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HIV and population mobility: reality and myths

The world's population has never been so mobile. Vast numbers of people today are on the move, both internally and across borders, temporarily, seasonally or permanently for a host of voluntary or involuntary reasons. Some are migrants, intending to take up residence or remain for an extended stay. Many others move back and forth frequently, such as transport workers and traders. The HIV epidemic can spell disaster for both sending and receiving communities, as well as communities along transit routes. In regions which do not yet have generalized epidemics (i.e., where adult HIV prevalence among the general adult population is at least 1 per cent), HIV and AIDS still have severe impacts at individual and family levels.

This chapter explores the linkages between HIV and labour migration and trafficking. Examples from different regions are given; these are not comprehensive, however. Subsequent chapters address forced migration due to conflict (Chapter 5) and natural disasters (Chapter 6).

The International Organization for Migration (IOM) estimates there will be more than 200 million migrants in 2008. Patterns of population movement are so extensive that today most countries are simultaneously, to varying extents, countries of origin, transit and destination (IOM, 2008). Some countries also have large numbers of mobile people within their borders. China's internally mobile population, for example, is estimated at 100–150 million (Tucker et al., 2005).

The pandemic has also generated new forms of migration. These include increased migration from rural to urban areas as a result of a decline in agricultural production; the movement of healthy migrants to take up job vacancies caused by AIDS deaths; the movement of people living with HIV to be closer to healthcare facilities or providers; the return of sick people to rural homes for support; migration for work by other household members when the primary breadwinner falls ill; displacement by people with HIV to avoid stigmatization by their community; and the migration of spouses upon the death of their partner (Crush et al., 2005; IOM, 2005a).

Children may be sent away from households affected by AIDS to receive care elsewhere, to work when household members fall sick or die or to assist ailing relatives (Young and Ansell, 2003). There is also evidence that children are moving large distances, even across borders, without the supervision of a relative or guardian. A study of unaccompanied children migrating to South Africa found that they did so because of a combination of the HIV epidemic (death of parents or caregivers), poverty and the lack of educational opportunities in their country of origin (Save the Children, 2007) (see Box 4.1).

Photo opposite page: Two illegal migrants from Myanmar work as prostitutes in the town of Rangon on the border between Thailand and Myanmar.

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While HIV is often driven by poverty, it is also associated with inequality and economic transition (Piot et al., 2007). Economic growth and trade between neighbouring countries increase mobility, particularly of transport workers, and stimulate the sex industry along transport routes. Migrants are sometimes unfairly stigmatized as spreading HIV, but often the reality is that they move from regions of lower to higher HIV prevalence. In relatively low HIV prevalence countries like Bangladesh, Pakistan and the Philippines, returning migrants are more likely to have HIV than the local population (CARAM Asia, 2007).

About 35 per cent of all documented HIV cases in the Philippines are among returning overseas workers, as were 42 per cent of new HIV cases recorded in 2006 (CARAM Asia, 2007). While a selection bias may be partly responsible for these high numbers (some cases were identified following deportation after the migrant worker tested HIV positive), it appears that a great number of these people were infected in the country where they were working, or in transit.

Box 4.1 The migration, and its effects, of children affected by AIDS

A great deal has been written about children whose parents are ill or who have died, of AIDS or of other causes, and it is frequently mentioned that migration of one sort or another is often involved (see Foster and Williamson, 2000, for a review). The majority of the research has been done in Africa. Migration decisions in families are better seen as a family strategy than as an individual decision (Booysen, 2006), and also in a context in which the migration of children is – and always has been – widespread: "where the importance of social over biological parenting resonates through the literature" (Madhavan 2004).

One of the rare studies anywhere in the world to focus specifically on the migration of children as a result of AIDS, carried out in 2001 in urban and rural communities in Malawi and Lesotho (Ansell and van Blerk, 2004; Young and Ansell, 2003), found that children leave their households for four main reasons, which may be exacerbated by HIV and AIDS:

- to care for sick relatives
- because of the death of one or both parents
- because of increased poverty due to illness/death in the family
- because of the remarriage of widowed parents.

Children are commonly sent long distances, often between urban and rural areas, on the basis of who is responsible for them (some maternal grandmothers, especially, cared for children because their daughter would have wanted them to, while in other cases care may be given out of obligation), who is able to provide for their needs (not all of those who could meet material needs could also meet emotional needs) and who might usefully employ their capacities (including to assist when relatives fall sick or die). One of the striking results of the study was that the children were generally not aware of the rea-

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sons for sickness and death among their family members, nor were they consulted about their subsequent migration. Relatives often made the decision to send a child away after the parent's funeral, and the children felt they had no choice but to accept what their relatives had decided.

Most children inevitably found migration after the death of a parent traumatic. They faced the same challenges as any other child who moves to a new place, such as missing old friends and having to make new ones, changes in school curriculum and teaching methods, possibly a change in language and learning new ways of life. But they had to deal with a host of other difficulties as well, starting with the trauma of losing a parent. Newcomers were often said to be withdrawn, finding it difficult to engage with other children. Many of the children were separated from their former siblings since families try to spread the burden of caring for children, and relations were not necessarily easy with their new siblings. Rivalry, jealousy and tensions between children of the household and children arriving were not uncommon, and new siblings were sometimes reluctant to share either material resources or the emotional attention that is required when a child is coming to terms with the death of a parent.

Children who had been adopted through obligation faced particular difficulties: they were frequently treated differently from other children in the household, or from the way they had been treated at home. Many felt discriminated against in their new family, particularly if resources were scarce. Some were expected to undertake more and different work from that they were used to.

AIDS complicated the adaptation of migrant children in other ways as well. For example, stigma – or the fear of stigma – often made their integration more difficult. Poverty created by extended AIDS care meant that the children often did not have resources to share with potential new friends. Repeated illnesses in their families meant that some children engaged in multiple migrations as they were sent to one caregiver after another. Finally, children's AIDS-related migration can take forms that make it particularly problematic: it is more likely to be unaccompanied, it may happen suddenly, leaving children unprepared and disrupting their education, and it is also more likely to move them to environments in which they are ill prepared for the tasks that will be required of them.

Some of the migrations failed, resulting in renewed migration and trauma. Failures happened either because orphans felt ill-treated in their new families or because of changes in guardians' circumstances. Some of the children were unhappy with the decisions made. Some had engaged in multiple migrations. In extreme cases they left the extended family altogether to form alternative families on the streets, making it increasingly difficult to maintain links with relatives or to return home: "I don't know anybody to visit [at home]" (Young and Ansell, 2003). ∎

A 2007 survey of Albanian, Moroccan and Peruvian migrants in Italy found that they were most vulnerable in their first year in the receiving country. While many of these migrants had heard of HIV through education campaigns in their home countries, they had only superficial knowledge of the modes of transmission and how to protect themselves. Moreover, they wrongly perceived the lack of such education campaigns in Italy, unlike those in their home countries, as an indication that HIV did not exist in Italy (IOM, 2007a).

Not all migrants and mobile people are at equal risk of HIV, and interventions should prioritize those at greatest risk. For instance, behavioural surveillance in Lao People's Democratic Republic (PDR) found that only 6 per cent of mobile male seasonal labourers reported having a commercial sex partner in the previous 12 months, compared to 12 per cent of military personnel, 24 per cent of police and 31 per cent of truck drivers (Family Health International, 2006).

Many of the underlying factors driving mobility (such as an unbalanced distribution of resources, local unemployment, socio-economic instability and political unrest) also increase the vulnerability of mobile populations to HIV infection. Because of their mobility and their status as non-nationals, migrants may fall through the cracks in HIV responses in countries of origin, transit, destination and return (IOM, 2002). In countries such as China and Viet Nam, where freedom of movement is restricted and access to government services is tied to the place of legal residence, irregular internally mobile populations are similarly disadvantaged.

HIV is rarely the most immediate health threat that migrants face. Physical violence, illegal detention in poor conditions, work-related hazards, sexual abuse, mental health issues and infectious diseases such as tuberculosis are often seen as more immediate priorities than HIV. These issues, let alone the complex challenges of HIV, will never be addressed successfully until migrants' rights are respected and protected.

> "Unfortunately, there is a widespread belief that it is migrant workers who carry and transmit the virus. Not surprisingly, therefore, most of the employing nations enforce mandatory testing for HIV and other communicable diseases to ensure that their countries remain free of HIV."
>
> (Wulan and Lingga, 2007)

Migrants living with HIV and those taking anti-retroviral medication face additional challenges. Pre-deployment testing and exclusion of migrants with HIV means some will hide their status and their medications when crossing international boundaries. It is in everyone's interest, not just their own, that migrants taking anti-retroviral medications adhere to these regimes throughout the migration process. The development of drug-resistant strains of HIV is an impending personal and societal disaster which

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will be hastened if treatment access is interrupted. However, government health schemes rarely provide anything other than emergency services for undocumented migrants (also referred to as migrants 'in irregular situations'). IOM notes:

> "The health of migrants in an irregular situation, such as undocumented labour migrants and trafficked persons, can be at risk due to poverty, powerlessness, discrimination, and vulnerability to exploitation. Migrants in an irregular situation often lack access to health care and social and legal services in host communities. Even if social and health services are available and affordable, migrants in an irregular situation are often hesitant to use them for fear of being reported to immigration officials, or deported."
>
> (IOM, 2006b)

Internationally funded initiatives, even if in collaboration with the Ministry of Health and local health providers (e.g., PHAMIT: Prevention of HIV/AIDS Among Migrant Workers in Thailand), are time-limited and dependent on ongoing support from the international community.

Labour migration and HIV

As noted in Chapter 2, HIV and AIDS is already beyond the capacity of communities to cope in many parts of sub-Saharan Africa, where mobility associated with mining and transport facilitated the early and rapid spread of HIV (Williams and Gouws, 2001; Crush et al., 2005). Workers in other relevant sectors include commercial farm workers, construction workers, domestic workers, factory workers, entertainers and informal traders.

Gender trends in labour migration

IOM reports that although the proportion of women in global migratory flows has not fluctuated markedly over the past few decades, there are distinct regional trends. Latin America records the highest proportion of women (54 per cent) among international migrants in developing parts of the world. Women represent about 60 per cent of migrants from the Philippines, Sri Lanka and Indonesia. In Oceania, women migrants have outnumbered men since 2000 (IOM, 2008). In recent years nearly three in four Cambodian migrants to Malaysia were female. Most of these women work as domestic workers; some also work as factory workers, shop assistants, plantation workers and construction workers (Lee, 2006).

Women are also on the move within countries. For example, in Viet Nam's burgeoning industrial parks and export processing zones, 63 per cent of the workers are women, as are many of the labourers who work in the border areas with China. The

proportion of female migrants has increased due to a greater demand for female labour in services and industry, and also because of growing social acceptance of women's mobility. The feminization of migration is one of the major recent changes in population movement within Viet Nam (Dang and Luu, 2008). Women's HIV vulnerability is often increased by mobility, and undocumented female migrants are among the most vulnerable to exploitation and abuse (see Box 4.2).

Mine workers

The apartheid system in South Africa established and reinforced patterns of circular migration that persist to this day. Men from rural areas and neighbouring countries were permitted to work in South African mines, but only on annual contracts, without bringing their families and with no right of permanent residency. Large numbers of single men continue to move periodically from their homes to the mines and back again.

> "The high HIV-prevalence countries of southern Africa are bound together by their dependence on mining, especially hard rock mining for gold and other metals in South Africa and Botswana. In the 1980s and 1990s, for example, the South Africa gold mining industry employed half-a-million migrant mineworkers from rural areas in South Africa, and from Botswana, Malawi, Mozambique, Lesotho and Swaziland."
>
> (Williams and Gouws, 2001)

Mine workers in southern Africa are typically young men from rural areas who work in dangerous, stressful conditions and live in single-sex hostels with easy access to sex workers and alcohol. The work is exhausting and dangerous, which also shapes the

Box 4.2 Importance of inclusive, gender-sensitive approaches

Only focusing on 'high-risk groups', such as truck drivers, fails to address the risks to large population groups, including the wives of men who may have multiple sexual partners. In India, Oxfam and the South Orissa Voluntary Action (SOVA) support self-help groups in tribal areas to empower women with greater individual and collective strength by helping them to purchase seed and fertilizer, or manage the government ration scheme. SOVA realized these groups could also be used to disseminate HIV information. Working with the community in this way has helped overcome challenges in accessing truck drivers and has also enabled women to achieve greater autonomy in their sexual relations. Oxfam also reports that sex workers are now much more likely to refuse sex without condoms and that there has been a reduction in HIV-related stigma (Oxfam, 2006). ■

way miners view the risks of HIV compared with the daily odds of being maimed or killed. In 2000, men who moved from Hlabisa in rural South Africa to mines in Carletonville were twice as likely to be HIV-positive (28 per cent) than non-mobile men (14 per cent). Yet in 40 per cent of discordant couples the woman at home was HIV positive, indicating that the wives of mobile men are sexually active in their absence and risk infecting their partners when they return home (Williams and Gouws, 2001).

The lifting of South African apartheid laws in the early 1990s led to increased mobility throughout southern Africa and probably contributed to the further spread of HIV in the region (Lurie et al., 2003). Yet increased mobility does not necessarily increase HIV risk: mine workers who return home four or more times a year appear to be at significantly lower risk of HIV infection, possibly because they have fewer concurrent partners (IOM and UNAIDS, 2003). Structural interventions to reduce mine worker vulnerability to HIV include comprehensive approaches involving family housing for mine workers, extending health, HIV and sexually transmitted infections (STI) services to the sexual partners of mine workers (including sex workers around the mines) and building social capital through support for community associations such as sports clubs and youth groups. Today, improved transport routes and more flexible work arrangements mean that mine workers can return home more often. While this can lessen the pressures for multiple concurrent sexual partners, it also means that the rural areas are far less insulated from HIV and other infectious diseases (Crush et al., 2005).

Truck drivers

Truck drivers and their assistants are also usually sexually active men, living and working in a stressful macho culture and separated from regular partners for extended periods of time. They are particularly vulnerable to HIV infection because of several structural and environmental factors: they often move between regions with different levels of HIV, they usually carry significant sums of cash to meet their travel needs and they often have inadequate access to health services, including to STI treatment (IOM, 2005a). Other factors increasing their vulnerability include spending idle time due to delays in loading and unloading goods, crossing borders or broken bridges and mechanical failures; a lack of suitable accommodation at rest stops; the availability of unregulated sexual services in the 'hot spots' where trucks stop; and the relative poverty of the regions through which the truckers pass.

Studies in West Africa found HIV prevalence in truckers of between 3 and 32 per cent (IOM, 2005b). HIV rates are lower in regions outside sub-Saharan Africa but the potential for disaster exists: in a Bangladesh study 7 per cent of truckers tested positive for syphilis. Other studies indicate that it is possible to protect these mobile populations. In Hong Kong, 90 per cent of truck drivers interviewed reported using

condoms with sex workers. In a Vietnamese study 55–85 per cent of truckers reported always using a condom (IOM, 2005b).

Interventions with truck drivers largely focus on information, education and communication (IEC), peer education and treatment of STIs. However a multisectoral, rights-based approach is needed to address the underlying reasons why these truck drivers remain vulnerable to HIV infection, including regulation of working conditions in the transport sector (ILO, 2005). Some governments are taking steps to integrate these mobile populations into the national response, including addressing the sectoral level. Lesotho and Zambia both make explicit reference to mobile populations, including transport workers, in their national AIDS plans. The South African Department of Transport has had an HIV and AIDS strategic plan since 2001. The Cambodian Ministry of Public Works and Transport adopted a policy mandating HIV education in the transport sector, such as professional training programmes in driving schools, in 2006. However, in the absence of adequate human and financial resources, challenges remain in implementing such policies and plans.

Construction workers

Construction workers are usually (but not always) male, young, single and semi-skilled or unskilled. Most construction workers are inherently mobile: as one project is completed they are laid off and return home or are moved to a new site. Construction workers face many of the same structural and environmental factors that place migrants in other sectors at increased risk of HIV infection. Sites are often located in remote, underdeveloped areas. Foreign construction workers may have difficulty obtaining work visas.

Many workers are undocumented and hence do not have access to government health and STI services, where they exist. Work sites are also dangerous; the workers experience boredom and loneliness, and there is little social cohesion. Subcontracting arrangements common in the construction industry make allocation of responsibility for HIV programmes more difficult because they often require the various subcontractors to indemnify the general contractor for responsibility for workers' health and safety. At the same time, subcontractors may wish to avoid the costs associated with providing HIV programmes and STI prevention and treatment (IOM, 2007b). The typically impoverished local communities surrounding the site are also at risk, as women from these communities may engage in sex with male construction workers for money or other promised rewards. Ethnic minority women have been noted as particularly vulnerable, for example in the border areas between Lao PDR and Viet Nam (Dang and Luu, 2008).

In some countries, HIV levels in the construction sector are high and are believed to contribute significantly to the national epidemic. In 2003, the South African Deputy Minister of Public Works noted that the construction sector had the third highest HIV

incidence of the economic sectors in the country (IOM and UNAIDS, 2003). According to the Asian Development Bank (ADB), rapid growth in the construction sector in Indonesia has caused HIV transmission to increase 'exponentially' since 2000, as migrant workers in the sector are more likely to engage in high-risk sexual behaviour.

In response, some governments require social impact assessments in the planning stage of large infrastructure projects and the inclusion of impact mitigation plans, including HIV mitigation, in the contracting process. As of 2007, the Cambodian Ministry of Public Works and Transport requires new contracts for public infrastructure construction to contain a budget for HIV and STI prevention. An evaluation of recent experience in Asia has found that including general HIV prevention requirements in construction contracts is insufficient. Following a review of its road projects in Yunnan, southern China, the ADB found that "contracts need to clearly define a minimum package of interventions and indicators to measure performance as well as provide tools and resources to help companies implement HIV prevention in the workplace" (ADB, 2007) (see Box 4.3).

Major infrastructure works such as dams can result in the relocation of tens of thousands of people, with consequent health impacts, including HIV and STIs, due to loss of immediate livelihoods, rupture of the social fabric and recourse to transactional sex or sex work. These impacts are in addition to the risks to local communities resulting from the presence of large numbers of construction workers, noted above. In Viet Nam it is anticipated that more than 90,000 people will be relocated by 2009 due

Box 4.3 HIV and infrastructure: the Asian Development Bank's experience in the Greater Mekong subregion

In 2007, the ADB reviewed HIV prevention initiatives in four road construction projects in the Greater Mekong subregion of South-East Asia (ADB, 2007).

The key lessons and recommendations are to:
- develop programme support through capacity-building of the transport and infrastructure sector institutions
- consolidate HIV implementing arrangements
- design self-contained HIV prevention components
- adopt a holistic 'settings' approach rather than focus on target groups

- integrate HIV prevention into the contractors' occupational health and safety programmes
- collaborate with local AIDS authorities
- partner with other specialized agencies for anti-drug and human trafficking activities
- synchronize the implementation schedules of HIV activities to coincide with the programme of construction
- ensure condom availability during and after construction
- incorporate gender. ∎

to the construction of the country's largest hydroelectric dam in a north-western mountain region near the border with Lao PDR. In China, government sources have indicated that as many as 4 million people could be relocated by 2020 as a result of the Three Gorges Dam project.

Health workers

The global scarcity of health workers has been attributed to various factors, including inadequate investment in the health sector, difficult working conditions, high levels of responsibility coupled with inadequate remuneration and lack of occupational status. Although all regions are affected, health worker migration away from severely HIV-affected countries and regions, particularly in southern Africa, is having a devastating effect on the population. Among health workers themselves, there is increased mortality and morbidity, increased absenteeism and reduced productivity. In addition, the clinical and psychosocial care for patients with AIDS impacts heavily on the morale and stress of health professionals. The lack of qualified doctors, pharmacists, nurses and other health workers has created a vicious circle. AIDS has depleted the health workforce and deteriorating conditions force even more health personnel to leave their home countries. As a result, there are not enough trained staff to deal with the existing case load, let alone manage the expanded provision of combination treatments for AIDS (IOM, 2006c).

Practical responses (beyond increased investment in training and working conditions) include reviewing retirement policies, improving management of the existing workforce (including standards of health and safety), protecting migrant health workers from discrimination and social exclusion, facilitating return migration and guest worker schemes (IOM, 2006d).

Sex workers

Sex workers are often highly mobile, and studies show that mobile women may be more likely to engage in sex work. Research in China has found that mobile women (typically those moving from the countryside to urban areas) were more than 80 times more likely to engage in commercial sex than their stay-at-home counterparts. Even when age, education and marital status were taken into account, these women were still more than 15 times likely to engage in sex work (Yang and Xia, 2006). Many women engaging in sex work in China never use condoms (only half on average in one study across 19 provinces) and STIs are common (14 per cent of sex workers surveyed in Guangdong province had syphilis in one study). Predictably, increases in HIV infection have been recorded in sex workers in Yunnan, Guangdong and Guangxi (Tucker et al., 2005).

Government policies can exacerbate or mitigate the potential harms of sex work. In China, police crackdowns and incarceration in re-education centres promote sex worker mobility, distancing them from healthcare services and the stability of local social struc-

tures. Progressive policies have been demonstrated to work, even in countries where sex work remains technically illegal: undocumented Vietnamese sex workers in Cambodia benefit from free STI treatment and that country's 100 per cent condom-use policy in the sex industry. Brothels are allowed to operate without criminal prosecution in return for open access for healthcare workers, regular STI checkups for sex workers and the assurance of condom use in all sexual encounters (Phalla, 2005). In Can Tho in southern Viet Nam, provincial government support for a drop-in centre for mobile sex workers provides an opportunity for mutual support, HIV education and condom distribution (CSEARHAP, 2006). It can be harder to reach women who migrate to study or to work in factories, bars or construction, or as domestics, and sell or barter sex.

Trafficked people

Approximately 800,000 people are trafficked annually across national borders. Millions more are trafficked within their own countries. The majority of trans-national victims are females trafficked into commercial sexual exploitation (US Government, 2007). In addition, some economic migrants including sex workers choose to utilize traffickers as the way to move across borders which exposes them to criminal networks. Structural causes of vulnerability to being trafficked include poverty, limited access to education, lack of legal sanction and enforcement, and social and cultural attitudes and practices that devalue and degrade women and girls (UNAIDS, 2004).

> "We were told that we had to make the customers wear condoms. If they did not, we were fined. If the customer refused to have sex with us because he had to wear a condom, we were fined. Sometimes we would not tell the bar owner the client refused to wear a condom because we did not want to get into trouble and get another fine. We had to pay for all our condoms as well."
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> (Trafficked sex-trade worker in Moldova, cited by IOM, 2006b)

Children by their illegal squatter home, overshadowed by high-rise apartment buildings in Kowloon, Hong Kong, China.

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A 2006 study of trafficked women in three countries in east and southern Africa found that women were trafficked to the region from as far away as Thailand (IOM, 2006a). The risk of HIV infection was compounded by the sexual violence and psychological trauma these women suffered. A 2007 study of repatriated sex-trafficked Nepalese girls and women found high HIV prevalence (38 per cent). The median age at trafficking was 17 years, and girls trafficked at a younger age were even more likely to be HIV positive. The study noted that the repatriation of girls and women sex-trafficked to India was recognized as a barrier to HIV control in neighbouring low-prevalence countries such as Nepal. Returnees may be ostracized by local communities and re-engage in sex work to survive. The return of sex-trafficked survivors from India is considered a critical factor in the increase in Nepal's HIV prevalence (Silverman et al., 2007). There is also evidence that decriminalization of sex work, combined with such targeted interventions, is an important aspect of empowering sex workers to resist exploitation.

International and regional cooperation is essential to stop trafficking (see Box 4.4 for an example of a project to combat trafficking in Cambodia). Since 2003 the Southern African Counter-Trafficking Assistance Programme (SACTAP) has supported governments and civil society groups to address trafficking in southern Africa while also offering assistance to victims and raising awareness among the general public. Training includes the health implications of trafficking, including STI and HIV. In May 2007 member states of the Southern African Development Community (SADC) met to discuss trafficking issues through the IOM's Migration Dialogue for Southern Africa (MIDSA) process. In South-East Asia six countries agreed in 2004 to cooperate in a rights-based and victim-centred approach: the Coordinated Mekong Ministerial Initiative against Trafficking (COMMIT).

Box 4.4 Cambodia's response to human trafficking

Cambodia is still in the process of rebuilding after long years of turmoil and civil war. Human trafficking adds to the problems of reconstruction. It is a serious global social problem and violates many rights: the right to life, the right to free movement, the right to be free of torture, and others. Trafficking continues despite being a crime, because traffickers make a large profit from it, and have little risk of being caught and punished.

The traffickers may be neighbours, boyfriends, someone met on the street in a strange town, even someone in the family. Many victims are recruited by traffickers with false promises of a good job. They are trafficked across borders into other countries – Malaysia and Thailand, for example. Others come under the control of traffickers when they leave home following domestic violence or rape, or when they are in a foreign country and do not understand either the language or how things work there. Cambodians are also trafficked within their country; for example, girls from rural provinces are sent to the capi-

tal or to tourist destinations for forced sex work. Victims from other countries, such as Viet Nam, are sometimes exploited in Cambodia, or passed through Cambodia on their way to exploitation in other destinations.

Cambodians are trafficked into so-called '3-D' work which is 'dirty, degrading and dangerous'. They find themselves far from home, with little pay, or as virtual slaves with no pay at all. All contact with their family and friends is cut off. They are abused and mistreated, and some even die. Typically, they are exploited in sex work, begging, domestic service, factory work and agricultural work. Most of the trafficking victims are women and children, although men may also be trafficked; for example, many are forced onto fishing boats and never allowed back onto land. Victims of cross-border trafficking often have no proper documents, and if they escape or are rescued, they may be arrested and imprisoned for irregular migration.

Cambodia has responded to this crisis in many ways. For example, the government of Cambodia has developed a national task force, chaired by the deputy prime minister, and a national plan of action; a new law on suppression of human trafficking and sexual exploitation has just been passed; there are specialist law enforcement efforts; and there are a number of organizations that run shelters and provide services such as vocational training. However, there is still a great need for further programmes to prevent trafficking, as factors such as poverty, illiteracy and joblessness and the lure of better employment opportunities in other places make Cambodians very vulnerable.

The Cambodian Red Cross Society (CRCS), building on its traditional strengths in community service and emergency response, has initiated its own response to human traf-

ficking (RHT) programme, with humanitarian values at the core. Starting in 2006, the programme collected and analysed the available expertise and then held participatory workshops with government agencies, non-governmental organizations (NGOs) and local Red Cross representatives to map the situation and develop responses. In the pilot phase of the programme, three border provinces were selected and Red Cross volunteers were recruited and trained in villages and schools. These volunteers work with their peers and neighbours to provide information about trafficking and safe migration, and how to access the services provided by CRCS and other agencies. The new volunteers also learn about first aid and other Red Cross activities. As part of the wider CRCS network, they are able to help their communities in many ways.

As the programme continues, CRCS has expanded the volunteer networks and begun giving practical assistance to victims of trafficking and their families. This includes providing basic necessities such as food, water and immediate shelter; helping victims to re-establish contact with their families and return home and to access services from others such as shelter, medical care and vocational training. Survivors of trafficking who have returned home, and children whose parents disappeared after migrating, can receive both emergency aid and longer-term assistance. In the communities where the volunteers are active, CRCS also helps victims of rape and domestic violence, since they are especially vulnerable to trafficking recruiters. CRCS is also working with National Societies in neighbouring countries to develop cross-border responses to trafficking, building on the traditional International Red Cross Red Crescent Movement expertise in prison visits and in reuniting families.

The border areas where the CRCS programme is working are 'hot spots' for human trafficking problems. Local people knew that many of their neighbours had disappeared and then later returned with empty pockets and a troubled spirit – or did not return at all. They had even seen public service announcements on TV about human trafficking. But until a CRCS volunteer talked with them personally, one group of neighbours in Banteay Meanchey province whose children went missing under suspicious circumstances did not realize that they could do anything about it. With support from the CRCS, they contacted the specialist human trafficking authorities and soon most of the families had contact with their children. They hope to be reunited soon.

Red Cross youth and the fishing boat victim

With 2008 the new phase of the programme started, and the CRCS Koh Kong province branch saw the benefit of investing in young people. One of the Red Cross youth trained by the RHT programme saw a man looking lost and hungry by a bridge on the border with Thailand. It turned out that the man had been badly abused in Thailand, receiving only 500 baht (US$ 15) a month for hard work on a fishing boat. When he was sick and too weak to work, he was dismissed and tried to go back home. He ran out of money in Koh Kong, and by the time the Red Cross youth saw him he had not eaten for several days. After a quick series of phone calls, the man received emergency food, shelter and basic counselling, and was then helped to return home.

The CRCS works with other agencies on the project to combat trafficking, including the Ministry of Social Affairs, Veterans and Youth Rehabilitation, which is responsible for a mobile team that identifies trafficking victims at major border crossings and also for a variety of other repatriation, rehabilitation and reintegration services; the specialist anti-trafficking police in the Ministry of Interior; the Ministry of Women's Affairs, which conducts public awareness-raising and advocacy and is developing cross-border agreements; IOM, which works in a number of areas including awareness-raising and repatriation; the UN Inter-Agency Project to Combat Trafficking in the Mekong Sub-Region, which serves as an umbrella and support service for all of the efforts against human trafficking, and a number of Cambodian and international NGOs that provide services such as shelter, vocational training, legal aid and human rights advocacy. ∎

Responding to the plight of migrant workers

This section reviews some international, regional and national responses to address HIV in the context of mobility, notes the importance of addressing the underlying causes of vulnerability and proposes some practical steps which can be taken.

International and regional responses

The International Convention on the Protection of the Rights of All Migrant Workers and Their Families (UN, 1990) assures all migrants (including undocumented migrants) access to "any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned" (article 28). Documented migrants are entitled to the same access to health services as nationals, provided that the requirements for participation in the respective schemes are met (article 45). The convention entered into force in 2003 after ratification by 20 states. Since then, however, fewer than 20 additional countries have ratified it – none of them major recipients of migrant workers. Rather than pushing for universal ratification of this convention, members of the Association of Southeast Asian Nations (ASEAN) have toyed with proposals for a regional mechanism, which is almost certain to provide less protection, if it is ever adopted.

Regional intergovernmental and other stakeholder initiatives, such as the UN Regional Task Force on Mobility and HIV Vulnerability Reduction in Southeast Asia and Southern China (UNRTF), provide an opportunity to share perspectives and experiences, but the policy gap between sending and receiving countries in the wider region on issues such as mandatory HIV testing of migrant workers remains substantial. (By contrast HIV is not a bar to migrants' work or residence in the countries of southern Africa.)

Unfortunately, the response of intergovernmental bodies, development agencies and donors has been at times fragmented and conflicted. In 2006 the Global Fund to Fight AIDS, Tuberculosis and Malaria approved US$ 19 million for a regional response to HIV and mobility in West Africa, yet in 2007 it rejected a similar proposal from ASEAN in South-East Asia (where UNRTF has operated for ten years), with no invitation to revise and resubmit. At the 16th International AIDS Conference in 2006, the ADB supported a statement titled 'Joint Initiative by Development Agencies for the Infrastructure Sectors to Mitigate the Spread of HIV/AIDS' pledging close donor cooperation and partnership. Yet ADB support for the UNRTF-initiated national multisectoral technical working groups on HIV and mobility in South-East Asia has been largely absent. Worse, at the International Congress on AIDS in Asia and the Pacific in August 2007, the ADB floated a proposal to establish a regional network of governments, donors and civil society to address HIV and

mobility; in effect, a parallel mechanism to the existing UNRTF. Regional dialogue on mobility is important, but it should not replace urgent national action to scale up practical interventions with migrants and mobile populations already shown to work (see Box 4.5).

National responses

Some labour-exporting countries (e.g., Cambodia, Indonesia, Philippines, Viet Nam) require that intending migrant workers receive HIV education before departure. Recognizing that such 'pre-departure orientation seminars' (PDOS) can only provide the most basic HIV and other health information, attention has also focused on preparing potential migrants well in advance of their departure.

> "Let's talk about the PDOS. The [HIV/AIDS module] is barely an hour. You wouldn't be interested to listen to it because you're already contemplating on what will happen to you when you are abroad or whatever. You will not absorb it. It will never register in your mind, really."
>
> (Filipino migrant worker who had worked in Saudi Arabia, cited by CARAM Asia, 2005)

In the Philippines, pre-employment orientation seminars explaining the risks of HIV have been held for people considering working overseas. In Myanmar, a community

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Box 4.5 CARAM Asia migrant friendly testing campaign

Although UNAIDS and IOM advise that the exclusion of HIV-positive migrants has no public health benefit (IOM and UNAIDS, 2004), many migrant-receiving countries require an HIV test for a work visa and exclude all HIV-positive migrants. Some insist on a further HIV test on arrival or periodically thereafter.

For would-be migrants, an HIV diagnosis that follows routine medical screening in the last hectic days before planned departure overseas, can be devastating. The consequences for migrants testing positive in receiving countries can be worse, including immediate detention, without any psychological or other support, until deportation. CARAM Asia notes that much can be done now to improve the experience of pre-departure HIV testing for migrants, while advocating for the elimination of discriminatory immigration provisions in the longer term. In 2007 CARAM Asia launched the migrant friendly testing framework. The framework includes standards of informed consent, ensuring provision of pre- and post-test counselling, protecting confidentiality and providing proper referral for those who need support or treatment (CARAM Asia, 2007).

CARAM Asia is the Coordination of Action Research on AIDS and Mobility, an open network of community-based organizations and NGOs. ∎

International Federation of Red Cross and Red Crescent Societies

resilience approach pioneered in Mon state since 2006 goes beyond the provision of HIV information through the creation of village mobility working groups and intensive discussion of the risks, including HIV, faced by migrants and their communities (Fletcher, 2007). This approach also has the advantage of reaching intending undocumented migrants, who will be missed by the formal PDOS process. The focus is on the risk to the community, not just the individual, and empowering the community to develop its own responses to the challenges of HIV and AIDS.

Structural factors must be addressed

As noted above, mobility is often driven by the search for economic opportunity. The lack of rural development in many countries has led to mass movement towards the cities. Laws restricting internal freedom of movement have proved ineffective in such circumstances and have often created an underclass of disenfranchised workers without access to health or education services for themselves or their families.

The scale and the gender dimensions of this disaster are now becoming apparent. HIV vulnerability related to mobility is intricately linked to cultural, economic and political factors which must be understood and acknowledged if workable solutions are to be found. For example, the traditional preference for sons in countries such as China and India and the increasing availability of ultrasound technology over the past two decades has facilitated sex-selective abortion and is believed to have resulted in a significant alteration in the demographic sex ratio in these countries. In China there are an estimated 8.5 million more men than women in the generations born between 1980 and 2000. It is anticipated that as these men reach adulthood, many will move from poor rural areas to towns and cities in the east and south of the country in search of jobs and brides. Although poor, they will seek out sexual services (Tucker et al., 2005). However, sex work remains stigmatized and illegal in China, which contributes to an environment conducive to STIs and HIV.

> "Migrants' vulnerability to HIV is based in a complex and closely interwoven web of emotions (particularly fear, shame and love or desire), physical and cultural context, peer and family relationships, gender, economics, expectation, lack of information and habit."
>
> (Fletcher, 2007)

Young women in China are also severely affected by the political and economic shifts affecting that country. The transition to the market economy has weakened institutional support for gender equality, leading to greater sex segregation in the labour market. Female migrants are channelled mainly into low status service and entertainment jobs, perpetuating and reinforcing their subordinate status in cities (Yang and Xia, 2006). Casual sexual relationships or sex work may be their only means of survival, reflecting patterns of transactional sex and sex work in southern

Africa two decades ago which are believed to have contributed to the HIV epidemic in that region.

> "Internal migrants can become external migrants; external migrant returnees can become internal migrants before returning to their home town or village. The boundaries blur, and therefore so do the vulnerabilities. As with all HIV-related work the factors of timing, emotions, culture, society and context must not be overlooked."
>
> (Fletcher, 2007)

The necessary policy responses are familiar and daunting, in particular the need to move beyond focusing on individual risk behaviour to address the structural and environmental causes of HIV vulnerability. Practical steps include: decriminalize sex work and make it safer; abolish internal residency requirements for access to health services, and provide free and friendly STI and HIV services for all; address the social, cultural, legal and economic factors that lead to sex-selective abortion; enforce prohibitions against gender-based discrimination in employment; invest in rural development to offer young people an alternative to city life; research and publicize migrants' financial contribution to the economy and the other benefits of mobility; engage the media to address negative public perceptions about migrants and mobile populations; and assess the potential economic and social impact of not acting urgently to address HIV vulnerability.

The most effective solutions can only be identified in consultation with affected populations, which presumes they have a place to speak and will be heard. Freedom of speech and association are implicit in the realization of the right to health. The extent to which migrants and mobile populations themselves are engaged in the response to the challenges of HIV and mobility will greatly determine the success of our efforts.

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International Labour Organization: **www.ilo.org/aids**

International Organization for Migration: **www.iom.int**

Office to Monitor and Combat Trafficking in Persons (USA): **www.state.gov/g/tip**

Partnership on HIV/AIDS and Mobile Populations in Southern Africa:
www.iom.org.za/PHAMSA.html

Prevention of HIV/AIDS Among Migrant Workers in Thailand: **www.phamit.org**