Forced migration and HIV/AIDS in Asia: some observations

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Although most of Asia has not suffered from a generalised HIV epidemic, there is reason to be concerned about how forced migration and economic crisis-related migration may increase the risks.

A thorough discussion of how and why forced migration can increase risks of HIV transmission in the region would require reviewing a myriad of social, cultural, economic and even physiological dynamics. So I will focus on a few issues of particular relevance – HIV in humanitarian settings, security-related programme developments, and the special needs of the millions of Asians who, out of desperation, find themselves exploited and unprotected as labourers in foreign lands.

In my capacity as Special Envoy, I have advocated for stronger prevention, better care, and destigmatisation of HIV/AIDS throughout the region. I have also worked for the recognition that migration within and outside the region plays an important epidemiological role and that there must be much greater attention paid to the rights, needs and protection of migrants. Over the past decade, there has been significant progress in HIV awareness and adoption of ever more progressive and effective policies and programmes by many governments. A good example of recent change is the lifting of immigration restrictions based on HIV status by China, setting a good example for other countries.

But there remains much room for improvement when it comes to widespread establishment of effective, rights-based policies and programmes for HIV prevention and care. There are particular needs for more attention to those at risk due to being displaced. There are millions of Asians who have left their homes and areas of origin and are living, often without their families or other social support, in new communities. Many are facing circumstances which make them more vulnerable to contracting HIV while at the same time they have lost access to information and means of prevention.

Over the past decade there has been a great deal of conflict-related displacement in the region. Civil war or insurgencies in Afghanistan, Nepal, Myanmar, Sri Lanka, Indonesia, Pakistan, India and the Philippines and across Central Asia have created large numbers of refugees and IDPs who have required humanitarian support. Although HIV prevention, as a part of the minimum package of reproductive health services, was adopted as a critical component of humanitarian response in 1994[1], resource constraints and social and cultural factors have impeded universal access to information and means of prevention among these populations. (It should also be pointed out that for some people the first information they ever received on HIV was from humanitarian agencies.)

Some types of conflict or displacement have brought much more particular risks of HIV infection. For example, long years of refugee

camp life and lack of employment or recreational opportunities have contributed to intravenous drug use in Afghanistan and Pakistan border areas; this is a driving factor in the epidemic in these countries just as it is in Central Asia. The destitution of Burmese refugees in Thailand has led to widespread 'survival sex' which has driven the infection in that sub-region. The sexual violence used as a weapon of war in Timor Leste, Central Asia, Sri Lanka and other conflicts has undoubtedly increased HIV risks. And although it is often not considered an armed political conflict, the horrific levels of social and interpersonal violence in Papua New Guinea are also thought to be important factors in the epidemic there. Throughout the region, there is not only need to ensure that HIV prevention and care services are provided for displaced populations but there is also need for serious analysis of the HIV impact of the conflicts and for the inclusion of the special needs of the displaced in every national AIDs action plan.

The Asian region suffers more natural disasters, especially floods and earthquakes, than any other region in the world. The displacement of millions due to such events is a regular annual occurrence. In many places, such as Pakistan, Indonesia and Sri Lanka, populations have suffered both conflict- and disaster-related devastation. In addition to the trauma of the disaster and the difficulties of living in temporary shelter, the loss of livelihoods and assets accompanying natural disasters can affect families and communities for years, leaving them destitute and vulnerable to sexual exploitation or even trafficking. There is some evidence that domestic violence also increases in post-disaster periods. All of these are risk factors for HIV infection. While provision of HIV education and basic prevention measures, including condom distribution, are part of the minimum standards for humanitarian response[2], full implementation of these standards has not been accomplished due to resource constraints, or stigmatisation, or both.

HIV and the security sector

Many Asian countries have been leaders in the area of HIV and security. Thailand and India were among the first countries to recognise the need to provide comprehensive HIV prevention programmes within the security sector (national militaries, police and other uniformed services) and they have shown the way for many other countries in the world. The Thais, as in so many other aspects of HIV prevention, pioneered peer education and condom distribution programmes for uniformed services. The MAITRI programme in India was one of the first programmes established to support military families and dependents, not just individual members of the military, with comprehensive health and HIV education and counselling as well as other social support.[3]

With the support of UNAIDs, UNFPA and others over recent years, there has been good progress in the region among national uniformed services, groups who are important both because of their risk factors (age, mobility, etc) and because they can serve as role models in their societies. It is particularly important that members of militaries and police in the region have both knowledge of HIV and prevention skills because Asian countries provide a very large proportion of international peacekeeping forces and so are deployed all over the world, including to places with higher HIV prevalence. Pakistan, Bangladesh and India are the largest contributors to UN peacekeeping, sending on average over 10,000 peacekeepers a year; Thailand, Nepal, Australia, New Zealand, China, Indonesia, Fiji, Malaysia, Nepal, Sri Lanka, Mongolia, the Philippines and Korea are also significant contributors. Since the adoption of UN Security Council Resolution 1308 on HIV/AIDS in 2000, the UN has established HIV prevention programmes in all peacekeeping missions. For some troops from countries without national programmes, their first exposure to reliable information is during peacekeeping deployment.

Migration due to economic and social crises

Within migration studies there has long been a hearty debate about the 'push' and 'pull' factors determining individual decisions to migrate and what constitutes forced or voluntary migration. Traditionally, labour migration has not been considered as forced. I would like to challenge that notion in the case of much of the labour migration within and from Asia today. The severity of the economic and social crises in the region has led thousands to leave their families and homes to go to foreign lands and engage in low-wage labour with little protection from exploitation, no legal rights and inadequate access to even basic social services. This must surely be considered not as a lifestyle choice but as something forced on the migrant by circumstance. The conditions of such migrants are such that their risks of harm, including of HIV infection, are multiplied. And yet their resources for protection are sparse. This is an area in which I would like to encourage much more documentation and analysis to inform policy advocacy.

Thousands of Asian women are working as domestic workers or in the service industries, particularly in the Middle East and Europe, and there are daily and sometimes horrific examples of exploitation and sexual abuse, including HIV infection. Yet these workers are without consular oversight or legal protection in the countries where they are working.

To compound the problem, if they do become infected with HIV, they are deported and thus left without a livelihood. This has implications not only for their own health but for their families and communities and countries of origin who must then provide care. In some cases in the past, when the country of origin has protested at such policies, the receiving country has simply responded by suspending or restricting labour migration from that country, which can have enormous negative consequences for others seeking work.

At the same time, many countries in and outside the region require HIV testing for work permits and immigration (and sometimes even for a visit) and reject applicants based on their HIV status. So even if a person is under treatment and healthy, they will not be able to take up a job for which they are qualified. This stigmatisation and the denial of travel and employment rights are issues that have been taken up

by UNAIDs and the International Labour Organization as well as by parliamentarians seeking to change laws in countries such as India and Australia. While these are welcome developments, there remains much to do in the region both to alleviate the conditions leading to such migration and to protect the health and well-being of those who are forced to work abroad.

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1. UNHCR, WHO and UNFPA, *Field Manual on Reproductive Health for Refugees,* 1996. Now revised as *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings,* 2010. www.unfpa.org/emergencies/manual/

2. Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response,* 2004. www.sphereproject.org and IASC, *Guidelines for HIV/AIDS Interventions in Emergency Settings,* 2003.

3. http://www.maitri.org.in