDS, modes of HIV/STIs transmission and ways of protection through interactions and 23 events of VDC level orientations.

- Information on HIV and AIDS disseminated to 26594 individuals via 51 events of cultural programs comprised of song competition, street drama and others

- A total of 4958 IEC materials of various categories on HIV and AIDS/STIs were distributed to the targeted individuals

- 23 staff from three NGO partners were provided 5 days HIV and AIDS orientation training of trainer (TOT)

- 44 health care providers (government/NGOs) from project area of Bajhang and Doti districts were provided 5 days training on sexually transmitted infections (STIs) case management on syndromic approach

- Referred 42 targeted individuals for STI treatment

- 249 peer educators have received basic orientation training and 89 of them have received refresher training.

- A total of 2065 individuals received one day HIV and AIDS orientation. These individuals include members of S/HP management committee, FCHV/TBAs, VDC leaders and key persons, schoolteachers, non-formal education (NFE) members, students/JRC members, active male migrants/METS, shopkeepers and female sex workers)

- 3158 targeted people were educated on proper condom use through 807 events of condom demonstration. 12234 condoms were distributed to the target people. 22 migrants reported using condom consistently.

Source: CARE International in Nepal, E-mail: care@carenepal.org

Migrant and Mobile Populations

Migration and mobility of people have exacerbated HIV and AIDS epidemics, although its role in spreading HIV varies widely in the degree of documentation. Numerous studies have concluded that frequent or long-term travel away from home is linked with increased prevalence of risky sexual behaviours and increased infection by HIV.

Vulnerable populations engaged in voluntary and occupational migration include truckers, seasonal or migrant workers, miners, and women who engage in relationships with men in these groups. Seasonal and migrant workers include undocumented and female workers, who are particularly vulnerable to sexual violence while away from husbands and families. These populations often live in border towns and cities, which lack centers for health care and social services. Workers may be deterred from accessing prevention and treatment services because of financial, social, cultural and linguistic barriers.

> **Nepal Migration program – UNDP**
>
> *"To prevent HIV infection in labour migrants and young people in Nepal and provide care and support to the affected people"*
>
> *The programme is implemented in districts with high migration pattern, especially to India. The strategies to prevent HIV and AIDS/STI transmission executed by the programme are Advocacy; BCC; Peer Education; Establishment of Information Counselling Centres; and Establishment of STI/VCT centres.*

- Migrant workers may go abroad, have sex with multiple partners and bring sexually transmitted infections (STIs) – including HIV – home to their wives or regular sex partners.

- If a migrant worker falls sick due to HIV and AIDS, health-care costs may consume remittances, forcing wives to resort to survival sex in order to support their children.

- Infection in the home communities – where the family resides and where migrants return – is compounded by the lack of knowledge of HIV and poor health care infrastructure to care for people living with HIV.
- Workers without documents are particularly fearful that law enforcement may deter them from seeking health care services.

- "Hot spots" for the spread of HIV include border towns, economic centers and large work sites, as in mining camps. These sites include people from different places and sex-based industry often develops.

- "Risk zones" for HIV infection of mobile populations include truck stops, bus stations and markets where HIV transmission frequently occurs.

Conclusion

Although migrant and mobile people, as do any individuals, have a responsibility to take care of their own health, behaviour is often different when people are away from home and away from the social norms that guide and control behaviour in stable communities. People who move from a conservative society to one perceived to be more liberal may be ill-equipped to deal with sexual freedom: they may not understand the norms or the limits in the new society, and how to protect themselves. Migration stands for change: change of physical environment, of cultural traditions, of social norms, of power structures etc. Migrant workers move between their home country, where they are located within familiar local structures and practices, and the mines, where they live in a new environment, often devoid of traditional social norms... Separation from home, sharing crowded rooms in large hostels, loneliness, and the harsh working conditions seem to add up to a feeling of helplessness.

Part C
Global Scenario

Introduction

Throughout history, population movement has been an important factor in the spread of infectious diseases. Mobile people can be described broadly as those who move from one place to another temporarily, seasonally or permanently for a variety of reasons. This movement may be voluntary or involuntary. Today hundreds of millions of people are on the move. The great majority is within their own countries, but about 200[10] million are migrants who live permanently or for extended periods in foreign countries. People on the move are often vulnerable to HIV infection. Factors influencing that vulnerability include gender, age, economic status, whether migration is forced or voluntary, living circumstances, the stage of the migration process, the attitudes of the host community, and the availability of services. However migrants are more often seen as a threat to public health than as a vulnerable population, and little has been done by governments to ascertain or meet their special needs in terms of prevention or treatment and care.

International Organisation for Migration (IOM) with the support from United Nations Development Program (UNDP) developed and documented subjects of relevance to HIV infection and AIDS, mobility and its link to the epidemic and existing best practices in mobility and HIV prevention, care and support. As a Compendium Collection the document includes a summary of the issues, challenges and solutions; programs/ projects as case studies from around the world with specific note of South Asia region and India; and a listing of key materials (reports, articles, books, audiovisuals, etc.) on the subject. Hundreds of existing documents are reviewed to develop this document. Synthesis of many published and unpublished documents are included as part of this document. In some cases, the relevant part of the document has adapted as it is. To have more details of the document, one can contact IOM at iomhyderabad@iom.int

A report of the United Nations population division stated that by 2050 demographic trends show that without migration, the working age population in developed countries is expected to decline by 23 percent and those countries will be competing not only for highly skilled migrants but also for low and semi skilled workers. Particular reference was made to health care, domestic care and service industries. But the report stated that 'the developing world can easily be the source of as many people of working age as are needed in developed countries with decreasing populations of working age. 'By 2050, Africa's total work force will almost triple from some 400 million in 2005 to 1.1 billion whilst China and India are likely to account for 40 percent of the total global work force. There are more than 200 million international economic migrants in the world today, almost half of which are reportedly women. According to a recently available data, Europe collectively hosted the largest number of immigrants with some 70 million people in 2005. North America, with some 45 million and Asia, with approximately 25 million immigrants were in second and third position. China with 40 million and India with 20 million are the largest sources of migrant workers with the Philippines in third place[11].

Migration, mobility, and HIV and AIDS are major global phenomena at the beginning of the new millennium. Since the start of the HIV and 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 and 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.

Mobility, especially in the context of those who are moving in search of employment due to lack of opportunities at the source leads to high degrees of vulnerability to various social, economic and health problems. Lack of hygiene, poverty, powerlessness and the precarious family situation make mobile workers and migrants vulnerable to health hazards, especially HIV and AIDS. Mobile groups are vulnerable to HIV and AIDS in different respects and this is a primary reason for the prevention strategies to be complicated. In terms of HIV and AIDS, certain groups are identified as "high risk behavioural groups." These would be groups of the population identified to be at a greater risk of contracting the disease due to their job profile, living conditions, behavioural trends etc. Although technically HIV and AIDS is a health problem, it has become evident that it is a major development issue with a capacity to threaten a reverse in the advancements attained by generations of mankind. Its impact on the informal sector in the world of work has been very disruptive, leading to low productivity, threatened occupational safety and health especially among certain groups at risk, such as migrant workers and their communities.

"Despite stereotypes and common assumptions it is neither migrants nor migration per se that increase the risks of HIV transmission: it is the trying conditions and hardships that many face throughout the migration experience that makes them more vulnerable to infection."
    – United Nations Population Division
    State of the World Population 2006

10.   World Population Data Sheet - Population Reference Bureau
11.   4th world Migration Report, IOM Dec 2008

The process of migration and mobility

In order to understand HIV and AIDS in the context of migration and mobility, it is necessary to understand the process of migration. According to IOM, migration and population mobility in terms of HIV and AIDS can be understood as a process with the following stages:

> ### *Capacity Building for HIV and AIDS Prevention and Care for Migration Affected Communities in Myanmar*
>
> *This twelve-month pilot project would establish community based mechanisms for preventing and mitigating the impact of HIV and AIDS in mobility affected areas of the Mon state. The initiative adapted community based development models, including Participatory Action Research (PAR), to enable communities to develop their own programmes for prevention, care and support. The project involved advocacy and capacity building to assist communities to further their own understanding of HIV and AIDS and its local health, social and financial impacts. It aims to reduce stigma and promote inclusion. The project also involves capacity building of targeted townships and village community members and basic health staff to deliver pre and post-test counselling as well as care and support. Recognising the importance of continuum of care for successful prevention, the project would, in the absence of local NGOs, INGOs and other stakeholders, assume financial responsibility for and procurement of Opportunistic Infections drugs, nutritional and social (educational, funeral costs, etc) support for AIDS patients through its network of Outreach Health Workers.*
> *Source: IOM*

Source: Where people come from, why they leave and the relationships they maintain at home while away

Transit: Places people pass through, how they travel and their behaviour while they travel

Destination: Where people go, the attitudes of people they encounter and the living conditions in the new place

Return: The changes that have occurred in people/s lives and the conditions they find upon their return.

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 and 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

> ### *Lessons from HIV and AIDS Transport Corridor Projects - Africa*
>
> This is the regional HIV and AIDS project for the Abidjan-Lagos transport corridor, which was formally launched in December 2003. The project objective was to increase access along the corridor to HIV and AIDS prevention, basic treatment, support and care services for underserved, vulnerable groups – including transport sector workers and their clients.
> The project was based on a declaration of agreement at the level of the Heads of State of the five corridor countries (Cote d'Ivoire, Ghana, Togo, Benin and Nigeria) – further to which a specific, representative institutional structure has been created to manage the project. Member countries contribute to the upkeep of this management structure through annual payments. Particular attention was given to transport sector workers, the migrant population, commercial sex workers and local populations living along the corridor, especially at the border towns. The project was expected to contribute in reducing the spread of HIV and AIDS and to mitigating the adverse social and economic impact of HIV and AIDS along the transport corridor.
>
> The project had three components: (i) HIV and AIDS prevention services for the targeted population; (ii) HIV and AIDS treatment, care and support services for the targeted population; (iii) Project coordination, capacity building and policy development.
>
> With the assistance of the Executive Secretariat, an early focus was on getting stakeholder committees established in each of the eight border areas. This was successful and, by mid 2004, 8 committees were in place and 37 committee members from various backgrounds had received training. Wide stakeholder participation had been assured, notably from local government and uniformed services and also the transport sector.
>
> Refer: The impact of HIV and AIDS on the labour force in Sub-Saharan Africa: a preliminary assessment at http://www.ilo.org/public/english/protection/trav/aids/activities/research-policy.htm

of regional and international efforts to combat HIV and AIDS. Responses for migrants and mobile people must address HIV and 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.

Migrants are among the most vulnerable people. But not all migrants are vulnerable. When there is vulnerability, this is due to the conditions and structures of the migration process itself, including poverty, powerlessness and social instability. Xenophobia, discrimination, sexual and/or labour exploitation, lack of or even absence of socio-legal protection and often lack of access to health care and social services in receiving countries, all these factors enhance migrants' vulnerability, which is compounded by language and cultural barriers. The migrant's vulnerability to acquire HIV is often increased during transit and while living in destination communities, particularly if there is separation from families and partners, and separation from the socio-cultural norms that guide behaviours in stable communities. Put migrants and mobile people into HIV and AIDS strategic planning, and into national and community AIDS plans. Establish culturally and linguistically appropriate outreach in HIV and AIDS programmes targeted to migrants and mobile people. Establish peer counselling. Support associations of migrants, and help them integrate HIV and AIDS into their work. Focus HIV and 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 and AIDS.

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[12]. 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. 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[13]. Migrants are mobile people who take up residence or who remain for an extended stay in a foreign community. 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[14].

The Carletonville Mothusimpilo Project
A Community Intervention

One of the biggest gold mining complexes in the world is based in Carletonville, South Africa. The mines employ about 70,000 migrant male workers from the Southern Africa region, who live in single-sex hostels without their wives or families. Women from all over migrate to Carletonville to sell sex and alcohol (UNAIDS 2001).

The Carletonville Project, an intervention to reduce STI/HIV incidence in the mining community, focuses on implementing and improving syndromic management of STIs and developing strong peer educator programs in the sex worker community, the mine worker community, and among township youth. The project involves businesses, government, and communities to create a mobilised environment at the grassroot level (Campbell et al. 1999).

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12. For statistics on internally displaced persons, see: http://www.idpproject.org/ (Norwegian Refugee Council)
13. 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.
14. Martin, International Organization for Migration, 2000.

Migration, mobility and HIV and AIDS

Migration and population mobility are not static phenomena. Much population movement is highly fluid, with people moving back and forth frequently – often over a course of days, weeks or months. To be effective, HIV and AIDS responses must address the particular needs and vulnerabilities of mobile people at each stage of the mobility process.

There are many factors that contribute to the increased exposure to HIV infection of migrants and displaced populations. From a general perspective, the breakdown of social networks and institutions resulting from irregular migration and forced displacement reduces community cohesion, weakening the social sexual norms that regulate behaviour. Mobile populations, such as informal traders, temporary/contract workers and sex workers, lack access to much needed health care and support. Combined with extended or repeated overnight travel away from home and an imbalanced ratio of women to men, may lead migrants to resort to commercial sex work and increased number of partner, placing these labour migrants in particular vulnerability to HIV infection. Although innovative and target interventions in this scenario have generated positive results, a durable solution is yet to be presented. The international community needs to engage in further regional collaboration and in partnering to increase health care access to migrants, in an effort to protect both migrants and the society that embraces them.

HIV and AIDS is also a well established global phenomenon. More than 27 years after HIV was first identified, the virus is present in every region in the world. By the year 2008, it was estimated that almost 33 million people across the world were living with HIV[15]. More than 90% 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[16]. In addition, epidemiological studies focusing on more stationary migrant populations in several countries show that non- nationals are disproportionately affected by HIV and AIDS[17]. Such studies indicate that migration and mobility increase vulnerability to HIV and 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

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

Partnership on HIV and AIDS and Mobile Populations in Southern Africa (PHAMSA)

Partners: Governments, employers, unions and NGOs

Donors: European Union, Southern Africa

Development Community (SADC), SIDA

The Partnership on HIV and AIDS and Mobile populations in Southern Africa (PHAMSA), addresses the vulnerability of mobile populations to HIV in the Southern Africa Development Community (SADC) region. PHAMSA pulls together key stakeholders from the SADC Secretariat and sectors employing mobile workers, civil society, research organisations and international organisations in the region. This three year programme would carry out research, disseminate information, develop HIV and AIDS prevention and care programmes, undertake advocacy programmes, and develop regional guidelines. More information is available at www.iom.org.za.

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15. See Report on the Global HIV and AIDS Epidemic, December 1999, and the epidemic Update, June, 2000, available from UNAIDS, Geneva.
16. For a review, see International migration, 36/4, 1998.
17. 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.

not yet done enough to address HIV and 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[18]. However, according to the World Health Organisation, UNAIDS and the Office of the High Commissioner for Human Rights, these restrictions have no public health justification[19]. Such restrictions may in fact increase migrants' vulnerability to HIV and 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 and 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.

As already mentioned, stigma and discrimination is also a key challenge to mobility and HIV. While migration has been increasingly perceived by host communities as something negative, and xenophobia is increasingly becoming more common, people living with HIV are particularly vulnerable to stigma and discrimination in this context. Cultural misperceptions regarding HIV infection combine with existing power imbalances and gender inequalities to create a scenario of social exclusion that can further limit migrants' access to health, education and basic needs.

In addition, stigma and discrimination is increasingly being incorporated in societies' formal institutions. Stigmatising and discriminatory measures are expressed in several forms, such as compulsory screening and testing, restrictions of the right to anonymity, prohibition of people leaving with HIV to perform in certain occupations, or even isolation, detention and compulsory treatment of infected persons in extreme cases. Despite the efforts of international organisations and civil society and the firm steps towards unveiling some discriminatory practices against people living with HIV throughout the globe, much work remains to be done to provide PLHIV with the highest levels of human dignity.

Migration, mobility and HIV and AIDS are major global phenomena at the beginning of the new millennium. The 2008 UNAIDS Report on the global HIV and AIDS epidemic highlights relevant and crucial links between HIV and AIDS and Mobile Populations.

Southern African Migration and HIV and AIDS program

The SARC Project would develop partnerships with organizations in Southern Africa to conduct and disseminate applied research, to develop collaborative training in HIV prevention education strategies, to develop and implement participatory evaluation protocols, and to provide policy inputs regarding long term migration, health, and education initiatives regarding HIV and AIDS.

In practical terms, the project include: (a) applied research projects on regional migration patterns and their interaction with HIV and AIDS transmission; (b) training programs in social epidemiological research, innovative educational curricula, program evaluation, and policy analysis; (c) demonstration projects tailored to the specific circumstances and geographies of high risk groups (migrant workers, women, youth). These projects need to incorporate principles of adult non-formal education, portability, and a deep understanding of the dynamics and culture of the sexual relationship and consequent HIV risk behaviours; (d) evaluations of key intervention programs to define credible mechanisms for demonstrating best practices and lessons learned; and (e) policy analysis and recommendations to allow decision makers to appreciate the interacting influences of migration and HIV and AIDS. Ref: www.queensu.ca/sarc/Projects/AIDS/Back.htm

Challenges

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

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18. 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).
19. Global Programme on AIDS. Statement on Screening of International Travellers for Infection with Immunodeficiency Virus (WHO/GPA/INF/ 88.3), HIV and AIDS and Human Rights, International Guidelines, United Nations, New York and Geneva, 1998, HR/PUB/98/1.

About seventy per cent of the 33 million people infected worldwide with HIV live in Sub-Saharan Africa and within this region the countries of Southern Africa are the worst affected. The eight countries with the highest rates of infection are in Southern Africa, followed by six countries in East Africa, and then five other countries, only one outside Africa. The reasons why the highest rates of infection in the world occur in Southern Africa are unclear. Although the countries of the region have much in common, their histories over the last twenty years have been very different.

A number of different factors have been advanced to explain the general picture of HIV and AIDS in South Africa including its rapid spread, high prevalence and uneven distribution. They include poverty and economic marginalisation; differing strains of HIV; high rates of sexually transmitted disease and other opportunistic infection; sexual networking and patterns of sexual contact; the presence or absence of male circumcision; and the role of core-groups such as commercial sex workers.

Emergency Assistance to Mobile and Vulnerable Populations in Zimbabwe

Partners: Farm Orphan and Support of Zimbabwe (FOST), FACT Rusape and Mutare, Zimbabwe Community Development

Trust (ZCDT), Anglican Diocese of Manicaland, Help Age Zimbabwe, TARSC, National Aids Council, and Ministry of Health, Child and Welfare.

IOM was providing emergency assistance to approximately 160,000 mobile and vulnerable residual populations affected by drought, resettlement efforts and the decline of the Zimbabwean economy.

The HIV and AIDS component was implemented in coordination with the Zimbabwe Government, and NGOs. The overall objective was to provide prevention, and care activities among already-identified displaced ex farm workers and their families infected by HIV and affected by AIDS. Interventions include support for Home Based Care (HBC) through volunteer training and provision of HBC kits, and HIV prevention and awareness campaigns through workshops targeting different subgroups: elderly, children, and adults in general. Currently, 1,565 people (433 households) benefit from the HIV and AIDS component of the programme.

http://www.ministeriodesalud.go.cr/derechos%20humanos/sida/oimsidabrochure.pdf

Migration can play a significant role in transmitting infectious diseases. The level of migration can explain the dissimilarity in HIV prevalence figures in different parts of Africa (Decosas, 1999). In the case of southern Africa, the largely seasonal or temporary character of migration (especially labour migration), with migrants returning home to their families on a regular basis, has facilitated the rapid spread of HIV and AIDS (Fages, 1999: 40). However, this relation between population mobility and the spread of HIV and AIDS is not undisputed. There may not be a causal relation between migration per se and the transmission of HIV. This unclear relation between migration and the spread of HIV and AIDS influences the public opinion in various ways. For instance, governments become concerned that migrants might bring HIV and AIDS with them. Today, however, there is increasing recognition that mobile populations may be more vulnerable to HIV infection than non-mobile populations. Migration thus not only facilitates the rapid spread of the virus along so-called corridors of migration, but also causes behaviours and situations, which facilitate transmission from one person to another (Caldwell et al., 1997: 51). This shift in the thinking about migration and HIV and AIDS has led to numerous studies that focus on migrant's vulnerability.

Migrants and mobile people may be highly marginalised 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 Lesedi Project, South Africa

The Lesedi Project was set up in response to high rates of STIs, including rapidly increasing HIV prevalence in South African mining communities. The project provides STI treatment and prevention services to high-risk women in gold mining communities that have a large male migrant population. Intervention linked research was conducted from October 1996 to June 1997 to assess the immediate impact of the services on STI prevalence. A mobile clinic service for high risk women was set up near three mine hostels that have a miner population of approximately 3,700. Other more distant hostels served as control sites for project evaluation. Community mapping was used to identify taverns, shebeens (unlicensed liquor outlets), and other meeting places where miners relax after work. Many women frequent these establishments, providing sexual services to the miners in exchange for money or other material benefit. Peer outreach workers referred women having high risk behaviour to a mobile clinic where monthly examinations, presumptive treatment, prevention education, and condoms were provided. All women referred to the clinic received an initial assessment and treatment or referral. Promoting condom use and ensuring availability were essential components.

the host community. Such marginalisation increases vulnerability to HIV infection and also the difficulties of living with HIV and AIDS[20]. 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 organisations 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[21]. 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.

Although both migration and HIV have been examined separately in South Africa, we are still far from understanding in detail just how and to what extent migration affects the spread of HIV. Part of the reason for this is that studies of migration and disease tend to concentrate on the urban, or 'receiving' areas with little attention being paid to people living in the rural or 'sending' areas. Furthermore, there have been very few well-designed epidemiological studies documenting the relationship between migration and infectious diseases. Even more importantly, at this late stage of the Southern African HIV epidemic, there have been few intervention programmes, even on a small scale, which attempt to reduce transmission among migrants and their rural or urban partners.

Without a proper understanding of the social, behavioural and psychological consequences of migration, it will not be possible to understand the consequences of migration for the spread of HIV and the particular vulnerability to infection of mobile populations. To effect this conceptual refocus on the social (and sexual) disruption that accompanies migration and mobility, a number of reorientations are required, including:

- A more detailed understanding of the complex and changing patterns of migrancy in its different forms;

- Appreciation of the particular vulnerabilities of migrants as migrants (and those with whom they interact) and hence the economic, social, sexual and gender regimes associated with migrancy;

Toward a Higher Quality of Life for Migrant Populations

Strengthening Linkages between Source and Destination Communities

In 2000, PATH initiated a project to prevent HIV and AIDS and to improve the quality of life among Cambodian migrant workers in Thailand and their families. The project linked prevention activities at the migrants' sending, or source, community in Cambodia (Preyveng Province) with activities at the receiving, or destination, community in Thailand (Rayong Province). The first effort to reach out to the Cambodian migrants in Thailand and their source communities in Cambodia, improving living conditions in the source community, recreation activities at a Reduction of vulnerability to HIV and AIDS among migrants, potential migrants and families at source & destination, Reduction of HIV and AIDS/STD transmission and impact of HIV and AIDS among migrants and their families, Improve knowledge and attitudes on HIV and AIDS/STDs, Improve access to condoms and health services, Increase family/ community connections, Increase means to improve living conditions in Preyveng, Improve condom skills and condom use, Increase means for saving money at destination and improve means for investment at source community, Increase options for recreation and entertainment other than drinking and commercial sex, Increase partner communication on risk reduction, Increase realistic expectations of migrant life and its implications, Increase policy dialogues protection of human rights migrants undocumented migrants, Increase employer support to improve living/working conditions. Finally increasing the quality of work and developing better coordination and linkages.

http://www.cicred.org/Eng/Seminars/Details/Seminars/Sida/TH3.PDF

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

21. 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 and AIDS action programmes. Bangkok: UNDP, 2000, p. 87-103.

- Since generic HIV and AIDS interventions seem to be having so little impact in migrant settings and situations of high mobility, there is a need to develop models of intervention that are sensitive to the circumstances of mobile people;

- As attention is increasingly directed towards models of care and the development of appropriate 'toolkits', there is a need to develop interventions appropriate to the situation of migrants and their divided households.

Migration has been a catalyst in the rapid spread of HIV. The spread of infectious diseases that are transmitted from person to person will follow the movement of people (Decosas et al., 1995: 826). The spread of HIV and AIDS is thus likely to be accelerated in a situation of large-scale migration (Anarfi, 1993: 46).

The most vulnerable mobile people are refugees, those without legal status in the country in which they are living, and women. People displaced by conflict and other emergencies live through chaotic conditions, during which HIV and 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[22].

Legal status – Whether a person is in a country legally or illegally has a powerful influence on his or her vulnerability to HIV and 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 and 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.

Tajikistan project

The program would aim to mitigate the risks of HIV and sexually transmitted infections (STI) - in a context characterized by cross-border seasonal migration and human trafficking - during and after the implementation of the proposed Dushanbe-Kyrgyz Border Road Rehabilitation Project (II). This would be done by supporting local Government, NGOs and communities to develop and implement an integrated and gender responsive approach to HIV and AIDS and STI prevention in the campsites and corridor of influence. The Project area covers three districts from the Region of Republican Subordination, namely the districts of Nurabad, Rasht, and Tajikabad with 26 jamoats (or villages) and a population of about 180,900 (2003), and includes the 12 km section at the Tajik-Kyrgyz border (Karamik). The Project area - commonly referred to as the Rasht Valley - is characterized by a combination of gender relevant factors, which had to be considered in the design of HIV/STI prevention programs. These include: traditional rural societies, seasonal male labour migration to the Russian Federation, conservative religious beliefs and associated gender based practices, high percentage of female-headed (including Tajik war widow-headed) households, women's lack of employable skills, increasing drug trafficking and consumption patterns, and HIV and AIDS and STI stigmas and discrimination. The program had three subcomponents: (1) Capacity development for local government agencies and NGOs, providing training to implement the Government's policies, strategies, and regulations in HIV/STI prevention, anti trafficking and regulation of migration; (2) Behaviour Change and Communication for local communities and high risk behavioural groups, aimed at reducing the level of risk along the road corridor and establishing an environment conducive to the maintenance of safe behaviour among seasonal migrants; women; IDU; sex workers; and transport and construction operators; and (c) Clinical Support, through the provision of HIV testing kits and STI treatment packages to health clinics, to help them meet incremental needs of mobile populations and local communities.

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 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[23]. Other women and girls (and boys as well) are deceived,

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22. Piot P. HIV and AIDS in complex emergencies – a call for action. World Health Organization, Health in Emergencies, 7 (September 2000).
23. For more information on sex work see UNAIDS Technical Update on sex work.

coerced or trafficked into sex work[24]. 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[25].

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.

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).

Ethiopia: HIV and AIDS Prevention in Mobile Populations along the High-Risk Corridor

Timeframe: September 2002-March 2008

Partners: OSSA, Ministry of Health

Donors: Save the Children USA, UNFPA

Ethiopia is one of the most HIV and AIDS affected countries in Africa. HIV prevalence is particularly high among female sex workers living in the region of the major trucking routes between Ethiopia and Djibouti. Identifying and targeting the most vulnerable populations along these routes with improved access to voluntary counselling and HIV testing was thus essential. The main objective of this project was to ensure accessibility to HIV education and counselling, HIV testing and STI management for mobile transport workers, female sex workers and the affected sedentary populations along transit routes, while promoting capacity building and sustainability in the fight against HIV. 17 government health facilities, and one facility based in a local NGO (OSSA), were supported by the project to provide VCT and STI treatment to target communities. STI kits were provided by United Nations Population Fund (UNFPA).

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

In 1998, USAID's regional project, 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), spans four countries, including those with the highest rates of HIV prevalence in the region. A host of complementary strategies were employed by Population Services International (PSI), the NGO which coordinates the project, from social marketing to mass media and interpersonal communication. Of particular interest was the use of peer education among the target groups to convey adapted prevention messages. Truck drivers, sex workers and seasonal migrant workers in plantations were trained in STI/HIV and AIDS and communication techniques so that they could 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 was featured at the end to allow the peer educator to verify whether the information had been properly understood. One-on-one sessions were also conducted to allow the beneficiaries to ask more sensitive questions. Evaluations suggest that positive behavioural changes had 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 had 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%.

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24. For examples of work being done with trafficked women and girls, see IOM website http://www.iom.int
25. 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.

Financial, human and institutional resources in many countries are extremely limited for HIV and 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 and AIDS and mobility established in some developing countries by international agencies and non- governmental organisations (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 and AIDS among migrants and mobile people.

'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.[26]'

Responses to HIV and 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 and AIDS. Several strategies are necessary in order to establish such an environment.

> ### Community Mobilisation on HIV and AIDS prevention among labour migrants and their families
>
> *Project period: January - December 2006*
>
> *Donor: Global Fund - UNDP*
>
> *Education of Volunteers to disseminate information on HIV and AIDS among labour migrants and their families; education and research. Activities within the project include community mobilisation; assistance on building the capacity of governments and NGOs to address STIs/HIV and AIDS vulnerability among labour migrants and their families; promote access to adequate STIs/HIV and AIDS prevention; and facilitate the provision of STIs/HIV and AIDS counselling, education, diagnosis and treatment.*
>
> *On the basis of this project IOM plan to extend the activity among labour migrants and the mobile population, including activities among migrants in the countries of destination, mainly Russia and Kazakhstan.*
>
> *Ref: http://www.iom.tj/ongoing_projects.html*

'Migrant and mobile-friendly' interventions

A basic rule is that interventions for HIV and 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 and 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 and 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.

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26. 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.

Migration, HIV and AIDS in Europe

The past decade has seen dramatic changes with respect to HIV and migration in Europe with changes in the populations involved, nature of the epidemic and national policies relating to immigration. It is clear that migrants and ethnic minorities continue to experience serious inequalities in HIV and AIDS prevention, diagnosis and care. The past 10 years have seen an increase in the number of migrants, different populations migrating, shifts in migration laws and increased hostility in governmental and societal attitudes toward migrants. The priorities identified by organisations working in this field include the development of culturally and linguistically appropriate services and information, capacity building of migrant community-based organisations (CBOs) and improving access to care for migrants. Other priority areas identified by the evaluation include prioritisation of HIV and AIDS at EU level, increased advocacy and development of strategic partnerships and networks including host countries, CBOs and countries with emerging migration.

> ### *European Project AIDS & Mobility*
>
> *The European Project AIDS & Mobility (A&M) was a networking project that was aimed at the issue of migration and HIV and AIDS in Europe.*
>
> *The main objectives of the project were:*
>
> - *to highlight and respond to the specific needs of migrants, ethnic minorities and other mobile groups, with regard to HIV and AIDS and related issues; and*
>
> - *to facilitate and encourage collaboration and exchange between governmental, nongovernmental and community-based organisations.*
>
> ***Activities***
>
> *A&M documentation and referral service*
>
> *European Seminar I: 'AIDS Prevention and Care for Maghreb Populations in Europe'*
>
> *European Seminar II: 'East-West Mobility in Europe'*
>
> *Research Project I: African Communities in Northern Europe*
>
> *Research Project II: Comparative Study – AIDS Prevention and Care in Europe*
>
> *Exchange Visits*
>
> *A&M Newsletters*
>
> *National Focal Points Meeting*
>
> *A&M Steering Committee*
>
> *http://ec.europa.eu/health/ph_projects/2001/com_diseases/ fp_commdis_2001_exs_06_en.pdf*

The CIS and East European region has seen an increase in population mobility both within and between countries due to economic migration, the opening of borders and war. Many of Europe's migrant sex workers originate from Eastern Europe. HIV infections are increasing more rapidly in Eastern European and Central Asian countries than anywhere else in the world, with a nine-fold increase in infections in Eastern Europe in just three years. Ukraine recently became the first country in Europe with at least one percent of the adult population infected with HIV. Although HIV was mainly transmitted through injecting drug use, the region has recently shown signs of riskier sex and an increase in trafficking - both of which increase the chance of HIV transmission. The region generally lacks information and understanding about AIDS and very little research exists concerning migration and HIV and AIDS[27].

Caribbean and American scenario

The Caribbean region is the second most affected by AIDS after sub-Saharan Africa; AIDS is currently the leading cause of death for those aged 15-44[28]. In addition to being a popular tourist destination, the population within the region is quite

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27. Shcharbakova, N. Population mobility and HIV and AIDS in CIS countries, Paper to be presented at Technical Workshop on Population mobility, migration and HIV and AIDS (Geneva, 2002).

28. Caribbean Task Force on HIV and AIDS: The Caribbean Regional Strategic Plan of Action for HIV and AIDS, World Bank, (2000).

NYSDOH MIGRANT AND SEASONAL FARMWORKER HEALTH PROGRAM - US

The Migrant and Seasonal Farm Worker Health Program provides funding to 15 contractors including: seven county health departments, three community health centers, one hospital, a day care provider with 12 sites state wide, and three other organizations. Services were delivered in 28 counties across New York State. Each contractor provides a different array of direct and enabling services that may include outreach, primary and preventive medical and dental services, transportation, translation, health education, and linkage to services provided by other health and social support programs. The enabling/ support services were designed to reduce the barriers that discourage migrants from obtaining care such as inconvenient hours, lack of bilingual staff and lack of transportation. Health screening, referral and follow-up are also provided in migrant camps.

The objectives of funded providers include:

- Leading the development of a comprehensive local response to the health and human resource needs of the migrant population and their families.

- Providing access to health and human services for migrants and their families.

- Providing health education to migrants and their families in their native language that is culturally sensitive and promotes optimal health.

- Providing primary and preventive health care to migrants and their families.

Achievements till 2004, under this program:

- 8,250 adults and 5,410 children received medical/dental and enabling services
- 3,800 screenings for HIV and AIDS, STD and TB
- 2,700 screenings for vision and hearing
- 13,800 screenings for blood pressure
- 2,600 immunizations
- 9,900 health education encounters
- 19,000 home visits
- 6,000 instances of transportation
- 16,000 instances of translation/interpretation

In addition, the migrant Health Program has partnered with the NYS Immunization. Program to increase immunization rates in this population. Project goals include educating adult migrant on the benefits of immunisations and increasing the supply of vaccines to migrants via local health departments. Currently, this effort results in the provision of immunizations to migrants at 21 sites in 27 counties.

Migrant Health Project Communicable Disease Control, Reproductive Health, and Primary Care for Migrants and Host Communities

Timeframe: 2002-2007

Partners: Ministry of Public Health, NGOs

Donors: USAID, European Commission, IOM

Through this collaborative initiative, IOM and the Royal Thai Government's Ministry of Public Health aim to strengthen government response/capacity for providing accessible and culturally-sensitive health services to migrants and the local Thai communities. Focusing on Tak and Chiang Rai provinces, the project raises awareness on key health issues including HIV and AIDS, supports delivery of preventative and curative health services, and creates a replicable model for strengthening health interventions. The project has established a network of migrant community health workers and volunteers who assist local health authorities in health service delivery to migrants and their host communities. In Chiang Rai province, migrants are assisting the health authorities and Médecins Sans Frontières in providing care to AIDS affected migrants, including provision of antiretroviral therapy.

> *Generally, men who live away from their families, as well as the spouses of migrants, are more likely to have multiple sex partners and to maintain links to more than one "family". A study in South Africa's Limpopo province showed that migrant mineworkers who return home three times or fewer annually, report more concurrent partners than other men. Most migrant mineworkers who return home four or more times a year appear to be at significantly lower risk of HIV infection than other men working in the same area. This indicates that the commonly held assumption that migration itself leads to higher risk behaviour is not always justified, and that high risk behaviour can be as widespread among rural men as their urban counterparts.*
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> *Wolff, B., et al., Safer at home? Male labour migration and HIV risk behaviour in South Africa from a rural perspective, abstract nr (ThPeD7692), XIV International AIDS Conference, Barcelona*

mobile mainly due to socioeconomic reasons. Most of the migrants in Central America flow northward, toward Mexico and the United States. In Mexico, 25% of cases of HIV infection are among rural workers who had temporarily migrated to the United States[29].

Migrants' vulnerability to HIV and AIDS

If one were to design a social experiment in an attempt to create the conditions conducive to the spread of HIV and other sexually transmitted diseases, you would remove several hundred thousand rural men from their families, house them in single-sex hostels, provide them with cheap alcohol and easy access to commercial sex workers and allow them to return home periodically. These conditions roughly describe the situation for more than eight hundred thousand gold miners and countless other migrant labourers working throughout South Africa today (Lurie, 2001: 23). Vulnerability refers to the social, cultural, economic and political environment of individuals, families, communities and societies, and occurs in situations where people are limited in their ability to make free and informed decisions. In the context of the southern African HIV and AIDS epidemic, vulnerability is related to environmental factors that leave individuals or groups at risk of HIV infection. Webb (1997) defines these risk situations as 'socially and geographically defined zones where the capacity of the individual to respond effectively to a health threat is reduced' (Webb, 1997: 80).

West Africa Initiative

The West Africa Initiative for a response to the HIV and 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 had also utilised 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 sensitisation interventions should benefit both migrant and local populations. Another level of intervention was 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 was available, and that there was access to basic health care services, including HIV prevention and care services and condoms.

It is in these situations that people are vulnerable to HIV and AIDS. Migrants are more vulnerable to HIV infection than are people who do not move, both in southern Africa (Abdool Karim, 1992; Decosas, 1995; Gilgen et al., 2001; Lurie, 2001) as in other African countries (Kane et al., 1993; Nunn et al., 1995; Pison et al., 1993). This vulnerability is not the direct result of mobility. It is via circumstances and events related to the migration process that high risk of HIV infection is caused (Decosas et al., 1997). In other words: 'being mobile in and of itself is not a risk factor for HIV and AIDS; it is the situations encountered and the behaviours possibly engaged in during mobility or migration that increase vulnerability and risk regarding HIV and AIDS' (UNAIDS, 2001b: 5).

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29. Bronfman, M. Mexico and Central America. International Migration. 36/4, 1998, 609-642 (43).

Responses - 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).

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.

Responses - Focusing on cross-border and regional responses

Migration - movement across borders - can involve even greater challenges with regard to HIV and 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 marginalised 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 organisations, national, provincial and local governments, and most importantly a wide range of community organisations – have worked together to ensure effective implementation and to deal with the problems that have inevitably arisen[30]. 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.

> ### CARAM Asia
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> *An interesting example of a cross border response had evolved during the work of CARAM (Coordination of Action Research on AIDS and Mobility). CARAM was a partnership of seven NGOs from Bangladesh, Cambodia, Indonesia, Malaysia, Philippines, Thailand and Vietnam. Here were 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 had already returned from working in Malaysia to help in the training. Women attending the sessions were given orientation on where they could go in Malaysia if they had 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 carryout in Bangladesh. There were 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 involve efforts between respective governments to establish and harmonise 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.*

Mobilising communities of migrants and mobile people

HIV and 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

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30. 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.

willing to make significant contributions to prevent HIV and 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.

A number of factors may increase the vulnerability of migrant and mobile workers to HIV infection, and these vary in different situations. In general, however, vulnerability to HIV is greatest when people live and work in conditions of poverty, social exclusion, loneliness, and anonymity. The ILO Code of Practice on HIV and AIDS and the World of Work identifies work situations which cause the worker to be more susceptible to the risk of HIV infection, most of which apply to many mobile workers: travelling regularly; living away from spouses and partners; working in geographically isolated environments with limited social interaction and health facilities; single-sex working and living arrangements among men; and work that is dominated by men, where women are in a small minority[31]. For migrants relocating to a new community, social and sexual norms may be different than in their community of origin. Housing may be crowded and limited leisure opportunities encourage the use of alcohol, drugs and commercial and/or casual sex[32]. This may be especially true for workers who are not allowed to migrate with partners or families. In a study of seasonal migrants from Mali and Niger working in Cote d'Ivoire, 90% were married but less than 10% were accompanied by a partner[33]. Without the basic support systems provided by family and community, increased risk-taking behaviour is likely and those risks may then be passed on to the family and community of origin.

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, was composed of UN agencies, international NGOs, governmental AIDS authorities, and academic researchers active in AIDS mobility issues in South East Asia. It was currently involved in a number of projects. In the Irrawaddy River Love Boat Project, for example, AIDS prevention activities were 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 were distributed to the audience. In another series of activities, rapid situation assessments had 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.

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

Regional Caribbean Initiative on HIV and AIDS and Mobile Populations - Phase I

Timeframe: November 2002-June 2004

Partners: CAREC, NGOs

Donors: Bureau of Population, Refugees and Migration, US Department of State

In 2002 the Caribbean ranked second only to sub Saharan Africa as the most HIV affected region in the world. Population mobility is also extensive in the region. A better understanding of the interaction between mobility and the spread of HIV was thus essential for developing effective HIV prevention and mitigation strategies. The study, carried out in Barbados, Curaçao (Netherlands Antilles), the Dominican Republic, Jamaica and Trinidad and Tobago, included an analysis of the existing literature and national policies, interviews with key informants, and a survey of target mobile populations identified as potentially vulnerable (commercial sex workers and petty traders). Among other conclusions the study found that access must be improved for HIV and AIDS prevention, care and treatment among mobile populations in the region. Interventions must also address trafficking in persons and the specific needs of young women and girls.

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31. ILO: An ILO code of practice on HIV and AIDS and the world of work, ILO (Geneva, 2001).
32. Hugo, 2001
33. Lydié, N. and Robinson N.J., 1998

Gender plays an important role in vulnerability to HIV infection and female migrant workers are among the most vulnerable to exploitation and abuse. Large numbers of women become domestic workers - for example, more than 60 per cent of migrants from Sri Lanka are women, employed primarily in domestic service[34]. They are frequently undocumented, have few rights and are usually not protected under local laws. They also have little power to refuse sex with their employers. Income-earning prospects are limited for migrant women and the commercial sex industry offers a major (rare) employment opportunity. Local women who live in high migration areas are also at risk when sex work is often the only viable means of income support. Itinerant traders are often women who must travel long distances and be separated from their families. They are especially vulnerable to HIV infection since many may have to offer sexual services to supplement earnings in addition to trading activities[35]. In addition, there is extensive trafficking of young women throughout the world. Women and girls are forcefully abducted or tricked into prostitution and can be transported and sold within national or across international borders.

Migrant and mobile workers are often seen as a threat to the cultural integrity of a country or to job security for the national population, a misperception that often gives rise to xenophobia. Thus, migrants with actual or suspected HIV may be subject to double doses of discrimination, resulting from fear of HIV together with the reinforcement of already existing stigmatisation[36]. As noted in the ILO Code of Practice: "A climate of discrimination and lack of respect for human rights leaves workers more vulnerable to infection and less able to cope with AIDS because it makes it difficult for them to seek voluntary testing, counselling, treatment or support; they will also not be in a position to take part in advocacy and prevention campaigns[37]."

Countries have been slow to give resources for HIV programmes and mobile populations. Although some countries are developing national AIDS plans for migrant and mobile workers, there lacks a comprehensive response among governments, international agencies and non-governmental organisations (NGOs). A number of different agencies and organisations are addressing the issue of mobility, migration and HIV and AIDS.

> ### *CARE PROJECT*
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> *CARE Nigerâs AIDS and Migration Project focuses on rural communities in Tahoua Region where the majority of the able bodied men migrate annually for work, the communities situated along the main migratory route between Tahoua and Abidjan in CÃ´te d'Ivoire (the main destination of Nigerâs migrants). The project works with high risk behavioural groups, including the wives of migrants who remain in their home villages, commercial sex workers and the predominantly young male migrants. Key activities address providing education and information services that result in desired behavioural changes, greater access to condoms, enhance capacity to diagnose and treat STIs, and provision of social support for high risk behavioural groups. The overarching project goal is to reduce the risk of propagation of STI/HIV and AIDS and mitigate their medical, psychological and socio-economic, nutritional and cultural consequences on the target populations of migrants of the Tahoua Region, the migration mainline and the host communes of Abidjan. It was hoped that the capacities of the health services and staff were strengthened in: mother and infant health; sexually transmissible infections (STI); Counselling and Voluntary Screening (CVS); and, reference cases of HIV and AIDS. It was also hoped that the capacities of the community based organisations were strengthened in: logistical cycle of condoms, and community based healthcare. Finally, the project hopes to reduce stigma and the discrimination towards PLHIV and that action research on the pilot activities contribute to a better understanding by CARE and its partners of new approaches to support PLHIV.*

The African population has always been extremely mobile. Pre-colonial migratory patterns occurred without barriers or legal restraint, driven by agricultural resources, trade and labour. Similarly, in the post-colonial period migration has become a vehicle for economic betterment as well as an escape valve to overwhelming tensions caused by displacement, conflict, poverty, and resource deprivation. Today, international labour migration is commonplace.

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34. Martin, S.: An Era of International Migration, World Migration Report, International Organization for Migration, (Geneva, 2000).
35. Lydié, N. and Robinson N.J., 1998
36. UNAIDS: Stigma and discrimination fuel AIDS epidemic, UNAIDS Press Release (Geneva, 2001).
37. ILO code of practicev

With the increased sophistication of globalisation a common pattern of regional and international African migration has emerged. The vast majority of migratory routes now steer northwards towards Europe and westwards towards the Americas. Migratory highways extend from as far as Somalia through Sudan, Libya to Tunisia and across the Mediterranean into Spain and Italy. According to the International Labour Organisation (ILO), over 20 million African men and women are migrant workers. The World Bank reports that remittances by Africans working aboard now account for a substantial portion of the gross domestic product of Lesotho, Senegal, Uganda and Nigeria. In spite of the critical role they play in the economic development of their adoptive countries, these workers are, at best, treated as second class citizens. Recognizing this reality, the international community has sought ways of achieving justice via the creation of specific international migrant worker rights conventions, including the Migration for Employment Convention (Revised) of 1949; the Migrant Workers (Supplementary Provisions) Convention of 1975; and the United Nations Convention on the Protection of the Rights of Migrant workers and their Families, adopted by the United Nations General Assembly in 1990. These legal instruments created principles for the establishment of national laws and judicial and administrative procedures related to the human rights of migrant workers (such as equal treatment in employment, social security, non-discrimination, and anti-trafficking activities). It is important to note that the U.S and most of the western European counties that receive migrant workers have not yet ratified or adopted the recommendations in these aforementioned treaties and therefore are under no legal obligation to extend to migrant workers the kind of protections envisaged in these conventions.

> ### Preventing HIV and AIDS on Road Projects in Yunnan
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> *Model highway construction HIV prevention project, implemented as an operational research initiative in Yunnan Province of the Peoples Republic of China (PRC) on the border of Myanmar. Recognising the HIV risk that the Baolong Highway construction project potentially posed to local communities and migrant construction workers. The project integrates a package of interventions covering health sector interventions, behaviour communication change (BCC), condom social marketing, advocacy, community mobilisation, and policy and structural change in an effort to advance the knowledge base for HIV prevention through its quasi-experimental design (intervention-control baseline research and a follow-up study). This project sought to reach over 20,000 migrant construction workers, villages and townships along the highway - with a focus on preventing HIV and AIDS along the highway during the construction phase and the goal of testing a model communication strategy that could be shared and adapted to other highway construction projects in PRC and elsewhere in the region. The key to the initiative had been the development of a health service referral network which had involved expanding a number of previously existing private and public health services into model sexually transmitted infection (STI) and voluntary counselling and testing (VCT) health services and pharmacies. This framework has informed BHSA activities to reduce HIV risk, which were described in this document, and which - broadly - include making "settings" (e.g., the construction workplace, entertainment centres, transport corridors) "safe" through such communication channels as film nights, photo exhibitions, VCT, condom social marketing, the training of peer educators, and the creation of mirror hangers (for truck drivers) that reinforce HIV and road safety messages and a road safety-kit including a condom. Other strategies detailed here include participatory learning and action (PLA) that was designed to facilitate community plans that promote the benefits and ameliorate the risks of highway construction. This process involves a team of volunteer social mobilisers working with mobile and out-of-school youth to foster life skills related to HIV prevention and to provide information about safe migration. - http://www.comminit.com/en/node/269706*

Migration, HIV and AIDS in Africa

AIDS in Africa is a pandemic -- affecting the lives of over 22.5 million people in sub-Sahara Africa alone. In popular lure, migration and HIV and AIDS are often described as associated phenomena, with the migrant commonly considered the host and vector of HIV and AIDS. Despite the prevailing myth that migrants, refugees and other mobile populations spread HIV and AIDS, studies have shown that they have significantly lower prevalence rates than the surrounding communities wherein they reside. In no less than 60 countries, African migrants are forced to undergo mandatory HIV testing as a pre-condition for work permits and immigrant visas. In other countries, mandatory testing is a condition precedent for being granted an extension of work permits. A positive HIV test often leads to repatriation or denial of a visa or work permit for migrants. Mandatory HIV testing for purposes of exclusion must be discouraged; however HIV testing accompanied by assurances of access to appropriate treatment and care following a positive diagnosis should be made available.

In many African countries, regulatory frameworks are being revised with the objective of integrating HIV and AIDS related human rights principles into a national legal fabric. Some countries are going as far as drafting provisions in the law that clearly stipulate that HIV positive people entering or returning will enjoy the same rights as non-infected persons, reaffirming that one's HIV status will have no bearing on the right of entry, freedom of movement or freedom to work. For example, the economically integrated regional trading blocs in Africa-known as the Regional Economic Communities (RECs) have subscribed to the commitments laid out in the 2001 United

> ### *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 were African, as were 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 might be settled far away from such appropriate treatment. Travelling to London for treatment causes administrative problems and extra stress. Another policy that causes difficulties was one of giving support in the form of food vouchers. Such vouchers could only be used in specified supermarkets, but culturally appropriate foods were not available in these stores.*
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> *Various groups within African communities in the UK had 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 had been gathering data to document problems, advocate, and lobby national authorities for policy change.*
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> *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.*

Nations General Assembly Special Session on HIV and AIDS Declaration. The declaration stipulates that RECs should develop and implement strategies that incorporate HIV and AIDS awareness, prevention, care and treatment into emergency response and national assistance programs that target refugees, internally displaced persons, and migrants. It is within this context that some African countries, already overburdened with the HIV and AIDS epidemic of their own nationals, have restructured their health systems so as to benefit foreign migrants by providing free HIV and AIDS related medical services.

Governments have an obligation to safeguard human rights protections for all people, irrespective of HIV status. As such, a strategic conscious-raising and advocacy campaign needs to be undertaken to change worldwide perception on migrant populations. Restrictions imposed on travel, entry and procedures related to immigration and asylum based on one's HIV and AIDS status are a violation of the right to equality of treatment before the law. National governments must ensure that such rights do not disappear once a migrant leaves his or her country of origin.

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 and 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 and 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[38]. 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 and 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 and AIDS.

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38 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.

> ### *HIV and AIDS prevention and health care for migrant and seasonal farm-workers - US*
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> *The goal of the HIV Prevention and Primary Care Initiative is to reach and serve high risk, underserved populations in order to prevent HIV infection and provide accessible, high quality, comprehensive health care and supportive services for those who were HIV infected. Five agencies, including a migrant health project, two community health centers, a county health department, and a community-based organization, were funded to focus in whole or in part on providing a range of HIV prevention and health care services for migrants, which could include all or some of the following services:*
>
> - *Targeted outreach, most often by peers or community members who can identify with migrants*
> - *HIV prevention education*
> - *HIV counselling and testing, including rapid testing*
> - *Primary medical care including screening for STDs*
> - *Assistance in enrolling in the AIDS Drug Assistance Program (ADAP), which was accessible to all migrant and seasonal farm workers in NYS.*
> - *Access to specialty care, radiology, laboratory tests, prenatal care, and mental health services as needed*
> - *Dental care*
> - *Transportation*
> - *Translation*
> - *Case management, including linkage to care in other locations*
> - *Counselling and peer support*
>
> *The funded agencies deliver services to farm workers whenever possible on mobile vans and on-site clinics, and at unconventional hours. They report serving individuals of diverse backgrounds, including Mexicans, Jamaicans, Haitians, Guatemalans, other Central and South Americans, Africans, and African-Americans.*

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[39].

> ### *Research and Capacity Building on HIV and AIDS and Croatian Migrant Workers - Croatia*
>
> *Partners: School of Public Health Andrija Stampar*
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> *Donor: Global Fund for HIV, TB, and Malaria channelled through the Croatian Ministry of Health and Social Welfare*
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> *This programme to support the capacity of Croatian institutions to prevent HIV and other STIs among Croatian migrant workers combines: 1) KAP and vulnerability assessment among migrant workers; 2) training occupational health professionals on pre- and post-test HIV counselling so that they might teach other health professionals and advocate for HIV prevention programs for migrant workers; and 3) awareness raising, design and distribution of IEC materials, targeted condom distribution, assessments among sea farers and migrant construction workers working periodically abroad indicated inadequate access to HIV/STI prevention materials, particularly in work settings. Migrant workers showed relatively high HIV knowledge, but low condom use and lack of knowledge about voluntary HIV counselling and testing. New strategies and educational programs focusing on behavioural change were recommended. The second and third year would concentrate on research among truck drivers in Croatia, additional HIV counselling training for occupational health professionals, further awareness raising, and development of a HIV counselling manual for Croatian occupational health professionals.*

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39. See UNAIDS Technical update on voluntary counselling and testing, May 2000.

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 and 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 medicalised 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[40].

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 and 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 and AIDS from longer-term residence due to concerns about economic costs, States should not single out HIV and 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'[41].

> ### *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 and 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 were placed within an overall national HIV and AIDS prevention strategy for everyone living in the country, a government- sponsored HIV and 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 and 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.*
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> *Haour-Knipe M, Fleury F, Dubois-Arber F. HIV and AIDS prevention for migrants and ethnic minorities: three phases of evaluation. Social Science and Medicine, 49, 1357-72, 1999.*

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

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40. 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.
41. HIV and AIDS and Human Rights, International Guidelines, United Nations, New York and Geneva, 1998, HR/PUB/98/1, para 105 and 106

HIV and 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 and 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.

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 and AIDS. Such responses are critical to the effectiveness of national AIDS program. Responses for migrants and mobile people must address HIV and AIDS prevention, care and support throughout their journey before they leave, as they travel, in communities and societies they stay and after they return home. These responses must be based on the social contextual realities faced by migrants and mobile people and should be part of an empowerment that improves their social, economic and health status.

Pre-migration orientation for HIV and AIDS high risk group in hill tribe villages

Population mobility is the most significant factor for Thailand's rapid transmission of HIV and AIDS. Thailand alone hosts around 1 million migrant workers from the Greater Mekong Sub-region and mobility is very fluid internally. HIV moves with people who, while on the move, pass through varies risk situations (hot spots) that force or encourage them to get involved in unsafe sex or drug use. In Northern Thailand, where HIV epidemic is over 12 years old has a slogan for people who worked in big cities and imported HIV and AIDS back to the rural communities- "she/he went to Bangkok". Together with the public health bureau, the project starts with a baseline survey on hill tribe villagers and focus on the teenagers who are ready to go to big cities. The project provides those who indicated interest to work in big cities an orientation of the project, VCT and an opportunity to join vocational school by providing scholarships. Once the target group completes vocational training, the project finds safe and monitorable employment in Chiang Mai city. The target group is monitored and guided by the project's partner local foundation. By intervening at the appropriate level and time has proved to be extremely crucial not just in terms of protecting the mobile workers from exploitation on wage and right but also sexual exploitation and risky behaviour. The original intention of any mobile worker (be it permanent or seasonal) is to earn more money even if it means leaving from home and taking some risks. This project recommends that health bureau work with the Ministry of Labour and vocational training centers to enhance HIV high risk group's skills and knowledge on HIV and AIDS.

Migration and AIDS in Mexico

The VSRS program was developed within the Model of Integrated Attention to Migrant Health (Modelo de Atención Integrada a la Salud del Migrante (MAIS), which determines international coordination strategies to avoid duplicated efforts. The MAIS highlights the responsibility of the governments, federal and state, in migrant health and works to make health services accessible for all migrants in national territory, regardless of their migratory condition. Within the Mexican Ministry of Health structure, the VSRS program was coordinated by the National Center for Infant and Adolescent Health. The VSRS had 2 stages of action. The first implements the component to address the internally migrating population. Actions to respond to the international migratory population were developed in the second stage. One of the proposals was to establish a personal identification scheme, such as a migrant health card, to allow the migrant to use National Health System services throughout his or her travel and temporary stays. Another proposal was to call for intensive health promotion campaigns to foster self-care. The program directs its execution based on 4 areas: information to the population (eg, identifying social networks, developing information guides on disease prevention, first aid, personal hygiene, community training); preventative care in the place of origin, travel, and destination (eg, prevention and control of illnesses preventable by vaccination, nutritional surveillance, sexual and reproductive health counselling); medical attention in origin, travel, and destination (eg, migrant health card, sensitizing health service providers, incorporation of migrants within care modules regardless of non-residence in the area); and simplified epidemiologic surveillance (eg, outbreak studies, opportune notification of mobile populations of more than 100 persons). Given their great importance, the strategies focus on the most vulnerable population, such as children and reproductive age and pregnant women, offering them simple and clear information in a sensitive manner, even translated into their own language (Náhuatl, Zapoteco, and Mixteco).

At a glance: suggested action for migrants and mobile people

- Put migrants and mobile people in to HIV and AIDS strategic planning and into the community AIDS plan

- Establish culturally and linguistically appropriate outreach in HIV and AIDS programs targeted to migrants and mobile people. Establish peer counselling

- Support associations of migrants, and help them to integrate HIV and AIDS into their work.

- Focus HIV and 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 stops, harbours, markets.

- Develop and implement pre-departure briefings, post arrival and reintegration programs, and use the experience of those going back and forth across states.

- 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.

Safe mobility, in essence, is migration of people based on informed choices and reducing the risks on their way. Informed choices begin with the basic ability of people to decide whether to migrate at all or not. To make this feasible, there should be increased avenues for livelihoods in their host societies, better social and gender equality, less distress situations, not to mention conflicts and various forms of discrimination. Efforts on this count will prepare the ground for a sustainable, multi-sectoral response.

> ### *Construction of an intersectoral response to sexual and reproductive health with emphasis on prevention and attention of STD/HIV and AIDS among adolescents and young adults in a context of internal forced displacement - Colombia*
>
> *Partners: Colombian Country Coordination Mechanism (Ministry of Social*
>
> *Donors: IOM (Pilot phase)*
>
> *The Global Fund for Aids, Tuberculosis and Malaria (GFATM) (Main phase)*
>
> *This Global Fund project, for which IOM was the principle recipient in 2004, targets 600,000 ten to 24 year olds affected by forced internal displacement in Colombia. Implemented in 48 municipalities with high numbers of IDPs and high HIV prevalence, activities include engaging local civil authorities and community based, faith based, and private sector organisations to reduce young IDPs' vulnerability to STIs and HIV; strengthening the local health and educational sector to increase access to sexual and reproductive health services including testing, treatment, and sex education; and collaborative implementation of social, cultural, and income generating projects among the target population. A pilot project had previously tested the methods for the activities now being carried out through: 1) designing a toolkit tailored for internal displacement and STI/HIV; 2) creating local partnerships by training personnel working with the IDP and/or host communities; 3) sensitising local stakeholders as to issues surrounding youth, sexuality, and internal displacement; and 4) empowering internally displaced youth through peer-education. Lessons learned included: a) beyond providing education and information, it was essential to improve the socioeconomic conditions of IDPs; b) host communities must be involved in any work with IDP communities, or tensions would be created between IDPs and hosts; and c) specific support mechanisms must be created to guarantee the emotional and physical security of project beneficiaries. These lessons learned would be applied as good practices in the main project.*

Another important step is to empower potential migrants with information and services that make migration safer, free from exploitation and situations that make them vulnerable to HIV at source, transit and destination areas. This includes providing them with information about the situation in destination areas, the opportunities, services and networks available.

HIV information and services specifically to prevent HIV infection should be an integral part of this effort. Studies and experience of working with migrants in the field have shown that faced with challenges for survival, migrants do not see HIV as a priority issue. Therefore, the information and services on HIV should be part of an integrated package that also addresses other vital needs such as livelihoods, shelter and health care. Special emphasis has to be given to make the outreach efforts innovative and effective owing to the displaced status of migrants, particularly in the case of those who are undocumented.

Many migrants return to the source areas periodically and such visits can be considered as a possible route of HIV transmission to their spouses, partners and host community. In order to prevent this mode of transmission, initiatives are needed to equip the migrants, their spouses, partners and others on how to protect themselves against possible infection. More importantly, the special vulnerability of women needs to be addressed through concerted empowerment efforts.

Another challenge that calls for attention is the need for reintegration of returning migrants, both permanent and temporary, with a particular emphasis on the HIV context. Avenues for investment, jobs, socio-cultural reintegration, access to treatment and care and a stigma-free environment need to be seriously looked at.

In view of their vulnerability to HIV and AIDS, there is an increasing need for treatment and care at the destination and source areas. Voluntary counselling and testing services, treatment for opportunistic infections and referral for antiretroviral treatment are the elements that should form part of a comprehensive treatment and care plan.

CSEARHAP Program

In an effort to address the growing spread of HIV and AIDS in Southeast Asia, the Canadian government was funding the Canada South East Asia Regional HIV and AIDS Programme (CSEARHAP). This project seeks to strengthen the capacities of governments in Cambodia, Lao PDR, Thailand, and Vietnam to reduce male and female mobile populations' vulnerability to HIV and AIDS in a regionally coordinated and gender-sensitive manner. This is achieved mainly through multi-sectoral support for the implementation of the Regional Strategy of Mobility and HIV Vulnerability Reduction created by the United Nations Regional Task Force on Mobile Populations and HIV Vulnerability.

A key forum for capacity building and training had been the establishment in each country of a core Multi-Sector Team (MST), comprised of representatives of various government departments (such as Health, Education, Women's Affairs, Labour, Defence, Justice, etc.), the national AIDS authority, international organizations, non-governmental organizations, and people living with HIV and AIDS. In addition to training and joint work on concrete issues such as the development of policy recommendations, the MSTs provide a venue for information exchange and collaboration between government departments; in many cases cross departmental and cross sectoral activities were occurring for the first time.

CSEARHAP was also making creative and innovative efforts to ensure the inclusion of migrant and mobile populations (MMP), as well as people living with HIV and AIDS (PLHIV), in the project's activities. To date, the inclusion of PLHIV has been more successful, given their greater accessibility and availability. CSEARHAP's country teams had developed a number of national and cross-border demonstration mini projects, which serve to pilot or test new approaches or to develop new models to address HIV and AIDS vulnerability among specific mobile/migrant groups. These demonstration projects would contribute to CSEARHAP's three key results areas.

To strengthen coordination at the regional level, CSEARHAP fostered the development of MAP-4, a sub-group of the United Nations Regional Task Force focused on the four project countries. Membership in MAP-4 comprises the project's government focal point in each country, as well as other nominated government officials, associations of PLHIV and representatives of MMP. One of the key objectives of MAP-4 was to establish systems and mechanisms for sharing best practices from the national implementation of the Regional Strategy.

The following results had been noted to date:

1. *National Policy Self-Audits and Policy Reviews had been completed, outlining gaps and opportunities in existing national policies and legislation.*

2. *In all four countries, policy and/or policy-related documents had been developed to address HIV and AIDS vulnerability among migrant and mobile populations.*

3. *There was broad evidence of enhanced knowledge and skills among individual stakeholders, and increasing changes taking place at the institutional level in the four countries.*

4. *CSEARHAP had gained the status of one of the key players on MMP and HIV issues in the region, and was widely acknowledged by local and international stakeholders. CSEARHAP was making considerable contributions to bringing the issues of MMP and HIV and AIDS onto regional and national agendas, and pushing at the various levels for addressing this topic.*

> ## HIV and AIDS Awareness Campaign for the Sidama, Silti and Gurage Zones in the SNNP Regional State, Ethiopia
>
> *Timeframe: July 2003-December 2004*
>
> *Partners: Regional Health Bureau, Regional HIV and AIDS Secretariat*
>
> *Donor: Ireland Aid*
>
> *This project addresses HIV and AIDS awareness in selected Zones of the Southern Nations, Nationalities and Peoples Regional State a region of Ethiopia characterised by great ethnic, linguistic, religious and cultural diversity, and where very few people read and write the Amharic spoken in the rest of the country. The main objective is to increase awareness and demand for HIV and AIDS information and services among mobile/migrant populations (including demobilised soldiers and their wives, migrant labourers and traders, transport workers, sex workers) and affected sedentary populations. This Project counters stigma by training peer educators in community conversation techniques, problem identification and solving, and information dissemination. They give HIV and AIDS information and encourage use of existing services. New IEC materials will be produced in local languages for non-literate populations. The Regional Health Bureau and the HIV and AIDS secretariat actively supervise the peer education programmes at Zone and Woreda levels. Almost 500 community educators, largely male, have been trained by the project so far, with a further 250 female community educators to be trained as of the end of 2004.*

Conclusion

Human rights abuses based on people's HIV status often take place at the workplace. These can take numerous forms such as: mandatory HIV testing of job applicants or persons in employment; breaches of confidentiality regarding HIV-related personal information; discrimination in access, terms and conditions of employment and stigmatisation of workers living (or presumed to be living) with HIV and AIDS. By threatening fundamental rights, the epidemic reduces the opportunities for decent work for women and men and erodes the realisation of the key goals of social justice and equality.

The protection of human rights, and in particular protection against discrimination on the basis of HIV status (real or perceived), is essential for the prevention of HIV and AIDS. HIV and AIDS should be recognised as a workplace issue. This is necessary not only because HIV and AIDS affects the workplace — violating workers' rights, undermining incomes and livelihoods, cutting the labour force, reducing productivity and profitability — but also because the workplace has a role to play in the wider struggle to limit the spread and effects of the epidemic.

The rights-based approach to combating HIV and AIDS at the workplace is underpinned by several instruments with a sound basis for the protection of the rights of those infected and affected by HIV. It is important to have equality of opportunity and treatment in employment; occupational safety and health; social protection; labour inspection; the worst forms of child labour; and many others form the basis of an ethical and human rights-oriented legal framework for national policies and programmes on AIDS.

> ## Responsiveness of an Ethiopian Community Living in Italy to HIV and AIDS Prevention Material
>
> *Timeframe: August 2003-June 2004*
>
> *Partner: Ethiopian Embassy*
>
> *Donors: DFID/DKT*
>
> *National HIV and AIDS prevention campaigns for 'general populations' did not necessarily reach migrants living in the country. Observation, semi-structured interviews, and focus group discussions involving Ethiopian immigrants confirmed very low levels of information, and confusion between HIV and AIDS. Being infected with HIV was thought to be linked to poverty and the risk in Italy was perceived to be extremely low. Attitudes towards condom use were negative. Stigma of people living with HIV and AIDS was high, leading people to hide their HIV positive status. Training activities for Ethiopians and their leaders living in Italy were suggested, as well as providing more HIV and AIDS information in the migrants' languages. The study was presented at the 2004 International Aids Conference in Bangkok. Report and materials are available at IOM Rome and Addis-Ababa.*

The guidelines for developing concrete responses to HIV and AIDS at enterprise, community and nationals levels in the following key areas[42]:

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42. ILO Code of Practice on HIV and AIDS and the World of Work

- Prevention of HIV and AIDS, management and mitigation of its impact on the world of work,
- Care and support of the workers infected and affected by HIV and AIDS and elimination of stigma and discrimination on the basis of real or perceived HIV status;
- Non-discrimination in terms of employment;
- The banning of screening for employment purposes;
- The continuation of the employment relationship;
- Confidentiality and;
- Gender equality - are among its fundamental principles.

AIDS related stigma is increasingly recognized as a big barrier to effective HIV intervention and education among migrants. So far, there is virtually no qualitative research on AIDS-related stigma among migrants, especially among rural-to-urban migrants, a very vulnerable population to HIV infection. Most of the migrants possess severe stigma which is expressed as misperception, fear and discrimination. Their limited knowledge on HIV and AIDS contains severe misperception on AIDS symptoms, transmission and prevention. Cultural taboos and migrants' status in cities have been their obstacles to talk about HIV, receive health promotion services and practice protective skills. The groups (e.g., drug users, STD patients, commercial sex workers) who are disproportionately affected by HIV are highly discriminated and rejected by the society. There is a boundary between "us" and "them" where risks were perceived belong to "others" only. A good understanding of AIDS related stigma is very important for implementing effective HIV surveillance program and HIV intervention program. It is crucial to include stigma reduction in HIV prevention programs.

GLOBAL POLITICAL AND LEGAL FRAMEWORK

The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families manifests the belief in the principle of indivisibility of rights (civil political, socio-economic and cultural). It took more than 12 years for the convention to come into force on July 2003 after reaching the minimum required ratification of 20 countries in addition to the ten countries which had signed the convention. By 5 October 2004 there were a total of 27 ratifications and 15 signatures by UN member states. Of these, 11 ratifications and 7 signatures are from African countries[43]. The countries ratifying this Convention are low-income countries and home to some 4.5 million migrants (2.6 per cent of the world total migrant population). Major migrant-receiving countries located in wealthy regions – such as Western Europe and North America – have not ratified the

Convention, even though they host the majority of migrant workers (nearly 100 million out of a total of 200)[44]. Other important receiving countries – India, Japan, Singapore, Malaysia, Australia, and the Gulf States – have not ratified the Convention either.

> ### *Philippines policies*
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> *At government level, the Department of Labour and Employment (DOLE) is at the forefront of social and industrial policy and services of 35 million Filipino workforce. It has taken the lead in policy formulation and program implementation on HIV and AIDS and STDs in cooperation with bureaus, agencies and a network of Regional Offices throughout the Philippines the DOLE is accountable for overseeing labour standards and developing policy studies and labour rights and workers' protection programs. It works with its social partners in government, employers and workers as well as with NGOs and civic groups that can be mobilized for advocacy and awareness raising.*
>
> *Both the National Workplace Policy and the Strategic Plan were subsequently ratified by the participants of the Workshop in September 1997 by way of a Joint Communiqué, which summarizes the commitments of the DOLE and its social partners.*

Governance Frameworks for the Movement of People

The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families and Mode 4 of the General Agreement on Trade in Services are frameworks governing the movement of people. The issues they individually cover, and the relative strength and status they enjoy as international legal instruments, reflect the current patterns of polarisation in international political economy.

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43. http://www.december18.net/web/general/page.
44. Statistics are from the UNESCO Information Kit on the UN Convention on Migrants Rights. See also the websites of December 18 and Migrants Rights International for more information on the convention.

Irrespective of the form of migration – whether 'regular' or 'irregular', the Convention recognises that migrants are entitled to a minimum set of rights which includes humane living and working conditions, education and health services, legal equality including correct procedures, and the freedom from sexual abuse. The Convention also specifies that migrants have the right to return to their country of origin and participate in the political procedures of their home country. The Convention accepts that even undocumented migrants are entitled to basic protection and recognition of their rights as human beings. Although countries that have ratified and signed the Convention are primarily sending countries, some are also transit and receiving countries. Signatories must treat migrants according to the principles of the Convention, irrespective of their documented or undocumented status. Articles 10 and 11 make provision for the prevention of, and the imposition of penalties on, human trafficking. As Taran points out (2000: 30) 'the fundamental challenge for the extension of human rights to migrants is the sharpening contention between basing an overall international approach to migration on a framework of control versus establishing a migration management framework in which human rights is a fundamental basis'. As he notes (2000: 36), the tension between global competition and the protection of migrants is tending to shift migration issues into a framework of migration management. States may still use their discrete sovereign power to refuse to extend human rights provisions to undocumented migrants – especially socio-economic rights.

Mr. Bertrand Ramcharan, the then Acting High Commissioner for Human Rights, noted in his speech marking its entry into force: "the Convention will assist in securing a protective international mechanism of the human rights of migrants, including those in irregular situations. If States manage migratory flows in a manner that is respectful of human rights of migrants, a climate of non-confrontation and a feeling of security will grow in society. By defining migrant workers and their basic rights, the Convention seeks to play a role in preventing and eliminating the exploitation of all migrant workers and members of their families throughout the entire migration process. In particular, it seeks to put an end to the illegal or clandestine recruitment and trafficking of migrant workers and to discourage their employment in an irregular or undocumented situation." (http://www.migrantsrights.org) African countries are members of the WTO; many of which have 'Least Developed Country' status.

Key Points on HIV and AIDS and migration

1. Non-Discrimination: Persons living with HIV and AIDS are entitled to live their life in dignity, free from discrimination and stigmatisation. Migrant and other persons of concern who are living with HIV and AIDS should not be subject to discriminatory measures. Misconceptions about migrant, refugees and other persons of concern being associated with an increased prevalence of HIV and AIDS may lead to discriminatory practices and should be dispelled.

2. Access to HIV and AIDS Health Care: Migrants and other persons of concern benefit as any other individual from the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health." This right entails non-discriminatory access to services which are equivalent to those available to surrounding host communities. In terms of HIV and AIDS, in order to respect and fulfil the right to the highest attainable standard of physical and mental health. States must take steps towards realising access for all to HIV and AIDS prevention, treatment, care and support. This would necessarily include antiretroviral therapy (ART).

3. Protection from Arbitrary Detention and Unlawful Restrictions on Freedom of Movement: Detention or restrictions on the freedom of movement of persons living with HIV and AIDS would be in violation of the fundamental rights to liberty and security of the person, as well as the right to freedom of movement, if carried out solely on the basis of a person's actual or suspected HIV status. There is no public health justification for restrictions of these rights due to a person's HIV status alone. Moreover such restrictions would be discriminatory.

4. Respect for Confidentiality and Privacy: In principle, personal data is confidential and should not be shared without the consent of the individual concerned; this includes data on the health status of the person. Those who have access to the health status of persons of concern must take appropriate measures to maintain its confidential nature.

5. Provision of Voluntary Counselling and Testing (VCT): VCT programmes play an important role in preventing HIV transmission by providing people with accurate information about the virus. Without proper standards, however, there may be breaches of confidentiality resulting in other protection problems.

6. Freedom from Mandatory Testing: There should not be any mandatory HIV testing of migrants and other persons of concern as this is at variance with relevant human rights standards. WHO and UNAIDS have asserted that there is no public health justification for mandatory HIV screening as it does not prevent the introduction or spread of HIV. Public

health interests are best served by promoting voluntary counselling and testing in an environment where confidentiality and privacy are maintained.

7. Access to Durable Solutions: The attainment of a durable solution should not be jeopardised by the HIV status of a migrant or a family member. The right to return to one's country may not be denied on the basis of HIV status. With respect to local integration, ensuring access to local health and HIV and AIDS-related services on an equitable basis with nationals in the host country is critical to protecting the basic rights of refugees.

8. HIV-related protection needs of women, girls and boys: Women and girls are disproportionately affected by HIV and AIDS and gender inequality can play a significant role in the protection problems they face, including increased exposure to violence. Appropriate measures need to be taken to ensure their protection against sexual or physical violence and exploitation. Special attention must also be paid to children affected by HIV, including those orphaned or otherwise made vulnerable by HIV.

9. Access to HIV information and education: The right to health includes access not only to HIV treatment, but also to HIV-related education. States should ensure the widespread provision of information about HIV and AIDS to migrants and other persons of concern, particularly with regard to HIV-related prevention and care information as well as information related to sexual and reproductive health

UN Declaration of Commitment – HIV and AIDS

The relationship between the HIV and AIDS epidemic and migration was recognized by the United Nations during the General Assembly Special Session on HIV and AIDS in June 2001. Paragraph 50 of the Declaration of Commitment stipulates that Member States should "[b]y 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV and AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services" 3.

Inter-Agency Standing Committee (IASC) - Guidelines for HIV and AIDS interventions in emergency settings

These Guidelines for HIV and AIDS interventions in emergency settings provide valuable information for organisations and individuals involved in developing responses to HIV and AIDS during crises. There is also a Matrix, designed to present response information in a simplified chart, which can be photocopied for use in emergency situations. The topics covered include: prevention and preparedness; responding to sexual violence and exploitation; food aid and distribution; IDU care; safe blood supply; condom supply and usage; women and children, orphans, uniformed services; personnel, refugees; and safe deliveries.

United Nations General Assembly Special Session (UNGASS) on HIV and AIDS

In June 2001, the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS adopted the Declaration of Commitment on HIV and AIDS which acknowledged the needs of migrants and mobile populations as a vulnerable group. In paragraph 50 of the Declaration countries commit to: "By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV and AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services"

Batswana Policy

The Ministry of Labour & Home Affairs, as one of the implementing partners of the national HIV and AIDS policy has undertaken to contribute to the national reduction of HIV infection and the mitigation of HIV and AIDS among Batswana through its various Departments, and in collaboration with its key stakeholders in the civil society, the vocational education & training sector and the private sector. In this regard, its efforts will be consistent with the National Strategic Framework (2003-2009), the Public Service Code of Conduct on HIV and AIDS in the Workplace, the national Industrial Relations Code of Practice. In addition, the International Labour Office (ILO) Code of Practice on HIV and AIDS and the World of Work will serve as a reference document during the development and implementation of the ministry HIV and AIDS Workplace policy.

Background Information: The Global Strategy Framework on HIV and AIDS, Joint United Nations Programme on HIV and AIDS (UNAIDS)

In June 2001, the United Nations General Assembly held a Special Session (UNGASS) on HIV and AIDS to address the global pandemic and secure a global commitment from world leaders on the issue. This event reflected the gravity of the pandemic: HIV and AIDS had only been on humanity's radar screen for 20 years, yet the disease had seen unprecedented spread and, in the worst-affected countries, threatened to reverse decades of hard-won human development progress. The Special Session provided world leaders with an opportunity to follow up on the General Assembly's Millennium Declaration, in which a commitment was made to stop and begin to reverse the spread of HIV and AIDS by 2015. Political leaders and HIV and AIDS experts from around the world came together to look at what we have learned about HIV and AIDS epidemics from the first two decades and to build a framework for action. This strategy builds upon the key lessons learned over the first 20 years of the pandemic to provide a model for a coordinated global response to the HIV and AIDS pandemic.

These lessons are that:

- It's possible to prevent a larger pandemic in the future
- Over the years, capacity and commitment to address the pandemic have increased.
- Prevention works
- More effort is needed to ensure that access to care, support and treatment is widespread and affordable
- The most successful responses have their roots in communities
- Empowering young people and women is essential to halting the pandemic
- People living with HIV or AIDS need to be seen as central to any response

Recognizing that a global problem requires a global response, those present at the UNGASS on HIV and AIDS created The Global Strategy Framework on HIV and AIDS. This document is not meant to act as a blueprint for responding to HIV and AIDS epidemics but rather as an adaptable guide for effective response.

As Peter Piot, Executive Director of UNAIDS said:

"This Global Strategy Framework is guided by an understanding of the epidemic in its totality, driven by a vicious cycle of risk, vulnerability, and increasing impact of the epidemic. To replace this dynamic with a virtuous cycle of risk reduction, vulnerability reduction and impact mitigation, requires society-wide action against AIDS. It needs to focus equally on preventing the further spread of the epidemic, supporting better care for those infected and affected by HIV, and building capacity and resilience to withstand the impact of AIDS."

Source: The Global Strategy Framework on HIV and AIDS

Declaration of Commitment on HIV and AIDS The Declaration of Commitment on HIV and AIDS signed at the United Nations General Assembly Special Session (UNGASS) in June 2001 maps the actions needed to mount a comprehensive and coordinated global response against the epidemic. Among the commitments: "By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV and AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services." (para 50)

> ### *American legal considerations*
>
> *The following laws must be kept in mind when making decisions that affect any staff/worker with HIV and AIDS:*
>
> - *Americans with Disabilities Act (ADA)*
> - *Occupational Safety and Health Act (OSHA) and the OSHA Bloodborne Pathogens Standards*
> - *Family Medical Leave Act (FMLA)*
> - *Health Insurance Portability and Accountability Act (HIPAA)*
> - *Consolidated Omnibus Budget Reconciliation Act (COBRA)*
> - *State, county, and municipal laws on HIV testing, discrimination, etc.*

The ILO Code of Practice on HIV and AIDS and the world of work

The Code of Practice is the framework for action related to the workplace. It contains key principles for policy development and practical guidelines for programmes at enterprise, community and national levels. It covers in the following main areas:

• Prevention of HIV

• Management and mitigation of the impact of AIDS on the world of work

• Care and support of workers infected and affected by HIV and AIDS

• Elimination of stigma and discrimination on the basis of real or perceived HIV status.

The ILO developed the Code in response to many requests for guidance, on the basis of a widespread consultation with its constituents in all regions, and a range of other stakeholders.

Trafficking

Since 1996 West and Central African governments, individually and collectively, have made significant efforts to reform the judiciary to address human trafficking. The Libreville Common Platform of Action of the Sub-regional Consultation of the Development of Strategies to Fight Child Trafficking for Exploitative Labour Purposes in West and Central Africa was signed in 2000 by 21 countries in West and Central Africa, supported by UNICEF and ILO with the cooperation of the government of Gabon. This was followed by the Declaration of Action Against Trafficking adopted by the Economic Community of West African States (ECOWAS) and the endorsement of ECOWAS Plan of Action18 in Dakar in 2001 by 15 member-states. This Common Platform of Action identifies the main characteristics and causes of child trafficking, and specifies government commitment in several areas.

A tradition – such as the 'placement' of children – can be subject to alteration by exogenous forces which commercialise it and turn it into child trafficking. The issue at stake is not only what kind of legal label should be placed on this practice, but also adequate understanding of exogenous forces that can help neutralise them. Public debates and political contestation about human trafficking should be about ways to connect cultural factors with other structural issues regarding human mobility.

Driven as it is by both supply and demand, human trafficking has gradually acquired a combination of local and global characteristics that resemble commodity chains with different nodal points involving different actors with a varying degree of power and authority (Truong, 2003c). Therefore, the 'realities' that are being shaped and formed need to be subject to cross-cultural and historical comparisons in order to sharpen analytical tools and interpretation. Too previous a pronouncement of root causes with limited validation can be counter-productive. For example, pronouncements about 'traditions of migration' and 'traditions of placing children' being the causes of greater incidence of trafficking can obliterate labour market dynamics and policy neglect of the social domain in an era of global competition. Furthermore, a strong focus on traditions as a root cause can lead to the practice of blaming the trafficked person rather than promoting needed structural changes[45]. In addition to the required deep understanding of the social, political, economic, and cultural milieu, more questioning is necessary by which to ascertain the source(s) of this understanding and to discover exactly which 'understanding' becomes the 'received' knowledge that influences policy processes.

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45. For example, Stillwaggon (2003) conducted in-depth research on the literature and metaphors used in regard to African behaviour which seem to increase the incidence of AIDS in Africa. She notes that earlier research set the tone for later policy decisions. By systematically uncovering textual messages that became ingrained among policy makers, she showed how the social construction of these behaviours influenced policy agendas and ultimately held back other ways to address the AIDS situation.

The United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children

The strong call for the adoption of an internationally recognised definition of human trafficking in the late 1990's sought to consolidate the diverse ways of understanding it. Since the adoption of a definition of trafficking from the United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, supplementing the Convention against Transnational Organised Crime in 2000, the discussion on human trafficking has been made easier, but not without controversy.

The definition is contained in Article 3 of the Protocol:

(a)   "Trafficking in persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs;

(b)   The consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph (a) of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used;

(c)   The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered "trafficking in persons" even if this does not involve any of the means set forth in subparagraph (a) of this article;

(d)   "Child" shall mean any person under eighteen years of age.

The Protocol provides an internationally binding definition. It aims to eliminate differences between national legal systems and to set standards for domestic law to address organised crime. Bound as it is by social and cultural contexts the interpretation of crime and penalty has been subject to many queries. Particular concern about the interpretation of crime – in the context of those who give non-commercial help to would-be migrants crossing national borders for reasons of political safety perhaps destroying ethical norms of human solidarity – has led to a differentiation between 'human smuggling' and 'human trafficking'[46]. As Nadig (2002) points out, only human smuggling in the context of offering the service of undocumented or falsely documented entry against payment would be liable to penalty. Practices of human trafficking are embedded in social relations and are therefore diverse. It is difficult to generalise interpretations based on fragmented evidence. As illustrated earlier, a number of international non-governmental organisations have noted peculiarities of human trafficking in Africa that do not entirely fit the international definition[47]. The definition bases itself on the 'model' of transnational trafficking, often attributed to the presence of large networks of organised crime. Trafficking in Africa is through small, family-related networks and does not always take place across national borders. Terms such as 'trafficking', 'abduction' and 'sale of children' all have different meanings, depending on the particularity of contexts. Even the term consenting party is controversial as regards the involvement of the parents and sometimes the children in the decision-making process. A criminalisation approach may have to impose penalty on entire communities. A more positive perspective is the broad definition adopted by ILO-IPEC that allows for its application in a wider variety of situations. In a 2001 report ILO-IPEC states the following:

"[i]n some respects, the variations found in the definition of trafficking in international instruments and frameworks are both inevitable and legitimate, and in no way represent confusion or disagreement. Each international instrument relates to the place the organisation of reference occupies in the international multilateral structure — be it a crime-focused or rights focused body. As a result, what might at first seem an uneven handling of trafficking issues across organisations is actually more a question of approach and context than a difference of intent.''

ILO-IPEC sees the merit in maintaining some flexibility in the use of the concept of 'trafficking' to accommodate institutional objectives and contextual requirements. A wide definition permits the practical accommodation of the specific objectives of the different, yet complementary, international instruments.

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46. A few examples include ideological commitment, friendship or compassion.
47. A few examples are Anti-Slavery International, Terre des Hommes, and Human Rights Watch.

Other International Conventions

Other international organisations have formed an understanding of 'trafficking' and its related situations by combining the definition in the Trafficking Protocol with other related agreements and conventions. Among these are the UN Convention on the Rights of the Child of 1989 (UN CRC), the ILO Worst Forms of Child Labour Convention of 1999 (No. 182), the ILO Forced Labour Convention of 1930 (No. 29) and the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1949. Additional international frameworks that can be used to supplement the Trafficking Protocol include the General Agreement on Trade in Services (GATS) and the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (also called the UN Migrant Rights Convention).

There are also concerns about the lack of definition of the terms 'exploitation of the prostitution of others' and 'coercion', see reports cited at the end by Save the Children- Sweden (2004) and UNICEF (2003)[48].

Using ILO Convention 182 as a reference point, Article 3 of the convention clearly indicates the inclusion of trafficking of children in the areas of concern[49]. "For the purposes of this Convention, the term the worst forms of child labour comprises:

(a) all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict;

(b) the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances;

(c) the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties;

(d) work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children."

The Convention on the Elimination of All Forms of Discrimination against

Women (CEDAW) – adopted in 1979 by the UN General Assembly and often described as an international bill of rights for women – defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination. By 20 October 2004, 179 countries had ratified or acceded to the convention (with 98 signatures). Discrimination against women is defined as[50]:

"…any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

Pertinent to trafficking of women and children the convention calls on states to take appropriate measures against all forms of trafficking in women. It also affirms the reproductive rights of women as well as their rights to acquire and change or retain their nationality and the nationality of their children. The UN Convention on the Right of the Child (UN CRC) is the most universally accepted human rights convention with the most number of ratifications by member states – with 192 countries being party to the convention. This convention recognises the human rights of children and the standards to which all governments must aspire in realising these rights. By ratifying the convention national governments commit themselves to protecting and ensuring children's rights. It elaborates the basic human rights which all children everywhere are entitled to, which are: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to full participation in family, cultural and social life. It includes the child's human right not to be trafficked or exploited. There are two Optional Protocols to the convention that have been adopted to strengthen the provisions of the Convention in specific areas, being: the involvement of children in armed conflict and on the sale of children (entered into force in February 2002); child prostitution and child pornography (entered into force in January 2002).

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48. Boonpala and Kane (2001).
49. http://www.ilo.org/public/english/standards/ipec/ratification/convention/text.htm#top
50. http://www.un.org/womenwatch/daw/cedaw/

Selected Key Materials

Bennett T. An aura of risk. In: Second technical consultation on transnational population movements and HIV and AIDS in Southeast Asian countries. Proceedings of a seminar in Chiang Rai, Thailand. Asian Research Centre for Migration, Bangkok, May 1997.

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

Brown T. The relationship of HIV and STD declines in Thailand to behaviour change—a synthesis of existing studies. Draft monograph. UNAIDS, Geneva, 1997.

CARE International/Laos. Three provinces focus group project. Project report. AIDSCAP/Family Health International, Bangkok, 1995.

Chin J, Bennett A and Mills S. Primary determinants of HIV prevalence in Asian-Pacific countries. AIDS, 1998; 12(suppl B):S87–S91.

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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 and AIDS projects for migrants.

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.

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

Family Health International, AIDS Control and Prevention Project. Application of a behavioural surveillance tool. AIDSCAP Evaluation Tool Module Series, module no. 4. Family Health International, Arlington, VA, 1995.

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

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.

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Papers cover: population movement, development and HIV and 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.

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Rao A, Sundararaman R, Shrestha BK. Report of the study team for the assessment of the AIDS situation on the trucking routes between Nepal, India and Bangladesh. AIDSCAP/Family Health International, Kathmandu, 1995.

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.

Review of the literature concerning HIV and AIDS and migration in Central America and Mexico: migration legislation; epidemiological data; migrants' STI/HIV and 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.

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