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, 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, 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.

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 heated 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
HIV/AIDS, security and conflict: new realities, new responses

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Ten years after the HIV/AIDS epidemic itself was identified as a threat to international peace and security, findings from the three-year AIDS, Security and Conflict Initiative (ASCI)1 present evidence of the mutually reinforcing dynamics linking HIV/AIDS, conflict and security.

ASCI’s findings reveal that a number of earlier, more alarmist, relationships assumed to exist between national-level state security and the HIV/AIDS epidemic were not borne out. Under-examined risks in humanitarian emergencies and post-conflict transitions are highlighted, as well as threats posed by HIV/AIDS to the operational capacity of armies and across the uniformed services (such as police, prison and border authorities). ASCI’s gender analysis exposes flawed assumptions that continue to guide epidemiological and behavioural approaches to HIV/AIDS prevention and response in conflict situations and fragile states. By focusing on intermediary levels of interaction – between macro-level assumptions and micro-level behavioural and biomedical approaches – ASCI offers a new agenda for action.

Summary of findings

■ Prevailing indicators of state fragility fail to capture the impact of HIV/AIDS on local governance, human resources, service delivery and community survival.

■ HIV and AIDS can threaten the operational capability of armies primarily at the tactical level of operations. HIV/AIDS can affect combat effectiveness, unit cohesion, morale and discipline.

■ Command-centred approaches to HIV prevention – i.e. that put responsibility for HIV policy and practice within the army command rather than on medical services alone – are likely to be more effective in reducing the risk of HIV infection and sexual violence among the rank and file than relying solely upon education and training based on individual behavioural, medical or human rights approaches.

■ The risks of HIV transmission, especially in epidemics concentrated among injecting drug users and sex workers, are influenced by law enforcement practices and by the drugs trade, human trafficking and those who control sex work – pimps, ‘protectors’, traffickers and long-term clients.

Post-conflict transitions are both a period of heightened vulnerability to HIV transmission and a neglected element in HIV and AIDS policy and programming.

Greater policy attention and service continuity are needed in post-conflict situations to respond to increased population mobility, demobilisation of combatants, disruptions in humanitarian assistance to displaced persons in camp settings, and the excessive demands on health and social services in areas of return.

Disarmament, demobilisation and reintegration (DDR) programmes are an important and consistently overlooked focus for HIV and AIDS prevention and response, especially among military and extended families, and women and children associated with armed forces.

Forced sex may increase individual risk of HIV acquisition for different scenarios of coercion based on genital trauma, relative probabilities of HIV and other sexually transmitted infections, and inadequate access to health services.

Key recommendations

1. Sexual violence needs to be recognised as a physiological and social factor in HIV transmission. Consistent with UN Security Council Resolutions addressing women, sexual violence and HIV/AIDS (1308, 1325, 1820, 1882, 1888 and 1889), sexual violence and HIV