

# International Migration and HIV/AIDS

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1 Nicholas, Suite 726 Ottawa ON K1N 7B7  
Telephone: (613) 233-7440 • Fax: (613) 233-8361  
E-mail: [info@icad-cisd.com](mailto:info@icad-cisd.com) • Web: [www.icad-cisd.com](http://www.icad-cisd.com)

## Introduction

The United Nations has characterized AIDS and the international migration patterns of millions of people in resource poor countries as two of the most crucial social issues facing today's world. While being a migrant in and of itself is not a risk factor, certain activities and conditions that are present throughout the process of migration substantially increase vulnerability to HIV/AIDS. Addressing these conditions must represent an essential component of a comprehensive and global strategy for HIV/AIDS.

According to UNAIDS and the International Organization for Migration (IOM), in 2003 approximately 175 million people lived and worked outside of their country of citizenship (1). Of this number, it is estimated that 15 million were undocumented or illegal migrants, half of whom were women (2). Before continuing with an analysis of the impact of HIV/AIDS on international migration it may be useful for the reader to know that the United Nations has developed a set of definitions to describe the different categories of mobile people (refugees, migrant workers etc). This factsheet uses the UN definitions, a description of which appears on page 6.

## Why People Migrate

Many mobile people move back and forth between their destination and home community on a frequent basis. In this manner international migration patterns are both cyclical and highly fluid. Unemployment, socio-economic instability, political unrest and the unequal distribution of resources are all-important issues that sustain mobility and represent common factors in both voluntary and forced migration. Specific reasons for migration are varied. Many people migrate voluntarily to access employment opportunities and a

better quality of life. As mentioned previously, others are forced to migrate because of war, violence, human rights abuses, ethnic tensions, famine, poverty or persecution. One of the largest causes of displacement is the construction of large-scale economic development projects. For example, ten million people a year are displaced by dam projects alone.

No matter what category they belong to, all mobile populations are often highly marginalized and stigmatized throughout the migration process, whether in transit, in the host community or upon their return home. They are vulnerable to discrimination, xenophobia, exploitation and harassment and may have little or no access to legal or social protection. Particularly vulnerable are those who are migrating involuntarily, notably indigenous peoples, ethnic minorities and the urban or rural poor. The legal status of mobile populations often determines their degree of vulnerability. Undocumented migrants are less likely to access education, health care and social services. As noted previously women represent 50% of all migrants and in addition to the constant stress related to migration they must also deal with the added pressures of gender discrimination and sexual violence.

## Migration and Risk

There is widespread evidence that migrant populations are at increased risk for poor health in general and HIV in particular. In many developing countries, regions reporting higher seasonal and long-term mobility also have higher rates of HIV infection. This is especially evident along transport routes and in border regions. This link between HIV and migration has been well documented. One study conducted in a rural community in Uganda found that the sero prevalence rate for those who had migrated was 11.5%, twice that of those who had not changed addresses (3). Equally as serious, in a study undertaken by CARE, it was disclosed that 50%

of migrants report having sex at their destination, while only 10% indicated that they use condoms (4).

There are a multitude of conditions and factors that encourage the spread of HIV/AIDS among mobile populations, many stemming from the cultural transitions that are present during the migration process. Migration typically involves a break down of cultural norms and traditions, and difficulties in interpreting and accepting a new environment. In societies where there is a tradition of restricted public discussion and strong controls over sex, migrant populations may or may not be aware that their behavior is in conflict with the public norms of their adopted community. The resulting confusion can lead to estrangement from the host culture which in turn may result in an unwillingness to engage with health care systems and professionals who are responsible for HIV/AIDS prevention and care programs. Naturally, this will have an impact on public health efforts to deal with the epidemic.

Inadequate social development is also a factor that significantly contributes to the spread of HIV/AIDS in migrant populations. Vulnerability to HIV is often greatest when people find themselves living and working in conditions of poverty, powerlessness and social instability. Such circumstances apply to many mobile populations and could undermine an individual's motivation and ability to negotiate safer sex. Many mobile populations have no access to education, health or social services and few are willing to seek medical help for fear of being detained or expelled. Furthermore host countries are often unwilling to invest in health and sanitation for migrants and many national health care plans discriminate by excluding migrants completely or by limiting their service delivery to emergency care only.

### **Factors Influencing AIDS and Migration**

The effects of regional conflict, globalization, environmental disasters and a global reduction in public spending on health care have had a major impact on both HIV/AIDS and international migration.

#### **Regional Conflict:**

Increasingly warfare is less a matter of confrontation between professional armies than one of struggle between military and civilian populations within the same country. In 2003 more than 72 countries were

identified as unstable due to regional violence (5). Unprecedented conflict within the world has led to mass population movements as people flee the chaos of war. Consequently, the global caseload of refugees from armed conflict has increased from 2.4 million in 1974 to 27.4 million in 2003 and the number of IDP in war ridden countries is estimated to be 30 million (6).

During war and armed conflict, civilians are often subjected to mass displacement, human rights abuses, sexual violence and poverty, and these conditions lead to an increased vulnerability to HIV/AIDS. It should therefore come as no surprise that of the 17 countries with the highest HIV/AIDS rates, 13 of them are in conflict zones. For example, during Sierra Leone's decade long civil war, HIV prevalence among sex workers rose from 27% to 71%. Other studies confirmed that 11% of Nigeria's peacekeepers returned from the conflict HIV-positive, a figure twice that of the general population. In Rwanda, the 1994 war and genocide is believed to have contributed to the epidemic spreading into rural areas (7).

There are several ways in which armed conflict can increase the likelihood of exposure to HIV. Mass population displacement can lead to people moving from areas of low to high HIV prevalence and thus increase exposure. This population movement disrupts social networks and institutions that normally protect and support people. Armed conflict can create conditions whereby women and girls are coerced into exchanging sex for money, protection and food. Rape is frequently used as a weapon of war by combatants further exposing women to the risk of HIV infection. This reality has been documented in a variety of recent conflicts including Bosnia-Herzegovina, Democratic Republic of Congo, Liberia and Rwanda.

#### **Globalization and Labour Migration:**

Rising economic globalization, trade liberalization, and newly opened borders have led to a dramatic increase in international population mobility. Growing poverty is generally acknowledged as a main factor behind the rapid spread of the AIDS pandemic and is closely associated with the current global economic order. Factors such as the unequal distribution of resources, and the growing disparity between the North and the South shape the extent and degree of labour migration. Clearly, conditions of poverty and unemployment are motivating people to relocate in search of work and the

possibility or opportunity of a better life in other countries.

The economic, technological and labour changes taking place because of globalization demand that people move in much the same way as materials and goods - freely and at short notice. Migrant workers are responding to unprecedented economic growth, increased trade and tourism, liberal economic policies and the relaxation of travel restrictions. Consequently this global economic development has been accompanied by rapid urbanization creating imbalances in social and community development. In many countries migrant workers are seen only as sources of labour and governments have failed to provide adequate health care and education services for these populations. In many cases, when economic growth declines, migrant workers are expelled from host countries and forced to return home.

As is the case with many mobile populations, labour migrants are susceptible to health problems including HIV infection. Widespread risk and vulnerability factors include substandard living environments, high rates of alcohol use, and sex with multiple partners or commercial sex trade workers. Prevalence rates among those who travel for employment reasons demonstrate the extent of this vulnerability. In southern African mining companies where 95% of the work force are migrant workers, the average HIV infection rates are close to 18% (8). Furthermore, in Senegal where 82% of men between 20-40 travel each year for employment, labour mobility has been found to be the only factor significantly associated with HIV/AIDS (9).

### **Environmental Degradation:**

Environmental disasters, whether man-made or due to natural causes, are a significant factor in driving population mobility. Droughts, famine and flooding can displace millions of people at a time, forcing them into conditions similar to those faced by refugees and internally displaced persons. Such disasters make mobile populations vulnerable to many diseases and put them at risk for HIV/AIDS. In 2004, flooding in South Asia wreaked havoc in Bangladesh affecting 25 million people. In Dhaka alone, 1.5 million people were forced to leave their homes to seek refuge. Immediately, outbreaks of diarrhea, dysentery, typhoid and jaundice were reported as floodwaters destroyed the sewage systems. This situation worsened the pre-existing

conditions of poverty and the lack of health services that had already put these populations at risk for HIV/AIDS.

Every year millions of people are compelled to migrate as a result of policies and projects aimed at enhancing development. These include mining operations, deforestation for logging and agricultural production, and the building of dams and roads. In the 1990's some 90 to 100 million people around the world were displaced as a result of development projects (10). These projects disproportionately affect already vulnerable populations such as indigenous groups, ethnic minorities and the rural or urban poor. Development displacees face the same risks as other forced migrants and often receive very little recognition, support or assistance from the outside world. In China, construction of the Three Gorges Dam is expected to alter the health and welfare of millions of people. The damming of the Yangtze River will displace at least three million people and will have adverse affect on up to 20 million people who live along its length (11). This population is already poor and health services, water supplies and sanitation are inadequate. The WHO predicts that there will likely be a resurgence of endemic infections such as malaria, encephalitis, and hepatitis B. HIV transmission is also a serious concern as an active nightlife and sex trade has emerged to cater to the large workforce that has assembled to build the dam. This risk is further exacerbated by the prevalence of gonorrhea, which is the third most infectious disease in China.

### **Reduced Expenditures in Public Health:**

Globalization has created a cycle of structural poverty that has crippled the ability of many developing countries to foster social development initiatives. Restrictive liberal financial policies have been imposed on developing countries as a condition for receiving aid or loans by the International Monetary Fund and the World Bank. The result of these policies has led to a decrease in public expenditures within these countries, creating conditions that have made it difficult to address basic health issues, including HIV/AIDS. Consequently in most African countries, the annual health budget is less than ten dollars per person and many sub Saharan countries are paying \$1.30 on debt service for every dollar received in aid (12).

Ongoing multilateral trade negotiations at the World Trade Organization (WTO) have led to freer trade and eroded the ability of governments to regulate and invest

in public sector services. This has had a significant effect on both HIV/AIDS and international migration. The proposed General Agreement on Trade in Services that is currently being negotiated would further liberalize trade in health care services. It can be expected that this agreement will increase the trend to private, for-profit, foreign-invested hospitals. This move would further erode the ability of resource poor communities to address the health of migrants as private health care traditionally neglects the needs of disadvantaged populations.

The reduction in public health expenditures has already had serious repercussions for the health of mobile populations. Migrant workers have difficulty accessing national health care systems and frequently aren't insured. In a study conducted with Mexican farm workers in California, 30% had never been to a doctor, 75% had no health insurance and only 7% were covered by a government sponsored health insurance plan (13). Many of these workers live in conditions that place them at increased risk for HIV, and yet they have absolutely no access to testing, treatment or prevention services. Meanwhile, rich countries continue to recruit doctors and other professionals from the developing world with the promise of better salaries and working conditions. This brain drain has exacerbated the already serious shortage of trained personnel in several countries. In Ghana the vacancy rate for doctors has been as high as 72% and Malawi has reported a 52.9% vacancy level for nurses (14).

Canada is one of the countries currently responsible for the recruitment of health professionals from developing countries. In some provinces, such as Saskatchewan, up to 54% of practicing doctors were trained outside of Canada. In 1998 Canada was home to 1,338 graduates of South African medical schools. This has prompted South Africa's High Commissioner to Canada to issue an unprecedented appeal to Canadian Health Ministers urging them to stop recruiting South African physicians.

In the 2004 UNAIDS report, the authors highlighted this issue and its effect on southern African countries in delivering vital public services. Similar comments have also been made by the World Health Organization (WHO), specifically with respect to its 3by5 strategy.

3by5 refers to the global target of getting 3 million people living with HIV/AIDS in developing and middle income countries on antiretroviral treatment by 2005, as a first step to towards the ultimate goal of providing universal access to treatment for all. The implementation of this strategy will require a concerted and sustained action by many partners, including wealthy nations which continue to recruit health care professionals from countries in which there is already an insufficient number of doctors and nurses and where the epidemic is at its worst.

## Regional Snap Shots

The following regional case studies illustrate the relationship between international migration and HIV/AIDS and its impact on those greatest at risk.

### **The Great Lakes Region:**

This area in Africa provides a relevant case study of the effects of armed conflict on HIV/AIDS and migration. In Rwanda, the 1994 genocide is believed to have contributed to the spread of the epidemic into rural areas which had previously been less affected. Pre-war levels of HIV infection were estimated at about 1 percent in rural situations. By 1997, prevalence had jumped to 11 percent. This increase has been attributed to the mixing of rural and urban populations in refugee camps.

Over two million refugees fled to other central African countries following the civil war. Among Rwandan refugees in a camp in Tanzania, researchers observed that adolescent sexual activity had increased since displacement, that commercial sex work had grown in the area surrounding the camps and that condom accessibility was low. In refugee camps, seroprevalence was six to eight times higher than rates in the rural areas where populations originated (15). Despite higher incidence, access to health services and family planning services is lacking in refugee camps.

Rape as a weapon of war has had serious implications following the Rwandan conflict. Seventeen percent of women who were raped during this period subsequently tested HIV positive. This phenomenon has also led to increased rates of sexually transmitted infections and HIV among uniformed service personnel including

peacekeepers. In some countries there is evidence of extremely high rates of HIV among armed forces personnel who have served in conflict situations. In Uganda, HIV prevalence in the military had reached 10%, prompting that country to introduce testing, treatment and support programs (16).

#### **South East Asia:**

The epidemic in Asia is expanding rapidly particularly in China, Indonesia and Viet Nam. Currently there are an estimated 7.4 million people living with HIV in the region. The greater Mekong sub region is an area that provides a telling example of the specific risks associated with the international sex trade. Although the overall HIV prevalence in this region is still under 1%, severe epidemics exist in the countries of Cambodia, Myanmar and Thailand (17). High infection rates are being discovered among sex trade workers across the region. In some extreme cases sero prevalence rates among this population are estimated to range as high as 40-60% (18).

International tourism, internal travel and its interaction with the sex industry have been identified as important factors responsible for the rapid spread of HIV in this region. This is particularly evident in the cross border region of Ranong, on the Thai-Myanmar border. People here have a high vulnerability to HIV/AIDS due to the presence of large numbers of young single men and women and large commercial sex venues. Often young women join or are forced into the sex industry in order to send money back home to support their families.

Trafficking in women for the purposes of the international sex trade is common and it is reported that brothel owners travel extensively to recruit women from the poorest, most isolated and uneducated communities. Nonetheless responses to the epidemic are often extremely limited particularly in Cambodia, Laos, and Myanmar and there is a lack of focus on migration and HIV/AIDS. An exception to this is Thailand, a country which has introduced wide ranging and sophisticated strategies to deal with HIV/AIDS.

#### **Southern Africa:**

South Africa is a significant destination for migrant workers. The SA mining industry, which employs over 300,000 workers from Lesotho, Botswana, Swaziland and Mozambique, offers a clear illustration of the

particular vulnerabilities that migrant workers face, due to HIV/AIDS. For example, the town of Carletonville (near Johannesburg), is home to the biggest gold mining complex in the world, employing approximately 70,000 men. Until very recently, most have lived in single sex hostels without their wives or families. It is not uncommon for the workers to have two wives, one in their home village, whom they see on rare occasions, and one in South Africa near the mine. Research conducted in this area show very high rates of HIV infection among mineworkers, sex workers and young women in communities surrounding the mines.

In 2003 it was estimated that one in every three miners has HIV/AIDS (19). In many cases they may unknowingly infect their wives and partners when they return to their home communities. This has played a crucial role in the rapid spread of HIV in southern Africa. In the country of Mozambique, which sends 65,000 laborers to the mines, the consequences have been devastating. Of a population of 18 million, 1.6 million Mozambicans have HIV/AIDS and over 350,000 have already died (20). All of the large mines are now in the process of establishing programs to provide infected miners with antiretroviral therapy and prevention education. However treatment is contingent on their employment with the mines. Many contracts are terminated when miners become too ill to work and they return home without pensions, health benefits or death benefits.

### **Implications For Public Policy**

Despite strong evidence linking the course of the pandemic to human mobility, there has been relatively little policy development focused on the relationship between migration and HIV/AIDS. In fact the IOM has demonstrated that ill adapted migration policies are behind many of the social factors that increase the health risk of mobile populations. Most policy is focused on restrictive measures and protectionist approaches. Host countries often profile mobile people according to their health status and routinely block entry to those who are HIV positive. In 2003, over 60 countries in the world required foreigners to be tested for HIV before being allowed entry, often using a positive test result to block entry.

This practice persists despite the fact that the WHO has published widespread information detailing the ineffectiveness of this approach. Profiling immigrants according to their health status is believed to contribute to illegal and undocumented migration and can deter migrants from utilizing effective prevention services. Many countries are unable or unwilling to invest in health and sanitation in refugee camps and numerous health care plans discriminate against migrant workers. Migration is frequently viewed as a security or national interest issue, but ignored as a public health issue.

These include a number of policy responses at the national level that address prevention, care, and support throughout the migration process. It is suggested that these responses be part of an empowerment approach that improves an individual's legal, social, economic and health status. Specific recommendations include creating a safe blood supply in areas of high population movement, making condoms easily available, supplying materials for universal precaution, providing HIV/AIDS prevention and counseling services, and increasing access to safe injection supplies and health services that include reproductive health matters.

### What Can CSO's Do?

In 2001 the relationship between HIV/AIDS and migration was recognized by the UN in paragraph 50 of the UNGASS declaration. This section urges member states to implement strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services.

Currently an unprecedented amount of resources are available for HIV/AIDS initiatives internationally. ASO's and NGO's can contribute to service provision that ensures the protection of the human rights of migrants. The IOM lists several measures that could facilitate such an approach, they include:

- Strategies that link efforts between originating, transit and destination countries.
- Twinning programs that foster cross border collaboration.
- Integrating HIV/AIDS programmes into other services for migrants.
- Conducting outreach to undocumented migrants that directs risk reduction towards the behavior and not the migrant.

- Involving migrant communities in advocating for public policy that ensures migrants fundamental right to health and social services.

### Definition of Main Categories of Migrants

The term **Mobile People** refers to people who move from one place to another, either temporarily or permanently, for a host of voluntary or involuntary reasons. Key groups within this category include transport workers such as truckers, train workers and bus drivers as well as itinerant traders, airline personnel, seafarers, agricultural workers, uniformed services, sex trade workers, and people employed in the tourism and hospitality industries (21).

**Migrant Worker** is a sub-category of mobile people and can be defined as a person engaged in a remunerated activity in a State in which he/she is not a national (22). Migrant workers can be classified as "external" - moving from country to country or "internal", moving from their home to another site or location within the same country. Examples of migrant workers include individuals traveling to obtain employment such as mine workers or agricultural laborers, and health care professionals seeking better salaries and conditions in developed countries. Migrant workers comprise a major category among mobile people; out of the 175 million mobile people worldwide 120 million represent migrant workers and their families (23). The majority of migrant workers are admitted to host countries for limited periods with the intention that they will return home when their contracts expire.

A **Refugee** is a person who because of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion resides outside the country of his or her nationality (24). Today, there are millions of civilians fleeing conflicts such as civil wars and ethnic, tribal and religious violence. The United Nations position is that persons fleeing such conditions should be considered refugees.

**Internally displaced persons (IDPs)** are also persons who have been forced to flee their homes. However they differ from refugees in that they have not crossed an internationally recognized state border. In 2003 there were over 42 million refugees and IDPs worldwide (25).

## **WEBSITES:**

*South African Migration Project:* <http://www.queensu.ca/sam>

*International Centre for Migration and Health:* <http://www.icmh.ch>

*International Organization for Migration:* <http://www.iom.int>

*United Nations High Commissioner for Refugees:* [www.unhcr.ch/cgi-bin/txis/vtx/home](http://www.unhcr.ch/cgi-bin/txis/vtx/home)

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