New publication from UNDP South East Asia HIV and Development Project

“Population mobility in Asia: implications for HIV/AIDS action programmes”

This publication is a compilation of eleven papers presented at the sub-track session, Migrant and Mobile Populations and HIV Vulnerability of the Fifth International Congress on AIDS in Asia and the Pacific (5th ICAAP) held in Kuala Lumpur, Malaysia from 23 to 27 October 1999.

In addition to reflecting current practice and actions from countries in Asia, this monograph covers: human rights, programme evaluation and monitoring, and recommendations for future direction to reduce HIV vulnerability among mobile populations.

It is hoped that through broad distribution of this publication the audience will be extended beyond those attending ICAAP and will, thereby, facilitate the promotion of quality action programmes and greater understanding of HIV vulnerability within mobile and migrant worker populations.

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Population Mobility in Asia: Implications For HIV/AIDS Action Programme

South East Asia HIV and Development Project

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Papers based on the "Mobile Populations and HIV Vulnerability"
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Foreword

The UNDP South East Asia HIV and Development Project (SEAHIV-UNDP), has prepared this monograph in collaboration with the Secretariat of the Fifth International Conference on AIDS in Asia and the Pacific (ICAAP). Its contents are based on manuscripts prepared and presentations made at the sub-track session, Migrant and Mobile Populations and HIV Vulnerability, conducted as a component of the Fifth Meeting of ICAAP held in Kuala Lumpur, Malaysia from 23 to 27 October 1999.

Eleven presentations that focus on HIV vulnerability in mobile populations are contained in this monograph. These provide experiences and knowledge gained during the conduct of HIV action programmes in selected countries of the Asia region. The human rights concerns among migrant worker populations are examined to identify their impact on the HIV epidemic. Monitoring and evaluation of the effectiveness of HIV/AIDS programmes are also included. The final papers were carefully selected from approximately 500 submitted abstracts and represent a broad range of experiences from a wide geographic range that includes Bangladesh; Brunei Darussalam; Hong Kong, SAR of China; India; Japan; Malaysia; Nepal; Thailand and Viet Nam. Some approaches, such as HIV screening tests of migrant workers, although not considered appropriate, are included here to reflect practices in the region.

The ICAAP occurs on a biannual basis to examine, discuss, and debate current knowledge and practices relating to HIV/AIDS in Asia and the Pacific. In previous years, considerable knowledge and wisdom was inaccessible, as a systematic method of documentation and dissemination was not undertaken. Several practitioners, researchers, and students have expressed a need for relevant knowledge to be disseminated as a reference source for future programming and research activities.

We hope that this monograph will provide a reference source on the practices, knowledge, and experiences gained. Extending the audience beyond those attending ICAAP will assist in the promotion of quality action programmes and a greater understanding of HIV vulnerability within mobile and migrant worker populations. By disseminating the findings of the ICAAP to a wider audience, the significance of mobility relating to HIV vulnerability in Asia and the Pacific region may become more effectively advocated. It is also expected that an increased understanding of HIV/AIDS programme responses for mobile populations and migrant workers will result.

The monograph is not limited to reporting past achievements but also offers a future direction by providing conclusions and recommendations to assist the United Nations system and other concerned agencies and individuals in their efforts to reduce HIV vulnerability among mobile populations.

We wish to take this opportunity to thank Professor Mary Huang, Co-ordinator of the Fifth ICAAP, for her initiative and the assistance of her team in supplying abstracts for our review and selection. We also wish to acknowledge the support of the Joint United Nations Programme on HIV/AIDS (UNAIDS) - Asia Pacific Intercountry Team (APICT) for providing the printing cost of this monograph. We also thank Colin Steensma, Canadian International Development Assistance (CIDA) intern to SEAHIV-UNDP for compiling the manuscripts.

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<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune-Deficiency Syndrome</td>
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<td>APICT</td>
<td>UNAIDS-Asia Pacific Intercountry Team</td>
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<tr>
<td>AR</td>
<td>annual adult rate</td>
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<tr>
<td>ASEAN</td>
<td>Association of South East Asian Nations</td>
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<td>ATFOA</td>
<td>ASEAN Task Force on AIDS</td>
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<tr>
<td>AusAid</td>
<td>Australian Agency for International Development</td>
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<tr>
<td>BAHAP</td>
<td>Border Area HIV/AIDS Project (Thailand, Cambodia, Laos, Viet Nam)</td>
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<tr>
<td>BMET</td>
<td>Bangladesh Manpower, Employment and Training</td>
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<tr>
<td>CARAM</td>
<td>Co-ordination of Action Research on AIDS and Mobility (Bangladesh, Cambodia, Indonesia, Malaysia, Philippines, Thailand and Viet Nam)</td>
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<tr>
<td>CARE</td>
<td>Care and Relief Everywhere</td>
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<tr>
<td>CBO (s)</td>
<td>community-based organization (s)</td>
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<tr>
<td>CCDB</td>
<td>Christian Commission for Development in Bangladesh</td>
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<tr>
<td>ELISA</td>
<td>Enzyme Linked Immuno Sorbant Assay</td>
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<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>Fomema</td>
<td>Foreign Workers Medical Examination Monitoring Agency</td>
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<tr>
<td>GTZ</td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit, German Agency for Technical Cooperation</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
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<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
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<tr>
<td>KABP (s)</td>
<td>Knowledge, Attitudes, Beliefs, Practice (s)</td>
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<tr>
<td>NGO</td>
<td>non-governmental organizations</td>
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<tr>
<td>PATH</td>
<td>Programme for Appropriate Technology in Health</td>
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<tr>
<td>PKK</td>
<td>Women’s organisation for family welfare and education, Indonesia</td>
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<td>SD</td>
<td>Standard Deviation</td>
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<td>SEAHIV- UNDP</td>
<td>UNDP South East Asia HIV and Development Project</td>
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<tr>
<td>SEAMEO</td>
<td>Southeast Asian Ministers of Education Organization</td>
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<tr>
<td>SHISUK</td>
<td>Shikkha Shasthya Unnayan Karzakram</td>
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<tr>
<td>Solidaritas</td>
<td>NGO, Indonesia</td>
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<td>Perempuan</td>
<td>NGO, Indonesia</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for Social Science</td>
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<tr>
<td>STD (s)</td>
<td>Sexually Transmitted Disease (s)</td>
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<td>STI (s)</td>
<td>Sexually Transmitted Infection (s)</td>
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<tr>
<td>Tenaganita</td>
<td>NGO, Kuala Lumpur, Malaysia</td>
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<tr>
<td>UCM</td>
<td>United Christian Mission</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNIFIL</td>
<td>United Filipinos in Hong Kong Special Administrative Region, China</td>
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<tr>
<td>USAID</td>
<td>United States of America Agency for International Development</td>
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<tr>
<td>WARBE</td>
<td>Welfare Association of Repatriated Bangladeshi Employees</td>
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<td>WHO</td>
<td>World Health Organization</td>
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I. Population Movement, Development and HIV/AIDS: Looking Towards the Future

Lee-Nah Hsu and Jacques du Guerny *

A. Introduction

For HIV to spread within a population, unprotected sex, networks with multiple partners, and the sharing of drug paraphernalia are some of the required factors. To move the virus from one population to another, human mobility is usually required. Population movement is a potentially significant factor in relation to the spread of the epidemics particularly when unprotected sex is practised in the sending and receiving areas and countries. Many studies have attempted to explain why populations move and the levels and trends of these movements. Triggers to movement may be grouped under the umbrella of development level differentials. These differentials may also increase vulnerability to HIV, particularly when difficulties occur in adopting safe sexual behaviours.

The purpose of this study is to examine how trends in development have substantially encouraged the considerable movement of populations that may be contributing to an increase in the spread of HIV. Development and its relationship to population movement is also studied to identify potential development strategies which could inadvertently facilitate the spread of HIV and may require revision to reduce HIV vulnerability. Such revisions may also provide an improved environment to change situations of risk.

B. Development, population movement and HIV vulnerability

1. Mobility and impacts

Development processes do not occur homogeneously, as they tend to be localised, create differences between geographic areas, and encourage population movement. The phenomena are complex and explanations can oversimplify the situation. Previously, populations that were isolated from others had minimal access to information and faced considerable obstacles to migration. These obstacles included a weak road and transport infrastructure, and high costs of migrating that dissuaded many potential migrants. Minimal development or remoteness to development encouraged many to remain at home.

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Jacques du Guerny, Chief, Population Programme Service, Food and Agriculture Organization of the United Nations (FAO) and FAO Focal Point on HIV/AIDS.

The opinions expressed in this paper are those of the authors and do not necessarily represent the official position of UNDP or of FAO.

1. Skeldon, R., 2000. Population Mobility and HIV Vulnerability in South East Asia: An Assessment and Analysis, UNDP, South East Asia HIV and Development Project, Bangkok, Thailand. This is a complementary paper stressing the importance of population mobility and interaction with local communities. ISBN: 974-85835-11
Population Mobility in Asia: Implications for HIV/AIDS

Despite these multiple obstacles, limited movement of individuals and populations has occurred throughout human history. Accounts of ancient Egyptian expeditions to Africa and later the Chinese and Arabic travellers in South East Asia form the backdrop to historical movements. Movements of individuals and populations have often brought change, disruption, and exchange of products and diseases.

The phenomenon that is new, is the scale of recent and projected population movement. For example, the urban population of developing countries was projected by the United Nations to increase by over 2 billion in the period 2000 to 2030, an increase that approximates to the world population of 1950. Although a major portion of this increase is due to urban fertility, many hundreds of millions of rural inhabitants are projected to settle permanently in towns and cities. Added to the rural to urban movement are the other forms of population movement: rural to rural; seasonal and circular movements and many other forms, all of which can potentially play important roles in the spread of the HIV virus.

Since the visionary announcement by McLuhan in the 1960’s of the arrival of the global village, globalisation is increasingly occurring. Few areas are now totally isolated, including rural households that seem to live by subsistence farming. They are no longer exclusively doing so and are increasingly dependent on links to urban areas for remittances and capital to purchase new inputs required for agricultural intensification. Links are established through the marketing of produce and the migration of rural youth. Push and pull factors triggered by enhanced communication further encourage movement. For example, soap operas are not just seen for their stories, but are carefully observed by rural viewers who take note of the electricity, running water, refrigerators and other modern amenities. These millions on the move, both spatially and socially, are attempting to improve the situation for themselves and their families and enjoy the results to be achieved and to avoid downward spirals. Movement in many directions with unpredictable results and changes often replaces a relatively small number of stable and traditional migration flows.

Globalisation stimulates exchanges between communities and nations at different stages of socio-economic development. Media and marketing create an awareness of the differences. Increased travel and population movement also spread messages of differences. Global markets create new employment opportunities when manufacturers establish production units close to transportation links, reliable infrastructure and consumer markets. New modes of production enable entrepreneurs to organize 24-hour production creating increased job opportunities but also new vulnerabilities for young workers. It is a changing world in which it is easy to lose one’s bearings; whatever one’s status.

Young people, particularly those from rural and low-income communities and countries that are economically disadvantaged are becoming increasingly attracted by the diverse offerings of the cities in economically booming areas. Areas and cities where shortages of skilled and unskilled labour exist or where opportunities are perceived to exist are also attractive. The contrast between their present reality in a rural area and their dreams of an accessible and a possible future paradise may often prove irresistible. It is like entering a different world, comparable to Alice stepping through the mirror to enter Wonderland. This new potential promises an opportunity to meet new people and escape from traditions perceived as enforced for the benefit of others. It also promises the opportunity to learn new things and adopt new behaviours away from the constraints of traditional social norms or cultural rules.

In the new environments of the cities, it is easy to understand that youth, in their need to escape poverty and fulfill their own and their families’ hopes and dreams, are ready to sacrifice traditions and norms when necessary to secure jobs, retain them and improve

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upon their low salaries. Fortunately, due to links within migrant communities, social networks and other forms of support, many youth do not have to repeal all norms and values. However, sufficient numbers of migrant youths remain vulnerable to HIV due to episodes of unsafe sex to contribute to HIV epidemics taking hold and spreading.

Migrants and other mobile populations such as long-distance truck drivers and seafarers, can also carry HIV to their home area or when moving to new destinations. This is not a moral concern of blaming any groups, but an observation that carriers from many spheres are needed to spread the virus. For example, in Africa the epidemic was for many years considered to be urban based which lead to an ignoring of the vulnerabilities of rural populations, returning migrants and other mobile groups such as travelling salesmen. This neglect of the rural populations led to the epidemic spreading unnoticed for a long period until countries were awakened to the high rates of infected adults in both the urban and the rural areas. Therefore interactions between development processes and changes of magnitude and direction of migration may lead to the creation of considerably more opportunities for HIV and also other infectious diseases such as tuberculosis and hepatitis to spread widely with increased rapidity.

2. Vulnerability of groups and populations and situations of risk

As development processes and population movement potentially contribute to the HIV epidemics by increasing vulnerabilities that lead to behaviour patterns with higher risks it is also possible that development policies and action programmes may be designed to promote development and concurrently reduce vulnerabilities. Vulnerability and development are to be viewed within the same context.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has published several documents related to the concept and concerns of vulnerability. A document prepared by Topouzis and du Guerny of the Food and Agriculture Organization of the United Nations (FAO) and published by UNAIDS focuses upon the impact of rural development projects on HIV vulnerability. Development, it is shown, may either increase or decrease vulnerability. It is therefore important to ensure that development activities result in a decrease in vulnerability.

Until recently, most strategies and efforts to combat AIDS have focused on the reduction of situations of risk, the immediate risk of infection. This focus has led to safer sex campaigns, promotion of condom use, improvement of negotiating skills, raising of awareness and dissemination of information. These activities are necessary, but are they sufficient? For example, the 100 per cent condom strategy promoted in Thailand that has proven to be effective, aimed at modifying the situation of commercial sex activities and reducing the vulnerability and lack of negotiation skills to reduce situations of risk. This strategy addressed the immediate situations of risk that were occurring. As the programme in Thailand demonstrated it is necessary for the commercial sex workers to have knowledge of HIV risks and how they may be reduced or eliminated and to improve their own negotiation skills. Furthermore, the support from establishment owners and managers, the police and behaviour change communication programmes are also required.

Development strategies can expand on such approaches and address vulnerability in a broader environment where situations of risk occur. These strategies aim to reduce the propensity to enter situations of risk. Harnessing development strategies that reduce risk focuses on the distant backgrounds that create vulnerabilities such as poverty, gender relationships, governance, rights, education and income distribution.

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For example, development activities to reduce un- and under-employment also reduce the need for those searching for employment to take unnecessary risks. Reducing on-the-job sexual harassment events may also have similar results. However, there is a need to be cautious as development may also increase vulnerabilities. This may occur when development does not recognize its potential effects on the more distant backgrounds of poverty, gender relations, governance, rights, education levels and income distribution. This is seen when constructing rural infrastructures such as dams, irrigation systems and roads that bring into rural areas construction workers who may be vectors of HIV transmission. It is only recently that activities are increasingly accompanied by efforts to protect the rural populations from their vulnerability to potential risks they are exposed to during the opportunity to earn money.

These examples illustrate the various forms of vulnerabilities that development programmes need to address. Mobile construction workers and their impacts on sedentary rural populations are of importance. Each development sector is required to examine its activities and their impacts on population movement and vulnerabilities that may increase or reduce risk. To date, minimal experience in development strategies for HIV vulnerability reduction has been gained. However, this appears to be a promising strategy to explore as it complements and reinforces the existing strategies focussed on the reduction of risk behaviour.

C. Development strategies to reduce HIV vulnerability as it relates to population movement

Technological and human developments are neither linear nor homogeneously spread through space and time. They occur by spurts and initially induce and widen differences between countries, cities, and urban and rural communities. The differences assume many forms: availability of basic amenities or latest technological developments, education institutions, entertainment, possibilities of employment and increased food security. The resultant differences are also reflected in the distribution of human resources in the form of labour, technical skills and the widening gaps between the haves and the have-nots.

Population mobility is a regional concern and requires regional collaboration. Uncoordinated and scattered efforts by national governments, international and local non-governmental organizations (NGOs) to provide HIV prevention programmes at border and other areas are unable to influence the entire systems under which population movements occur. To reduce development related HIV vulnerability, as it relates to population movement, the UNDP South East Asia HIV and Development Project (SEAHIV-UNDP) has initiated regional collaborative activities. Institutional partnerships have been formed to build local capacities within development activities with other United Nations agencies, governments, and local and international non-governmental organizations (NGOs). The harmonization of policies and strategies is critical for countries of the Association of South East Asian Nations (ASEAN) region to effectively prevent HIV and reduce HIV vulnerability in mobile populations and the region in general.

1. ASEAN Workshop: Population Movement and HIV Vulnerability, Chiang Rai, Thailand

Practitioners and policy makers have become increasingly aware of the crucial need to harmonise the various action programmes being conducted by national governments in parallel with the diverse interests and needs of their neighbours. Advocacy is required to increase the recognition of mobility as it relates to HIV. Responsive policies are also required to address development-linked mobility and its possible relationships to HIV epidemics in South East Asia.

SEAHIV-UNDP organized a consultative workshop on Population Movement and HIV Vulnerability that was held in Chiang Rai, Thailand, from 10 to 12 November 1999. The
A significant policy recommendation of the Chiang Rai Workshop to ATFOA, was:

ASEAN governments adopt a common policy requiring that foreign contractors, commercial developers, and investors in major construction projects fund an HIV prevention strategy in their activities as a pre-condition of approval of construction projects.

The recommendation was adopted by ATFOA and will be presented to the governments of ASEAN for consideration, acceptance and implementation. This would be the first joint regional effort in the containment of development linked HIV vulnerability.

2. UNDP/UNESCAP/UNAIDS Workshop, Reduction of HIV Vulnerability within the Land Transport Sector: Towards a Strategic Planning and Policy Framework, Bangkok, Thailand

SEAHIV-UNDP in collaboration with the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) and UNAIDS, organized a Workshop, Reduction of HIV Vulnerability within the Land Transport Sector: Towards a Strategic Planning and Policy Framework, that was held from 22 to 23 November 1999. The purpose of the Workshop was for the land transport sector to inform land transportation officials from governments, transport companies and workers' unions on how they could contribute to the prevention of the HIV/AIDS epidemic in Asia.

The Workshop proved to be instrumental in advocating to transport ministry decision-makers the importance of HIV prevention within the land transport sector inclusive of management, employees, and client users. Participating member countries increased their awareness and understanding of the potential and real links between the transport sector, population mobility and increased HIV vulnerability. A clearer understanding of the

potential effects on communities living in close proximity to transport routes was also
developed. Participants also conveyed that the land transport sector could contribute to the
reduction of HIV vulnerability along the major transport routes of South East Asia.

The Workshop participants recommended to the ESCAP Committee on Transport, Communications, Tourism, and Infrastructure Development that those ministries, agencies and parastatal organizations involved in the transport sector to take a more active role in the prevention of HIV infection. Specific actions included formulating HIV/AIDS policies for the transport sector, and developing strategic plans for implementation of HIV/AIDS programmes in the transport sector. The UNESCAP Committee has accepted the recommendations.

The acceptance of the recommended policy is expected to have wide ranging implications for mobility and HIV vulnerability throughout Asia and the Pacific regions. Consequent to acceptance of the recommendation by Member States, each Member would be expected to develop relevant policies and strategic plans. When each land route and the adjacent communities of South East Asia are extensively covered by HIV preventive education and vulnerability reduction programmes the potential to avert the occurrence of numerous HIV infections becomes clearly apparent. In addition, the health of the populations living along the routes will be improved for the benefit of economic and social development.

3. UNAIDS-APICT Regional Taskforce on mobility and HIV vulnerability

In 1999, recognizing the critical link between mobility and HIV vulnerability in the ASEAN region, the United Nations strengthened its effort in the area of mobility and HIV vulnerability. Firstly, the SEAHIV-UNDP was established in Bangkok, Thailand. The participating ASEAN Member States requested SEAHIV-UNDP to focus on mobility and HIV vulnerability. In addition, the UNAIDS-Asia Pacific Intercountry Team (APICT) established a regional advisor for mobility in late 1999. Previously, the United Nations Children's Fund (UNICEF) Regional Office for East Asia devoted efforts to study the situations of risk being faced by fishermen in Cambodia, Myanmar, Thailand, and Viet Nam. International NGOs have implemented activities for migrant workers crossing borders. However, previous efforts have been fragmented and generally they focus only on the needs of individual countries. SEAHIV-UNDP will provide the required co-ordinated regional response at programme and policy levels to HIV vulnerability in South East Asia.

In 2000, SEAHIV-UNDP was appointed by UNAIDS-APICT to convene a regional taskforce on mobility and HIV vulnerability. The taskforce will comprise members of the international NGO communities, government national AIDS programme policy makers, United Nations agencies and academics of the region who devote efforts to reduce HIV vulnerability among mobile populations.

The taskforce will serve as a technical advisory body for the United Nations system in South East Asia. Associated to the taskforce are academic researchers, government AIDS authorities, and NGOs who will jointly undertake the subsequent action programmes.

Among the many initiatives will be an effort to harmonize the pre-departure, post-arrival and returnee reintegration policies while integrating HIV vulnerability reduction measures

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as feasible and practicable among the countries. It is noted that this is the first co-operative regional action to eliminate duplication of effort, and enhance information and knowledge exchange. As a corollary, it is hoped that a system for early identification of vulnerable points for rapid and responsive remedial action will occur.

D. Conclusions

- Development is not neutral in respect to HIV epidemics. It is essential to integrate HIV prevention strategies and programmes within development activities to achieve the maximum benefit from investment and reduce potential costs. Modification of the background factors that affect situations of risk may create both positive and negative impacts on the spread of epidemics. It is critical that development practitioners consider the development process and the impact on HIV epidemics at the planning stage of economic and social development programmes.

- A joint effort by the United Nations system to coordinate the concerns of countries in the South East Asia region can contribute to the collaborative national and regional activities. This effort will address HIV vulnerability as it relates to development generated mobility that is beyond the boundaries of individual countries which require concerted regional responses to contain the spreading HIV pandemic in the ASEAN region.

- Activities are emerging that react to problems encountered and as responses to opportunities. Concurrent with an increase in experience and knowledge, understanding will improve and future activities are expected to evolve from fragmented and uncoordinated approaches to systematically and well-organized responses.

- By the facilitation of the United Nations it is hoped that nations and organizations will be able to respond to common concerns and harmonize the necessary HIV policies and programmes to reduce HIV vulnerability related to mobility. Concurrently investment for socio-economic development will be maximised as well as public health benefited and the threat to their security and survival reduced. These efforts would benefit from the good governance of the ASEAN countries.8

- International and national efforts are at their early stage in this field. Additional effort is necessary at the policy and operational levels to harmonise and promote effective responses and actions. New approaches, careful monitoring, and evaluation are necessary to develop a sound corpus of knowledge for the development of and support to effective programmes.

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II. Proposed Action Programmes for the Prevention of Sexually-Transmitted Infections and AIDS Among Mobile Populations

Promboon Panitchpakdi *

A. Introduction

The relationships between population migration and situations of risk that lead to HIV/AIDS infections are well-documented. High infection rates in northern Thailand are partly attributed to internal migration. Reported cases of HIV/AIDS events in Lao People’s Democratic Republic were attributed to nationals, who had been resident in Thailand, where they may have been exposed to situations of risk prior to their returning home. In migrant and mobile populations it is suggested that an effective method of reducing AIDS transmission is by actions undertaken at the work site or prior to their travel.

This suggestion introduces several questions:

- Who will be responsible for the development of action programmes for these populations?
- How can an effective programme be developed?
- Why is it important?

The primary questions are, however, why is it important, and why should action programmes be developed?

A review of data collected during the conduct of field programmes and subsequently shared and discussed within a series of meetings held during 1999, introduces elements that respond to the questions raised. Subsequent discussions are expected to address the need for effective planning and the programming of actions for AIDS prevention among mobile and host populations.

Experiences of South-East Asia have been gained from several projects and include:

- Migration and AIDS Vulnerability, Thailand. (This project worked with migrant workers from Myanmar)
- Border Area HIV/AIDS Project (BAHAP). (This project focussed on cross-border sites)
- Co-ordination of Action Research on AIDS and Mobility (CARAM) Asia.

* Country Director, CARE International, Thailand.
B. Experiences gained

Most, if not all, countries in Asia have AIDS/STI prevention programmes in place. However, these programmes are directed towards the general population and are often unable to reach mobile populations, due to:

- Language constraints.
- Cultural variations.
- Inability to identify the constituents of the mobile population.

An incorrect assumption in identifying responsible agencies is that the Ministry of Health in each country currently includes mobile populations within national programmes.

It is suggested that countries in Asia work in partnership through inter-governmental organizations to develop minimum standards of prevention and care, regardless of the legal status of the migrant worker in accordance with the norms of human rights.

Non-governmental organizations offer several advantages for working with mobile populations as they are flexible and are participatory in nature. Direct consultation and involvement of the mobile populations during planning and implementation of programmes offers several distinct advantages to achieve success.

C. Objectives

The programme objective for the target populations is the prevention of HIV infections and support to persons living with HIV/AIDS both in the host and the mobile populations. They should not segregate or isolate one population from the other but promote a healthy situation within all populations. Such a perspective is required to effectively plan action programmes that recognize cross-cultural differences and the sensitivities of all population groups.

D. Action research approach

As few situations of risk among mobile populations are clearly understood, it is suggested that an action research approach is appropriate. This is to include a combination of ongoing qualitative and quantitative data collection and to be participatory in nature.

Goals of this research include:

- Increased understanding of the needs of the target groups.
- Increased acceptance of proposed actions.
- Development of appropriate and suitable programmes.
- Testing of actions in a collaborative environment.

Rapid assessments have been used to identify project entry points, geographic locations and target groups to develop action programmes.³

"CARAM learnt the importance of building trust with our target groups, especially when discussing sensitive issues of sexuality and sexual practice. With garment workers, for instance, trust was important both in gaining access to garment workers, as well as building intimacy between them and our researchers, so that they felt confident in providing information."

CARAM – CARE Cambodia.

E. Behaviours, backgrounds, and new environments

Generally, STIs/AIDS prevention programmes focus on personal behaviour patterns. Although the importance of changing the behaviour of individuals is recognized, the behaviour pattern of the migrant worker is influenced by social factors that are referred to as the social context. Such factors include fear, anxiety, excitement, loneliness, helplessness, and the lack of confidence. Full understanding of this social context is imperative as it defines behaviour. A clearer understanding of each individual's social context can assist in determining suitable and appropriate strategies to promote positive behaviour changes to reduce situations of risk.

1. Inter-related target groups

A programme should address identified target populations as well as the related populations that may be involved or exposed to situations of risk.

One particular case is cited as an example of this approach.

Fishermen at Samutprakarn province composed the main target group. It was realized, at an early stage, that the project could not exclude a large group of migrant workers in the seafood-processing sector. This second group possessed different characteristics from the first. Male to female composition was different with a larger number of females in the latter group.

Another related population group was composed of Thai nationals working in Samutprakarn and included commercial sex workers at brothels, waitresses, and truck drivers.

2. Host populations are also targets for prevention programmes

The focus of effective AIDS prevention programmes should be inclusive of both the mobile and the host populations who may equally share situations of risk. In some instances, a host population may also be mobile in nature, such as those within military camps at border areas that are temporary residents.

3. Gatekeepers

Gatekeepers are defined as persons or organizations that can facilitate or hinder a project from reaching a target population. Such groups include employers, owners of commercial sex establishments, entertainment locations, immigration police, and local government officials. In some cases the gatekeepers may also form a target group. Programme activities to gain the full participation of gatekeepers are imperative. An example of this approach is seen in the BAHAP project where the Association of Fishing Boat Owners in Trad Province is a target for training as they are key persons who permit actions to reach the fishing boat workers.

F. Programmes

1. Source-based

Such programmes are targeted towards mobile populations before travelling away from hometowns and villages. Preparation programmes have not been generally implemented due to limited knowledge of the mobile population or lack of cooperation between the source and destination programmes. In many cases, however, the mobile populations may be

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2. CARE Raks Thai Foundation Programme in Samutprakarn, supported by AusAid.
3. CARE International in Thailand, Cambodia, Laos, and Viet Nam implements BAHAP. Funded by USAID through Family Health International.
traced as originating from the same regions or villages within one country or from within another country. In this case it is possible to prepare source-based programmes for potential migrant populations. This is based on the assumption that those who are planning to travel will be interested in learning details of the new location, and particularly of any potential risks that may be present.

The AIDSNet Study in Thailand showed that fishermen were from north-eastern Thailand, a landlocked region, with a large number originating from the same village. This creates an opportunity to conduct action programmes at the source of origin.

CARE, in their study, found that many migrant workers from Myanmar living in the same compounds came from the same area in Myanmar. Various sites in Thailand, contained migrant workers from different sources.

2. Pre-departure

These programmes are aimed at mobile populations at exit points of a country before they depart for another. However, both advantages and disadvantages exist due to the constraints at border-crossings and airports. Also, travelers are usually fully occupied with many other anxieties and are unlikely to benefit from an AIDS prevention session. Advice on preparing for living at a new location or referring the traveler to an existing programme at the new location may be effective.

3. Destination

Programmes that address vulnerable mobile populations at the destination are required, as this is where situations of risk are most likely to occur. Due to the varying situation within each mobile population many barriers exist in reaching the target population.

4. Peer outreach

Peer education is often effective in reaching a target group. However, mobile populations present particular constraints such as the high turnover in their composition creating certain constraints to the establishment of peer outreach programmes. Within some groups work fully occupies their time and participation in a peer outreach programme is not possible.

5. Clinic-based

Clinic-based programmes are often identified as a need of the mobile population. This is particularly apparent when a mobile population does not have immediate access to regular health services due to lack of documentation and language difficulties. Clinic-based programmes may also include common health and reproductive needs in addition to STI/HIV/AIDS action programmes.

Often the establishment of a clinic is difficult, as it is not an attractive proposition for the private sector. In addition, governments are often uninterested or lack policies to serve migrant populations. Sustainability potential is therefore questionable.

World Vision (Thailand) developed a health clinic in collaboration with the Ministry of Public Health in the province of Ranong in southern Thailand. This clinic was established to provide services to a large population of migrant workers from Myanmar with the anticipation that it will be self-sustaining.

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The CARE Raks Thai Foundation project at Mahachai, Samutsakorn developed a reproductive health clinic to serve a population of 5,000 to 10,000 migrant workers from Myanmar. However, since its commencement the project has experienced difficulties with recruiting a part-time doctor.

6. **Inter-country**

Inter-country programmes are possibly the most effective way of addressing migrant populations. Collaboratively such programmes may address the target population at source, and at pre-departure and arrival. Constraints to their implementation include government reticence to recognize large populations of undocumented migrant workers.

Although, in some cases, the migrant population may be documented, for example, Thai workers in Taiwan, and domestic workers from the Philippines few inter-country programmes exist.

7. **Timing**

Timing of actions is an important consideration as mobile populations may only have limited time to participate in education sessions. In other situations, optimal times should be identified for successful programme implementation.

Optimal time selection may be difficult as in the case of migrant workers from Myanmar working in Mahachai who work 7 days a week in shifts that begin at 3 a.m., and end in the early afternoon.

BAHAP reports that the time of the full moon may be suitable for Cambodian fishermen. At this time fishing boats stay in port and fishermen celebrate by visiting drinking establishments and brothels.

8. **Mobility**

On occasion, mobile populations are only temporarily stationed at a given location. This occurs with construction workers, seafarers, and commercial sex workers. Unskilled migrant workers may also be seeking new opportunities and rapidly move from place to place. Actions should recognise that only short periods of time may be available for programme implementation at one particular location.

9. **Information, education, and communication**

Printed and audio-visual materials may not always be appropriate due to levels of literacy and lack of required equipment and time. Well-planned and designed information, education, and communication (IEC) material may be effective tools. Of the best practices in IEC material development: target audience research, pre-testing, and evaluation, the key components are action research and participation by the target group.

10. **Target audience research**

BAHAP, Thailand reported that staff of an AIDS prevention project prepared material for a target group of Cambodian fishermen. The material, prepared in Thai, included photographs of Thai movie stars that were expected to be recognized as Thai movies and videos are available in most countries of the Mekong region. Audience response proved that these inclusions were inappropriate as the fishermen were uninterested in Thai movie stars and would prefer Cambodian personalities and fishermen such as themselves. The project eventually incorporated the suggestions of the target group into the programme material.
G. Legal status of migrant workers

A major impediment is that many people within a mobile population are not documented. This results in a lack of political will and legal support and efforts to reach the migrants are severely constrained.

It is noted that the economic crisis in Asia severely and negatively impacted migrant workers with several countries attempting to deport large numbers of migrant workers to create jobs for their own nationals. In Thailand, migrant workers went into temporary hiding to escape police attention.

It was noted by CARE, Thailand that although the government hospital in Samutsakorn was willing to treat migrant workers on humanitarian basis, the workers refrained from using the services due to fear of being apprehended by the police. Their limited knowledge of the Thai language easily brings them to the attention of such authorities.

H. Stereotyping

Over-simplified programmes tend to use stereotype groupings to represent the target mobile population. Often this is incorrect. Stereotyping may lead to an immediate failure by creating a rejection by the target group due to in-built prejudices. Actions implemented within a general host population are seldom effective in mobile populations.

BAHAP reported that in Klong Yai, Thailand and in Koh Kong, Cambodia it was assumed that information written in the Thai language would be readable by the Cambodian population. During a participatory educational materials development session it was learned that the target group of Cambodian fishermen did not fully understand the material written in Thai. Focus groups identified the need for the material to be available in Khmer and to use local photographs and depictions.

I. Participatory approaches to action plan development

Preparation of programmes by external personnel often fail due to a lack of understanding of the needs of mobile populations to subsequently influence their attitudes and behaviour patterns. This indicates that members of the target group and the local action groups should fully participate in the planning, implementation, and evaluation of action plans. Such participation is expected to create suitable programmes and to develop trust that is crucial to achieve success.

J. Related concerns

A focus on STIs/AIDS in isolation is not always appropriate. The varying nature and composition of the target population often requires that parallel and related concerns are included. Additional concerns may also offer the opportunity to develop new partnerships of value to the project and also create additional benefits to the migrant workers. For example, reproductive health may be included when the target population is composed of both males and females. Also drug use related aspects might be included.

“\text{We have learnt that we cannot look at HIV/AIDS and mobility in isolation. There are so many other issues (labour rights, poverty, general health) that we should address with the target groups. Limiting ourselves to HIV/AIDS alone falls very short of addressing the needs.” CARAM – CARE Cambodia.}
K. **Advocacy and human rights**

Advocacy is a key aspect of action within mobile populations as they are often neglected and victims of discrimination. Advocacy is required and directed towards both governments and the general public.

Some aspects of advocacy include:

- Access to health information and medical treatment
- Voluntary HIV/STI testing and confidentiality of results
- Protection of basic human rights of migrant workers

Close interaction with all forms of media is important to eliminate the stereotyping of migrant workers with negative images.

Structural changes in industry and government procedures may also be required to reduce vulnerability.

L. **Impact measurement**

Measuring the change in behaviour patterns within a migrant population group is difficult due to various factors. These include language and cultural differences, fear created by unknown persons asking questions, and mobility. It is therefore necessary to develop new methods of programme monitoring and impact assessment. Such methods may involve the use of qualitative techniques and proxy indicators such as STI rates, and the number of condoms distributed or sold.

M. **Partners and networks**

Networks among organizations working with migrant workers to promote health and AIDS prevention within countries and the region require strengthening for effective AIDS prevention. Regional networks enable the sharing of experiences and knowledge gained from working with the same populations on both sides of a border. To be effective, cultural sensitivities need to be built into these networks.

The Border Area HIV/AIDS Prevention Project (BAHAP) attempts to reach host and mobile populations at border sites. The “twin city approach” is used where actions are developed in two connecting cities divided by a national border.

N. **CONCLUSIONS**

- Mobile populations pose a challenge to AIDS prevention programmes in view of their complex and diverse nature, cultural backgrounds, and behaviours.
- Programme planners to eliminate pre-assumptions that relate to the needs of the population by undertaking participatory action research.
- Action research assists in improving understanding of the needs of the target population and interaction with the new host environment.
- Subsequent actions to recognise the specificity of all situations. Concurrently, actions are expected to include host populations in AIDS prevention activities.
- Emphasis is also required on the host’s role as a gatekeeper to facilitate effective access and programme implementation for mobile populations.
III. Migrant Workers and HIV/AIDS: Prevalence, Barriers and the Service Model in an HIV-Epicentre, Northern Thailand

Manit Koedkan, Sawarin Sinsomboonthong, Somsak Supawitkul, and Bongkot Supawitkul *
Megan Janssen and Somthong Srisudthiwong **

The HIV epidemic in the Province of Chiang Rai, Thailand during the period 1988 to 1998 was the most serious that had been experienced in the country. Due to the shared borders with the Lao People’s Democratic Republic and Myanmar and proximity to Southern China, a large number of migrant workers entered the country to service the commercial sex and other industries. The study provides details of the prevailing situation, constraints, and a service model for HIV/AIDS prevention and care in this particular population.

Data collected by focus groups during in-depth interviews and outreach service projects during the period 1996 to 1998 were analysed.

The migrant worker population of the area was estimated at 20,000. The annual adult rate (AR) for HIV prevalence in the 15 to 49 age group applying for temporary work permits from 1996 to 1997 was 4.01 per cent and 3.67 per cent respectively. Voluntary testing of migrants participating in the outreach program yielded an AR for 1998, of 4.17 per cent. Of the 744 migrants who participated in this programme, 25.3 per cent worked in the labour sector, 19.0 per cent in the construction industry, and 7.5 per cent as commercial sex workers. The majority (77.7 per cent) earned an adequate income. The coverage rate of HIV/AIDS knowledge was 46.2 per cent with television reported as the main source of knowledge. Health service accessibility rate was 46.5 per cent. HIV blood testing rate was 11.6 per cent. Drug substance abuse behaviour was seven per cent. The health service model for migrant workers in the province included hospital-based and outreach programmes. Steps in the implementation process included workplace-based preparation, volunteer training, counselling and care services, and a referral system. One year of monthly services increased the knowledge level of HIV/AIDS to 78.2 per cent, provided care to fifteen HIV infected and AIDS patients, two of whom died within a supportive community.

Migrant workers are considered to be an extremely vulnerable population for HIV/AIDS. Constraints to HIV/AIDS control among this population include language abilities, cultural variations, levels of AIDS knowledge and access to health services. A high prevalence of HIV/AIDS suggests a strong need for intensive action programmes to control the HIV/AIDS occurrences in this population.

* Chiang Rai Provincial Health Office.
** Norwegian Church Aid.
### A. Introduction

Mobile populations are at an increased risk of HIV infection. The potential for contracting and spreading HIV among them results in loneliness, and separation from the family and community. Migrant workers who leave their homes and families for employment increase their vulnerability to HIV due to language constraints, limited entertainment opportunities, and easy access to alcohol, drug substances, and commercial sex workers. Their limited access to health services, both preventive and curative, may threaten the effectiveness of existing AIDS programmes. The spread of HIV in these populations has also burdened host countries and has the potential to amplify the epidemic in their home communities on their return.

Chiang Rai is situated in the most northern province of Thailand. It has an area of 11,678 square kilometres and a population of 1.178 million. In excess of ten ethnic communities reside in the border and mountain areas and form 12.9 per cent of the local population. This province is a centre for tourism and a gateway to countries of the Mekong sub-region. The AIDS epidemic arrived in the province relatively late in the pandemic. After the first case was reported in mid-1988, the spread has been rapid.

Chiang Rai and the other northern provinces have been severely affected and have the highest infection rates in Asia. Although the reported annual occurrences of AIDS appeared to peak in 1996, and sentinel serosurveillance in risk populations revealed a stabilizing or decreasing HIV prevalence trend, the epidemic still continues. Cumulative AIDS cases and its related deaths as at December 1998, were 9,222 and 3,276 respectively. These formed 8.88 per cent and 11.4 per cent of the national totals and 1.9 per cent of the total population. Heterosexual transmission was the major mode of transmission. The provincial response to the epidemic was directed towards control of the rate of increase.

The Lao People’s Democratic Republic and Myanmar share the border with Chiang Rai province. Distance from the Thai and Myanmar border to southern China is approximately 200 kilometres. Over the previous ten years the cross-border movement of migrant workers seeking employment has considerably increased. As a result of the economic variations among the adjacent countries of China, the Lao People’s Democratic Republic, and Myanmar, national and provincial policies have focussed on the expansion of the tourism industry and inter-country cooperation. A developing transport infrastructure and the wishes of local relatives has resulted in two forms of migration, the “pull-in and -out” factors. During the period 1996 to 1998, the number of migrant workers in the province was estimated at 20,000. Available data and information relating to AIDS programmes focussed towards this population is minimal. This current study explores potentials and suggests a model for AIDS prevention and care programmes for implementation within this population.

### B. Methodology

Since 1996, the government of Thailand has required the registration of illegal migrant workers wishing to undertake temporary work after being screened for tuberculosis, syphilis, filariasis, psychosis and drug abuse. Sera that remained from the testing of the 15 to 49 age group were randomly and anonymously tested for HIV infection by the enzyme linked immuno-assay method (ELISA). Subsequently, the positive sera were confirmed with the gel particle agglutination method (GPA). In 1998, the hospital outreach service and workplace programmes were implemented in four of the 18 districts. Activities included health and AIDS education, health volunteer training, AIDS counselling, physical medical

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check-ups, and enhancing the capabilities of hospital and workplace referral systems. Data relevant to demographics, socio-economics, health and HIV/AIDS, were collected by focus group discussions and in-depth personal interviews. HIV testing was offered to all and pre- and post-test counselling provided on a voluntary and confidential basis. An adult rate (AR) of HIV prevalence was calculated for those testing positive in the 15 to 49 age group.

C. Results

1. Migration patterns

Most migrant workers included in the programme were from Myanmar, 710 of 744 (95.4 per cent). Migrants from China, the Lao People’s Democratic Republic, and other ethnic minorities totalled 15. Refer to Figure 1. Migration was generally by illegal means through the many unofficial border crossing points. Those from the Lao People’s Democratic Republic preferred to work in central and southern Thailand, or at the border areas. Migrants from China often used Thailand as a transition country.

2. Demographic characteristics

Adults in the 15 to 49 age group totalled 729 (98 per cent) of the studied population. Those in the 50 years and older group, and those below 15 totalled 10 (1.3 per cent), and 5 (0.7 per cent) respectively. The ratio of male workers to female workers was 2.49 to 1 (531 to 213). The marital status and educational levels of the population are shown in Table 1.

| Table 1. Demographic characteristics of migrant workers, Chiang Rai, Thailand, 1999 |
|---------------------------------|--------|--------|--------|--------|
| Characteristics                | Male   | Female | Total  | %      |
| Age distribution               | Total  | %      | Total  | %      | Total  | %      |
| > 50                           | 7      | 1.3    | 3      | 1.4    | 10     | 1.3    |
| 45 – 49                        | 11     | 2.1    | 2      | 0.9    | 13     | 1.7    |
| 40 – 44                        | 11     | 2.1    | 9      | 4.2    | 20     | 2.7    |
| 35 – 39                        | 37     | 7.0    | 17     | 8.0    | 54     | 7.3    |
| 30 – 34                        | 70     | 13.2   | 18     | 8.5    | 88     | 11.8   |
| 25 – 29                        | 121    | 22.8   | 33     | 15.5   | 154    | 20.7   |
| 20 – 24                        | 173    | 32.6   | 62     | 29.1   | 235    | 31.5   |
| 15 – 19                        | 100    | 18.8   | 65     | 30.5   | 166    | 22.3   |
| < 15                           | 1      | 0.1    | 4      | 1.9    | 5      | 0.7    |
| Total                          | 531    | 100.0  | 213    | 100.0  | 744    | 100.0  |

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Figure 1. Countries of origin of migrant workers in Chiang Rai, Thailand, 1999

- Myanmar
- China
- Lao PDR
- Bangkok
- Thailand

- Various: 2%
- Myanmar: 2%
- Lao People’s Democratic Republic: 96%
3. Employment and income

Most migrant workers are unskilled labour: 25.3 per cent in the labour sector, 19 per cent in the construction industry, and 7.5 per cent in the commercial sex industry (26.3 per cent of female migrant workers). Approximately 77.7 per cent earned adequate pay. Approximately 18.5 per cent were able to have savings from their income. Only 26.6 per cent were adequately housed. Refer to Figures 2a, 2b, and 2c.

Figure 2a. Occupations of migrant workers, Chiang Rai, Thailand, 1999
(in percentages)

Figure 2b. Income levels of migrant workers, Chiang Rai, Thailand, 1999
(in percentages)

Figure 2c. Housing of migrant workers, Chiang Rai, Thailand, 1999
(in percentages)

4. Health

Access to health services was reported by 46.5 per cent. Health care treatment was primarily through employers, 31.1 per cent; government services 31 per cent; self-treatment 20.2 per cent, and the private sector 17.6 per cent. See Figures 3a and 3b.
5. HIV/AIDS relationships

Only 46.2 per cent of the migrant workers had previously received knowledge relating to HIV/AIDS, Figure 4a. The main source of knowledge was reported by 30.5 per cent as being received through television broadcasting. To determine HIV/AIDS situations of risk 69.9 per cent reported that they had not participated in unsafe sex and 84.5 per cent had not injected drugs. Blood testing for HIV/AIDS was reported by 12 per cent. See Figures 4b and 4c.
6. Health service model

To formulate a health service model, a needs assessment was completed. Economic needs were reported by 28.8 per cent as being the most important, with housing needs and amendments to various laws at 0.8 per cent, and health at 0.3 per cent. Most, 69.3 per cent, did not provide a response. Of the volunteer health activities, 66.9 per cent were directed towards health education, 34.9 per cent to the distribution of AIDS information, and 17.5 per cent to AIDS counselling. Data relating to rates of communicable disease occurrences indicated that the rate for HIV was at 4.2, and syphilis at 0.8. The health service model was implemented in four of the eighteen districts. See Figures 5a, 5b, and 5c.
Population Mobility in Asia: Implications for HIV/AIDS

Figure 5a. Health service model with activities, Chiang Rai, Thailand, 1999

![Health service model for migrant workers](image)

- **Employers**
  - Partnership
- **Steps**
  - Participative planning
  - Volunteer training
  - Service provision
  - Referral system in place
- **Interventions**
  - Workplace based
  - Outreach service
  - Referral system

Figure 5b. Health service needs assessment
Chiang Rai, Thailand, 1999
(in percentages)

![Health service needs assessment chart](image)

Figure 5c. Health volunteer duties, Chiang Rai, Thailand, 1999
(in percentages)

![Health volunteer duties chart](image)
7. HIV prevalence

Data from the period 1996 to 1998, showed that the adult rate (AR) of HIV prevalence for 1998 was the highest at 4.17 per cent, with slightly lower rates in 1996, at 4.01 per cent, and 3.67 per cent in 1997. According to estimates by the World Health Organization (WHO) the AR of HIV prevalence for Thai citizens has slowly declined from 2.34 per cent in 1996, to 2.23 per cent in 1997 and 2.14 per cent in 1998. In Myanmar the HIV prevalence rate has steadily increased since 1996, from 1.6 per cent, to 1.79 per cent in 1997, and 1.87 per cent in 1998. Refer to Figure 6.

![Figure 6. HIV prevalence rate by nationality](image)

Chiang Rai, Thailand, 1999
(in percentages)

D. Conclusions

- The HIV/AIDS epidemic does not recognize borders.
- Mobile populations lacking knowledge of HIV/AIDS are at a high risk of infection. Data contained in this study confirmed this situation and noted the problems being faced on a day-to-day basis, and the risks and constraints to AIDS prevention and care among the migrant population. Working as unskilled labour, unable to save for the future, and living in unsuitable housing are major constraints to the reduction of HIV/AIDS in the migrant worker population.
- Being single increases the incidence of alcohol, drug use and patronage of commercial sex workers.
- Illiteracy and minimal levels of education, minimal AIDS knowledge, and restricted access to health care services are additional constraints to HIV/AIDS prevention.
Approximately one-quarter of the female migrant workers were employed in the commercial sex industry and are the most vulnerable group to HIV infection. A study of HIV incidence among female sex workers in the province reported the highest rates of incidence of all populations.

Education, counselling, blood testing and inclusion of the experiences gained in AIDS patient care are intrinsic components of action programmes.

The role of employers in the provision of health care and knowledge featured prominently in the study. Without this support, outreach programmes in the workplace would not have been possible.

Language and cultural variations restrict the building of relationships between migrants and AIDS workers.

Prior to the inception of outreach services, the inter-related and controlling influences identified by this study require careful consideration and incorporation.

To achieve increased understanding and cooperation the participation of the migrant worker population is crucial.

The proposed model places emphasis on participation in planning, training of volunteers to maintain services in the workplace, and establishment of a referral system or link between hospitals and workplaces as core actions.

Supawitkul reported HIV prevalence in the migrant worker population in 1997. This current study reports that the spread of HIV infection in this population persists. In 1998, a small, restricted sample population was assessed for situations of risk in unprotected sex and drug use. This assessment showed a relatively high rate of infection.

Earlier, high HIV prevalence countries often ignored the spread of HIV by those from low prevalence countries. Recently, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported that the AR in many countries was underestimated. Migrant workers could bring HIV to their homes and country of origin.

The vicious cycle of HIV/AIDS transmission continues.

Action programmes for intensive and effective AIDS prevention and control are essential for migrant workers.

Cooperation among neighbouring countries to prepare potential migrants may assist in alleviating the epidemic.

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E. References


IV. Sexually-Transmitted Infections and Risk Exposure Among HIV Positive Migrant Workers in Brunei Darussalam

S. K. Parida *

A. Introduction

Brunei Darussalam has a large migrant worker population. In a 1997 report of the Economic Planning and Development Unit, Ministry of Finance, non-nationals formed approximately 25 per cent of the population of approximately three hundred thousand. Migrant workers are mainly unskilled and semi-skilled and originate from countries in Asia. Generally they are employed in the private sector. The distribution of the migrant worker population in the country is shown in Figure 1.

In July 1993, a screening programme was commenced to determine the prevalence of HIV among foreign workers. The programme was undertaken to determine the necessary steps to be taken to reduce and prevent the spread of HIV infection in the community. One additional aim was to provide counselling services to those detected as HIV positive.

Migrant workers pay considerable sums to recruiting agents prior to migrating. This sum ranges between US$ 1000 to US$ 2000. The results of the screening programme are expected to permit the Ministry of Health to direct attention to the various matters identified during meetings with neighbouring countries and other regional health meetings. In addition, the results are expected to assist other countries in the region in organizing effective HIV control and prevention programmes. At the same time, the psychological stress and strain on migrant workers will be reduced when they are informed of their HIV status.

B. Methodology

The screening programme commenced in July 1993. All migrant workers on arrival, at six months after arrival, and at departure are tested for the presence of the HIV infection. The six-month test is undertaken to identify cases of infection that were not detected on arrival due to the incubation period. During the period from July 1993 to December 1999, a total of 393,132 sera of migrant workers were tested. The Enzyme Linked Immuno Sorbant Assay (ELISA) and HIV agglutination tests were used to detect the HIV antibody. For those who tested positive, a second ELISA test and HIV agglutination test was undertaken to confirm the diagnosis. All positive cases were counselled and were asked questions relating to their past history of STIs, habits of condom use and mode of transmission by use of a questionnaire.

* Epidemiologist, Ministry of Health, Brunei Darussalam.
Figure 1. Distribution of migrant workers in Brunei Darussalam, 1999
In April 1997, the screening programme was computerised. Earlier, it was not possible to calculate the age and sex distribution of migrant workers from the manual register. The distribution of migrant workers according to nationality for 1996 and 1997 was calculated from the manual register with 1998 data extracted from computer records.

C. Results

The distribution of migrant workers, according to nationality, for the period 1996 to 1998 is shown in Table 1. Total migrant workers in 1997 and 1998 were lower than for 1996. This was due to the cancellation of numerous developmental projects during 1997. The five countries of India, Indonesia, Malaysia, the Philippines, and Thailand provided approximately 95 per cent of the migrant workers in 1996, 1997, and 1998. They contributed 70,546 (94.1%), in 1996, 41,044 (95.4%) in 1997 and 37,134 (95.9%) in 1998.

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<td>9,541</td>
</tr>
<tr>
<td>Total</td>
<td>74910</td>
<td>43010</td>
<td>38694</td>
</tr>
</tbody>
</table>

The distribution of migrant workers, according to sex and country of origin in 1998, is shown in Table 2. The three countries of Indonesia, Malaysia, and the Philippines contributed 11,060 (92.7%) female workers.

<table>
<thead>
<tr>
<th>Country of nationality</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>977</td>
<td>17</td>
<td>994</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>998.3</td>
<td>17</td>
<td>994</td>
</tr>
<tr>
<td>China</td>
<td>118</td>
<td>2</td>
<td>120</td>
</tr>
<tr>
<td>India</td>
<td>3030</td>
<td>77</td>
<td>3107</td>
</tr>
<tr>
<td>Indonesia</td>
<td>3770</td>
<td>6355</td>
<td>10,125</td>
</tr>
<tr>
<td>Japan</td>
<td>16</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Malaysia</td>
<td>6134</td>
<td>1412</td>
<td>7,546</td>
</tr>
<tr>
<td>Myanmar</td>
<td>54</td>
<td>3</td>
<td>57</td>
</tr>
<tr>
<td>Pakistan</td>
<td>67</td>
<td>2</td>
<td>69</td>
</tr>
<tr>
<td>Philippines</td>
<td>3522</td>
<td>3293</td>
<td>6,815</td>
</tr>
<tr>
<td>Singapore</td>
<td>127</td>
<td>40</td>
<td>167</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>103</td>
<td>31</td>
<td>134</td>
</tr>
<tr>
<td>Thailand</td>
<td>8854</td>
<td>687</td>
<td>9,541</td>
</tr>
<tr>
<td>Total</td>
<td>26772</td>
<td>11922</td>
<td>38,694</td>
</tr>
</tbody>
</table>

Table 1. Migrant workers by nationality, Brunei Darussalam
1996 to 1998

Table 2. Migrant workers by sex and nationality
Brunei Darussalam, 1998
From 1993 to December 1998, 465 migrant workers tested as HIV positive. Distribution of HIV positive migrant workers according to nationality and year of detection is shown in Table 3.

### Table 3. Cases of HIV infection in migrant workers by nationality and year of detection, Brunei Darussalam, 1993 to 1998

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>1</td>
<td>5</td>
<td>14</td>
<td>12</td>
<td>12</td>
<td>3</td>
<td>47</td>
</tr>
<tr>
<td>Indonesia</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Japan</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Malaysia</td>
<td>0</td>
<td>9</td>
<td>3</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>27</td>
</tr>
<tr>
<td>Myanmar</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Nepal</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Philippines</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Thailand</td>
<td>67</td>
<td>134</td>
<td>60</td>
<td>55</td>
<td>55</td>
<td>24</td>
<td>365</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>153</td>
<td>78</td>
<td>72</td>
<td>57</td>
<td>33</td>
<td>465</td>
</tr>
</tbody>
</table>

The HIV prevalence rate among migrant workers, according to nationality, for the years 1996 to 1998 is shown in Table 4. The prevalence rate for the period 1993 to 1995 was not calculated as the foreign workers screening programme only started in July 1993. Testing of migrant workers already in the country at that time was not completed until 1994. Also, results of the screening programme were not computerised until 1998. Although HIV prevalence was not calculated for the years 1993 to 1995 the number of positive cases reported in those years provides information on the total HIV positive cases detected since the commencement of the screening programme.

### Table 4. Prevalence of HIV by nationality, Brunei Darussalam, 1996 to 1998

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tested Positive</td>
<td>P rate</td>
<td>Tested Positive</td>
</tr>
<tr>
<td>India</td>
<td>6299</td>
<td>12</td>
<td>0.19</td>
</tr>
<tr>
<td>Indonesia</td>
<td>12815</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Japan</td>
<td>34</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Malaysia</td>
<td>19258</td>
<td>2</td>
<td>0.01</td>
</tr>
<tr>
<td>Myanmar</td>
<td>120</td>
<td>2</td>
<td>1.66</td>
</tr>
<tr>
<td>Nepal</td>
<td>126</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Philippines</td>
<td>14893</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Thailand</td>
<td>17281</td>
<td>55</td>
<td>0.31</td>
</tr>
<tr>
<td>Total</td>
<td>70826</td>
<td>72</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: P rate refers to the Prevalence Rate per 100.

Age and sex distribution of the HIV positive workers and their nationalities are shown in Table 5. A total of 449 male and 16 females were detected as HIV positive as of December 1998. Within the age group 21 to 30, 65 per cent tested as HIV positive. In the age group 31 to 40, 26 per cent tested positive. This showed that 91 per cent of those tested as positive were below the age of 40.

All HIV positive foreign workers were counselled and past histories of Sexually Transmitted Infection (STI) and condom use during casual sex were collected by questionnaire. Of the HIV positive results 29.5 per cent reported a past history of STI. Condoms were never used by 34.8 per cent, and 38.5 per cent reported using condoms only sometimes during casual sex. STI histories and condom use by those testing HIV positive are shown in Figures 2 and 3.

Heterosexual transmission during casual sex was identified as the main mode of transmission (88.8%). See Table 6.
Population Mobility in Asia: Implications for HIV/AIDS

Table 5. Age and sex distribution of HIV positive migrant workers by country of origin, Brunei Darussalam, 1998

<table>
<thead>
<tr>
<th>Age group</th>
<th>India</th>
<th>Indonesia</th>
<th>Japan</th>
<th>Malaysia</th>
<th>Myanmar</th>
<th>Nepal</th>
<th>Philippines</th>
<th>Thailand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>15 - 20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>20 - 30</td>
<td>35</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>31 - 40</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>41 - 50</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>51 +</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>24</td>
<td>3</td>
<td>12</td>
</tr>
</tbody>
</table>

Figure 2. Condom use in HIV positive migrant workers, Brunei Darussalam

Table 6. Mode of HIV transmission among migrant workers Brunei Darussalam

<table>
<thead>
<tr>
<th>Mode of transmission</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>413</td>
<td>88.8</td>
</tr>
<tr>
<td>Bisexual</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Homosexual</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Unknown</td>
<td>46</td>
<td>9.9</td>
</tr>
<tr>
<td>Total</td>
<td>465</td>
<td>100</td>
</tr>
</tbody>
</table>

D. Observations

Migrant workers who tested as HIV positive were mainly unskilled and semi-skilled and employed in the construction industry, factories, hotels, shops, and private houses. Approximately 95 per cent arrived from India, Indonesia, the Philippines, and Thailand. Ninety-two per cent of the female workers arrived from Indonesia, Malaysia, and the Philippines. Female workers were employed as waitresses, sales girls, and housemaids. Female workers from Indonesia (62.8%) exceeded the number of male workers (37.2%). As the local languages of both countries are the same, female workers are preferred as housemaids.

Approximately 97 per cent of those testing positive for HIV, by order of majority, arrived from Thailand (78.5%) India (10.1%), Malaysia (5.8%), and Myanmar (2.6%). The HIV
Infections and Risk

Prevalence rate from 1996 to 1998 was similar for those from Thailand (Prevalence Rate of 0.67) and India (Prevalence Rate of 0.23). This rate increased significantly during 1997 and 1998 among workers from Malaysia (Prevalence Rate of 0.01). The prevalence rate for workers from the Philippines and Indonesia remained low. For workers from Myanmar the rate was higher than for other countries approximately 1.5 per cent for the years 1996 and 1997.

In 1998, The Joint United Nations Programme on HIV/AIDS (UNAIDS) report stated that approximately 800,000 (2.3% of the total population) are living with the HIV virus in Thailand. It also stated that the HIV infection rate in India was below one per cent of the total adult population with an estimated 4 million living with the HIV infection. In Myanmar, the rate of HIV infection was rapidly spreading among sex workers and rose from 4 per cent in 1992, to over 20 per cent in 1996. For the Philippines and Indonesia the rate of HIV infection was reported as below 1 adult in 1000.

A study by Mehendale et al., in India, 1996, noted that HIV infection is spreading rapidly. It also noted that the prevalence and incidence rates of HIV infection among those who attended two STI clinics in Pune, India between May 1993 and October 1995 were found to be high. Results of screening 5,321 persons showed that the overall prevalence of HIV infection was 21.2 per cent higher in females (32.3%) than for males (19.3%).

The Brookmeyer et al., 1995, study in India concluded that the HIV epidemic in India is growing rapidly. An additional report stated that the epidemic in Malaysia is mainly focused on sexual transmission as in Thailand.1

Recent data indicates that the number of persons living with the HIV infection in Thailand, India, Malaysia, and Myanmar, is quite high. In the Philippines and Indonesia the number remains low. In the years 1996 and 1997, the HIV prevalence rate was highest among workers from Myanmar. Lower rates, by order of majority, were reported for Thailand, India, and Malaysia. In the same period the prevalence rate among workers from the Philippines and Indonesia was comparatively low.

Heterosexual transmission resulting from contacts with commercial sex workers was the main mode of transmission, 88.8 per cent. Condom use at all times during casual sex was reported at 8.6 per cent with their use sometimes at 38.5 per cent, and never at 34.8 per cent. Consistency in condom use with commercial sex workers was extremely low. Migrant workers, 88.8 per cent, were involved in high-risk behaviour with commercial sex workers and condom use remained low. Most did not perceive a risk of HIV infection in casual sex. A 1997 study conducted in Thailand by Rugpao et al., concluded that if the incidence of condom use was high during commercial sex encounters then the HIV infection rate may decline in the male population. A study in the United States of America during 1995 by Feldblum et al., reported that male latex condoms offered substantial protection against the HIV infection.

Past histories of STI occurrences in HIV positive migrant workers showed that 29.5 per cent had previously suffered from such events. This indicated that in those with previous STI occurrences and having casual sex encounters, the onset of an HIV infection was more rapid. In 1995, a random but controlled study in Tanzania by Grosskurth et al., observed that improved STI treatment reduced HIV incidence by approximately 40 per cent. The 1995, study by Mehendale et al., in India, showed that recurrent genital ulcer disease and urethritis or cervicitis were independently associated with a 7 (Prevalence Rate of <0.001) and 3 fold (Prevalence Rate of 0.06) increased risk of HIV seroconversion respectively.

E. Conclusions

- Most migrant workers were unaware of the risk of HIV infection during encounters with commercial sex workers and the importance of condom use at these times.
- HIV positive workers were involved in high-risk behaviour without protection.
- Use of condoms requires extensive promotion and social marketing and requires that top priority be given to these actions in each country.
- Programmes to achieve changes in behavioural patterns are also required.
- Migrant workers wishing to migrate should undergo blood testing to determine their HIV status before leaving their home country. This will alleviate mental stress or strain occurring on arrival.
- Recruiting agents in each country are to be made aware of the problems facing a migrant worker in the host country after being detected as HIV positive.
- Legal proceedings are required to be pursued when recruiting agents do not ensure that the HIV status of migrant workers is determined before departure.
- The free flow and exchange of relevant and related information between countries in the region is expected to strengthen action programmes that are undertaken to reduce, prevent and manage HIV infection.

References


V. Delayed Access to Health Care Among Undocumented Migrant Workers in Japan

Takashi Sawada, Masayoshi Negishi, and Mika Edaki *

In Japan, 28.8 per cent of reported HIV positive cases are non-Japanese nationals. Their access to medical care is restricted due to limited Japanese language skills and socio-economic barriers.

A study of non-Japanese nationals in 14 hospitals was conducted in the period April 28 to June 30, 1999. Data collected and subsequently analysed included demographic profiles, CD4 counts at first visit, and health insurance status.

The majority of respondents arrived from the developing countries of Asia (54.4%), Latin America (17.6%), and Africa (12.6%). Two-thirds of the patients were without medical insurance. CD4 counts of the uninsured (median 63) were significantly lower than for the insured (median 290).

Migrant workers from developing countries, especially those who are undocumented, have restricted access to medical care. Development of policies and intensive programmes to improve access to health care and preventive information is urgently needed to respect human rights and to prevent HIV infection.

Introduction

Migrant workers are vulnerable to HIV. In this paper, the factors that may influence access to health care services in Japan by HIV positive migrant workers is examined. Recommendations are proposed for strategies to improve health care access and to reduce vulnerability within this group.

A recent report prepared by the Japanese Ministry of Justice, Immigration Office stated that approximately 1.5 million foreigners had completed their alien registration. It was estimated that approximately 270,000 undocumented migrants were living in the country. In a total population of 120 million, non-Japanese nationals total 1.8 million (1.5%). See Figure 1.

In 1999, a report by the Japanese Ministry of Health and Welfare stated that non-Japanese HIV positive cases were 28.8 per cent of the total reported cases.¹ Since the early 1990’s, the public health sector has been aware of this situation and has attempted to control HIV infection among the non-Japanese population. Not all policies have been effective, and HIV infection is constantly increasing in both Japanese and non-Japanese populations.

* Takashi Sawada, and Masayoshi Negishi, Tokyo HIV Health Care Network. Mika Edaki, Network to Support HIV Infected Migrant Workers.

The medical sector reported that most HIV positive migrant workers did not request medication until they became critically ill. It was also reported that medical doctors are unable to select the best treatment as many patients had difficulty in paying for their treatment due to lack of health insurance.

When a significant number of persons testing HIV positive are unable to receive correct medical care and attention, and their first clinical visit occurs late in the disease cycle, it is not conducive to the protection of human rights, and control of the epidemic.

Data on the condition of patients at their first hospital visit were collected and analysed. The data analysis provided an opportunity to identify delays in treatment of HIV positive migrant workers, which are the most vulnerable to non-access to medical services.

### Methodology

Questionnaires relating to non-Japanese HIV positive persons were sent to 18 medical facilities in seven major cities that play a pivotal role in AIDS treatment. Responses by 185 persons from 14 facilities were returned and analysed. The reporting locations are shown in Table 1.

<table>
<thead>
<tr>
<th>Locations</th>
<th>Number</th>
<th>Resident non-Japanese population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excluded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hokkaido, Tohoku, Kyushu, Shikoku and Chugoku blocks</td>
<td>12</td>
<td>12%</td>
</tr>
<tr>
<td>Chubu block</td>
<td>1</td>
<td>9.8</td>
</tr>
<tr>
<td>Kinki block</td>
<td>1</td>
<td>6.8</td>
</tr>
<tr>
<td>Kanto block</td>
<td>12</td>
<td>80.2</td>
</tr>
</tbody>
</table>

Questionnaires were completed and returned by medical social workers and doctors responsible for HIV positive persons. The questionnaire contained details of age, sex, home country, present residence, CD4 cell counts at first visit, insurance status, and medical treatment payment history.
Delayed Access to Health Care

Results

The average age of respondents was 32.7 years and the male to female ratio was 10 to 7. Of the total cases, 82.3 per cent were within the 20 to 39 age group. The youngest reported case was nineteen years of age. The study did not include incidences transmitted from mothers to infants. See Tables 2 and 3.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>2</td>
</tr>
<tr>
<td>20-29</td>
<td>58</td>
</tr>
<tr>
<td>30-39</td>
<td>96</td>
</tr>
<tr>
<td>40-49</td>
<td>14</td>
</tr>
<tr>
<td>50-59</td>
<td>6</td>
</tr>
</tbody>
</table>

When analysed by area of residence 134 cases were in the Kanto block, 20 in Chubu, seven in Kinki, and 24 unspecified. This is similar to the distribution reported in statistics of the Japanese Ministry of Health and Welfare. See Table 4. Health insurance was available in 114 of the 182 cases (63%). See Table 5.

<table>
<thead>
<tr>
<th>Area</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tokyo</td>
<td>78</td>
</tr>
<tr>
<td>Other Kanto</td>
<td>58</td>
</tr>
<tr>
<td>Chubu</td>
<td>20</td>
</tr>
<tr>
<td>Kansai</td>
<td>7</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td>Abroad</td>
<td>1</td>
</tr>
</tbody>
</table>

By place of origin, 54.4 per cent were from South and South East Asia, 17.6 per cent from Latin America, and 12.6 per cent from Africa. The three areas totalled 84.6 per cent. Nationals of Brazil, Myanmar, Peru, and Thailand formed the majorities. Fewer people came from Europe, the Far East, and North America. See Figure 2.

The CD4 counts at the first visit were used as indicators to assess these workers accessibility to medical services. It was hypothesized that cases of low CD4 counts delayed their attendance at a medical facility until the occurrence of critical illness. Data relating to CD4 counts at first visit and population groups with low counts were analysed.

Average CD4 count on the first visit was 221.4 cells/mm3, with a median of 156 cells/mm3. These results are relatively low when compared to that of Japanese nationals.

Analysis of HIV cases by place of origin found that those from the Far East and Pacific Islands showed a median CD4 count of 379 at first visit. A relatively high count of median 303 was recorded for those from North America. Cases from South and South East Asia reported low counts at a median of 105 and Africa at a median of 108. The median of 183 counts was reported among Latin American migrants.

Comparison of the median CD4 cell counts at first visit by insurance status shows that the median counts of those insured was 290 cells/mm3 and for the uninsured, 63 cells/mm3. See Table 6. The CD4 counts at first visit of the uninsured were significantly low.
Table 6. Median CD4 counts by insurance status, Japan 1999

<table>
<thead>
<tr>
<th>Insurance status</th>
<th>Cases</th>
<th>Median</th>
<th>Mean</th>
<th>Prevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>73</td>
<td>290</td>
<td>311.562337</td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>100</td>
<td>63</td>
<td>159.962117</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

More than 63.4 per cent of the insured HIV positive migrants recorded CD4 counts of 200 or more cells/mm3. Among the uninsured, 73 per cent recorded less than 200 cells/mm3, with 45 per cent recording less than 50 cells/mm3.
Table 7 shows the insurance status of migrant workers by their place of origin.

<table>
<thead>
<tr>
<th>Area of Origin</th>
<th>Insured</th>
<th>Percentage</th>
<th>Uninsured</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>South and South-East Asia</td>
<td>23</td>
<td>22.2</td>
<td>80</td>
<td>77.8</td>
</tr>
<tr>
<td>Europe and North America</td>
<td>9</td>
<td>75.0</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Africa</td>
<td>5</td>
<td>23.8</td>
<td>16</td>
<td>76.2</td>
</tr>
<tr>
<td>Latin America</td>
<td>23</td>
<td>76.7</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Far East and Pacific Islands</td>
<td>9</td>
<td>60.0</td>
<td>6</td>
<td>40.0</td>
</tr>
</tbody>
</table>

Twenty-eight per cent of all cases had a history of unpaid medical fees. The average amount of unpaid fees was approximately US$13,000. Of the presently medically uninsured, a high proportion, 40.4 per cent, had a history of unpaid medical fee at an average of US$13,800. See Table 8.

<table>
<thead>
<tr>
<th>Insurance status</th>
<th>Cases</th>
<th>Unpaid</th>
<th>Percentage</th>
<th>Average unpaid costs (in US dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>69</td>
<td>6</td>
<td>8.6</td>
<td>2700</td>
</tr>
<tr>
<td>Uninsured</td>
<td>114</td>
<td>46</td>
<td>40.4</td>
<td>13800</td>
</tr>
</tbody>
</table>

D. Observations

Approximately 1.8 million foreigners live in Japan that are divided into three smaller groups. One group consists of those who have been resident for several generations with their origins in China, the Korean Peninsula and Taiwan. A majority possess permanent residency and health insurance. Cultural and language differences are small.

The second group is composed of those with resident visas such as students, spouses, and workers. Earlier this consisted of a large number from the Far East and Western countries. Recently, migrants from Latin America, inclusive of Japanese-Brazilians and Japanese-Peruvians, have increased in number. This has resulted from changes in labour policies. Most of these new arrivals are engaged in the manufacturing industry.

Approximately 1.5 million people fall within these groups and usually have health insurance provided by employers or by a local government. This group is not expected to experience constraints to their payment of medical fees.

The third group consists of approximately 270,000 classified as overstayers. This group rapidly increased in number during the early 1990s with most engaged in the manufacturing, construction, and entertainment industries. Some arrived from the Korean Peninsula and Taiwan. The majority, however, arrived from Pakistan, the Philippines, and Thailand. Refer to Figure 4. Recent policy changes do not permit the entry of, or issuance of a visa to unskilled migrant workers.

All legal residents are to have health insurance that provides equal benefits to all. National health insurance is not available to those without a correct visa. Therefore, those who overstay are not insured which restricts their access to medical services in the event of illness.

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The CD4 counts of HIV positive persons from South and South East Asia and Africa were significantly low with indications of a serious delay in completing a first visit at a medical facility. This group is similar in size to the group who do not have a proper visa and health insurance. Their limited access to medical services results from a perception by Japanese that they are an economic burden on the State and also a local perception that they are overstayers.

Cases of workers from Latin America registered low CD4 cell counts at first visit. The employers of most of these workers did not provide medical insurance. Possibly, language and cultural differences were the main obstacles to hospital attendance. Language constraints are attributed to the difficulties Latin American immigrants have with Japanese and English while few medical personnel were able to speak Portuguese or Spanish.

English language ability of the migrant workers from Brazil, Myanmar, Peru and Thailand is poor and most medical facilities are without interpreters. Training of medical interpreters is required as an immediate priority.

A payment of US$26 is required on the first medical visit by the uninsured. On occasion a payment of US$100 is required even for minor problems as medical services usually undertake blood tests and X-rays, and prescribe expensive medication. It is not unusual to pay US$500 per day for hospitalisation and treatment of opportunistic infections. For migrant workers this is a considerable burden as most are daily or part-time wage earners.

Prior to the 1990’s, there were very few overstayers and most of the population was medically insured with few cases of non-payment of medical fees. In the event that medical payments could not be made, the Livelihood Assistance law covered payments.

As the population of overstayers increased in the early 1990’s, some medical facilities refused to provide treatment to migrant workers who did not have proper visas. Policies to provide humanitarian assistance to undocumented migrant workers facing difficulties with medical fee payment have been developed. Since 1994, six prefecture governments, including the Tokyo Metropolitan Government in the Kanto block, have subsidised medical fees for the emergency care of undocumented workers. For payment, subsidies systems will make the necessary payment after the patient is unable to pay, despite repeated requests for
Delayed Access to Health Care

one year. Since the introduction of this subsidy medical payment system, the number of migrant workers refusing treatment has dramatically decreased. However, to date only six out of the 46 prefectures, have adopted this system.

Another law, the Unidentified Traveller’s Health Treatment Act, assures medical payments by local governments. To qualify, a person must be homeless or a traveller without a permanent address, job or relatives capable of completing payments. However, since its application in 1950 this law has not been used in all the prefectures by the Japanese National Government. Due to budget constraints of local governments this law has not been applied to undocumented migrant workers even when they are in a serious medical condition.

Enforcement of the two laws differs from prefecture to prefecture. This imbalance contributes to inaccessibility of medical services for migrant workers. Non-governmental organizations (NGOs) have reported that several severely ill AIDS patients suffering form severe opportunistic infections were refused hospital treatment where appropriate payment systems were not available. Such patients are confined to hospital after visiting an NGO or embassy in Tokyo. Most of these patients were critically ill and some died soon after confinement. Hospital personnel tend to neglect uninsured immigrants, which results in discouraging migrant workers from visiting hospitals. This is an inhumane situation and requires rectification to effectively control the epidemic.

In April 1999, three laws regarding communicable diseases were repealed and a new law, the Communicable Disease Prevention and Treatment Act was passed. The earlier law, the Communicable Disease Control Act focused on the quarantining of patients with communicable diseases. The new act with inclusions of "Respect for human rights" and "Provision of proper medical services," introduces more humane concepts to the control of epidemics. However, it does not provide for state subsidization for treatment of HIV infections. According to the guiding principles of the law, the government is obligated to provide appropriate treatment for HIV infected persons to the extent possible. Policies remain to be developed that will assist undocumented and uninsured workers, and foreigners possessing a limited Japanese language ability to access medical services in a timely manner.

Conclusions

The following public health sector recommendations relate to undocumented migrant workers and new arrivals as they are the most vulnerable population to HIV infection, and serious delays are occurring in their access to medical care.

- Policies are required that enable the provision of low cost and accessible medical treatment for uninsured persons.
- A supportive environment is required to facilitate access to health care services including interpreters and social workers.
- An international network for the exchange of information in the prevention, care and treatment of HIV infections is required in both sending and host countries.
VI. Migrant Workers as a High Risk Population – A Consequence of Blaming Others

Joachim Victor Gomes, S. M. Morshed and Elora Barua *

A. Introduction

In South Asia, action programmes designed to assess and prevent the risk of HIV/AIDS to migrant workers in sending countries remain to be implemented. The inevitable epidemic, considering the current situation relating to HIV in neighbouring countries, requires immediate attention. The Christian Commission for Development in Bangladesh (CCDB), as the partner of Coordination of Action Research on AIDS and Mobility (CARAM), Asia in Bangladesh, has been attempting to develop suitable programmes for delivery to potential migrants. The current examination was focussed on potential first time and returning migrants to identify the sexual practices normally conducted to determine HIV/AIDS risks as a consequence of being a migrant worker.

The objectives were:

- To assess the prevalence of HIV related risks among migrants returning home
- To assess the current situations of risk for departing migrants
- To assess the situations of risk at the destination country

To achieve the objectives a careful study of the sexual practices and behaviour of the migrant workers was undertaken.

B. Methodology

A behavioural study was conducted on the knowledge, attitude, sexual practices, and behaviour of 121 migrant workers. Data was collected through questionnaires and in-depth interviews in the period November to December 1997. The questionnaire survey was conducted at pathology and medical centres where departing migrants received compulsory pre-departure medical checks. Survey personnel were trained to elucidate sexual information and be non-judgmental of the information collected. The data was analysed by use of Statistical Package for Social Science (SPSS). This was followed by a qualitative examination to obtain additional clarification of the behavioural patterns and practices of the respondents.

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S. M. Morshed, Shikkha Shasthya Unnayan Karzakram (SHISUK).
1. **Migrants profile**

   The migrants were grouped within one of two categories:
   - First time migrants
   - Returnees

(a) **First time Migrants**

   This group was composed of those wishing to migrate for the first time for employment purposes and was expecting to stay in a host country for periods of three months to two years.

(b) **Returnees**

   This group was composed of those who had previously worked abroad and were undergoing the necessary processing for a second or a third period in the same or other job. To develop an improved analysis returnees were asked questions on their sexuality both in Bangladesh and abroad. The data on sexual behaviour was additionally classified into two categories:
   - behaviour at home
   - behaviour in the host country

(c) **Marital status of respondents**

   Of the 121 respondents, 57 (47.1%) were married, 63 (52.1%) unmarried and one separated (0.8%).

(d) **Categories of migrants**

   The marital status of the sample size was similar. Of the total respondents 70 per cent (85) were first time migrants and 30 per cent (36) were returnees.

   The majority of the job seeking migrants, 40.5 per cent, was in the 21-25 age group with 31.4 per cent in the 26–30 group and 14.9 per cent in the 31–35 group. Refer to Figure 1.

![Figure 1. Age distribution of migrant workers, Bangladesh](image-url)
(e) Education

Most migrants had completed between six and ten years of schooling. The second largest group had completed between one and five years and the third none. Refer to Table 1 and Figure 2.

<table>
<thead>
<tr>
<th>Years of Schooling</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 years</td>
<td>24</td>
<td>19.8</td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>30</td>
<td>24.8</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>45</td>
<td>37.2</td>
</tr>
<tr>
<td>11 – 12 years</td>
<td>16</td>
<td>13.2</td>
</tr>
<tr>
<td>13 – 14 years</td>
<td>5</td>
<td>4.1</td>
</tr>
<tr>
<td>15 and above</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>121</td>
<td>100</td>
</tr>
</tbody>
</table>

(f) Sexual relationships

The collected data did not indicate an increase in sexual relationships during overseas stays. Approximately 11 per cent of the returnees had sexual relationships overseas with partners other than their spouses. Two questionnaire phrases differentiated between the types of sexual relationships and contacts:

- Intimate sexual relationship: types of partners
- Types of sexual contact: various steps of intimacy commencing from hugs and kisses to intercourse
During the conduct of the interviews it was made explicit that sexual relationships included hugging, kissing, massage, deep kissing, mutual masturbation, vaginal and anal intercourse.

The types of sexual partners of the leaving migrants are shown in Table 2. Percentages shown in the table indicate multiple responses. Visits to commercial sex workers double in frequency in the host countries.

### Table 2. Intimate relationships in the home and host countries, Bangladesh, 1999 (in percentages)

<table>
<thead>
<tr>
<th>Type</th>
<th>First time migrant</th>
<th>Returnees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In country</td>
<td>In host country</td>
</tr>
<tr>
<td>Marital</td>
<td>42.4</td>
<td>58.3</td>
</tr>
<tr>
<td>Girl friend</td>
<td>22.4</td>
<td>27.8</td>
</tr>
<tr>
<td>Relative</td>
<td>10.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Commercial sex worker</td>
<td>9.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Others</td>
<td>32.9</td>
<td>27.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85.0</strong></td>
<td><strong>36.0</strong></td>
</tr>
</tbody>
</table>

Questions relating to sexuality implied the involvement of at least two persons for a relationship. Sexual acts, for example, masturbation and watching pornography were not considered as a relationship or contact as the study was focused on situations of high-risk. Such risks are high among migrants working in Kuwait and Saudi Arabia due to the prevailing social norms and cultures of the countries. However, 27.3 per cent of the returnees reported moderately high levels of intimate relationships in restricted cultures with commercial sex workers, 16.7 per cent, and with other casual partners, 22.2 per cent.

During stays in host countries, visits to commercial sex workers increased in frequency. As a result of language and cultural constraints difficulties are experienced in developing relationships beyond those with commercial sex workers. This situation creates increased vulnerability of the migrant workers to STIs and HIV/AIDS.

### (g) Forms of sexual contact

The forms of sexual contact by migrant workers in intimate sexual relationships were examined. Knowledge of sexual behaviour patterns has been viewed as resulting from differing cultural norms, media content, and openness in countries of the west. A comparison between the sexual contacts of returnee migrants and first time migrants, potential migrants, shows that the percentage of all forms of contact in a host country remain similar to those in the home country. Refer to Table 3.

### Table 3. Forms of sexual contact in home and host countries, Bangladesh, 1999

<table>
<thead>
<tr>
<th>Type</th>
<th>1st time migrant</th>
<th>Returnees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In country</td>
<td>In host country</td>
</tr>
<tr>
<td>Hug</td>
<td>49.4</td>
<td>44.4</td>
</tr>
<tr>
<td>Kiss</td>
<td>51.8</td>
<td>44.4</td>
</tr>
<tr>
<td>Deep Kiss</td>
<td>16.5</td>
<td>16.7</td>
</tr>
<tr>
<td>Massage</td>
<td>15.3</td>
<td>22.2</td>
</tr>
<tr>
<td>Masturbation</td>
<td>12.9</td>
<td>8.3</td>
</tr>
<tr>
<td>Vaginal intercourse</td>
<td>28.2</td>
<td>33.3</td>
</tr>
<tr>
<td>Anal intercourse</td>
<td>5.9</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85.0</strong></td>
<td><strong>36.0</strong></td>
</tr>
</tbody>
</table>
Question control: The use of the words, Deep Kiss, by the study was designed to elicit information on oral sex with the colloquial equivalent, and probing. This may be erroneous due to the incorrect application of the terms used during the data collection.

Additional questions related to situations of high-risk in sexual relationships with a number of partners were included. Figures 4 and 5 show the number of partners, by percentage, for migrants in the home country and returnees in the host country. Approximately 50 per cent of the migrants had partners, other than a regular sexual partner, in the home country and approximately 28 per cent of the returnees had partners in the host country.

(h) Condom use

Of the respondents, 19 per cent reported using a condom in their last sexual encounter. However, data on the use of condoms in an earlier situation analysis of migrant workers considerably differs from the present data that showed that approximately 61 per cent of migrant workers used condoms.

(i) Blood test

One data segment collected related to the testing blood of the migrants. Of the respondents, 87.1 per cent of the first migrants undertook blood testing during the migration process. Blood tests of 80.6 per cent of returnees were undertaken in the home country with 61.1 per cent being tested in the host country. Of the 103 persons who underwent blood testing only five persons received counselling. Two returnees received counselling at the time of blood testing in the host country. Counselling was the only occasion when the migrants were informed of the purposes of the blood test and the names of some diseases.

C. Summary of findings

Migrants do not increase their sexual knowledge and experiences when in a host country. Sexual relationships in the home country extend beyond marriage partners and include relatives, girlfriends, and commercial sex workers. When migrants leave their home country their access to spouses and relatives ceases, therefore, they maintain sexual contacts with casual partners and commercial sex workers.

Migrants learn and practice all forms of sexual practices in the home country. The situations of high-risk continue in the host country with similar occurrence patterns and the propensity of having sexual contact with multiple partners increases, because finding a steady partner while in the host country is often difficult. Figure 4 shows a higher percentage of 6 - 10 partners than in Figure 5. This suggests that the acceptance of situations of high-risk in both countries will enable the development of effective action programmes to achieve change in the behavioural patterns of the STIs, and HIV/AIDS vulnerable populations.
1. Knowledge relating to HIV/AIDS

Of the respondents 61.2 per cent had some previous knowledge of HIV/AIDS with the remaining 32.8 per cent having no knowledge. The level of knowledge of the 61.2 per cent with a previous knowledge of AIDS was examined and analysed. Refer to Figure 6.

Fifty per cent of the returnees and 42 per cent of the first time migrants knew that AIDS is a sexually transmittable disease. Forty-six per cent of first time migrants and approximately 42 per cent of the returnees knew that death ensued. Twenty four per cent of first time migrants and 20.8 per cent of the returnees had no knowledge.

Returnees with a previous knowledge of HIV/AIDS reported that it was obtained through personal contacts, television, and the print media. For first time migrants the source of knowledge was primarily through television followed by the print media and personal contacts. Personal contacts included friends, relatives, NGO workers, and doctors. Refer to Figure 7.
Knowledge gathered from the various sources was verified. See Figure 7. Specific questions relating to the modes of HIV/AIDS transmission were included and subsequently grouped into five categories.

1. Knowledge that transmission occurs through sexual contact, blood transfusions, unsterilised injection needles, and other surgical instruments, and from mother to child. Five modes categorised as having full knowledge, 4 per cent.

2. Partial knowledge. Knowing less than four modes of transmission, 43 per cent.

3. Knowledge with misconceptions. Knowing less than four modes of transmission and including others such as shaking hands, hugging, kissing, and mosquito bites, 12 per cent.

4. Full misconception. Knowing all kinds of transmission other than the four basic modes, 29 per cent.

5. No idea. Those without knowledge of the modes of transmission, 12 per cent.

To improve the transfer of knowledge, a comparison between television and personal contacts was made. A greater knowledge of transmission modes of HIV/AIDS was higher among those gaining knowledge from television. However, the sample was low (<5%). Partial information and knowledge with misconceptions was higher among those who gained knowledge from personal contacts. See Figure 8.

The study tends to suggest that peer education models are appropriate for behavioural action programmes focussed on this target population.

Of those with knowledge of HIV/AIDS only 16 per cent were aware of condom use as a form of prevention. Ten per cent thought that blood testing was also a method of prevention prior to blood transfusions. Another ten per cent considered it necessary to isolate those testing HIV positive. Thirty seven per cent considered that the best method to prevent HIV/AIDS was to avoid sexual relationships.
The opinion of the respondents was sought on the most suitable methods for providing HIV/AIDS knowledge. Most suggested the use of the print media. When leaflets were included with print media 38 per cent suggested that this was the most suitable system, as they preferred written information. Television was suggested by 20 per cent with 12 per cent suggesting personal contacts as the preferred method. See Table 4.

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print media</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>Television</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Leaflets</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Personal contacts</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Radio</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Seminars</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Posters</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>82</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Table 4. Methods suggested by respondents as being the most suitable for the dissemination of HIV/AIDS information.**

D. Recommendations

- An urgent need exists to reduce HIV vulnerabilities of migrant populations. Recent data provided by Bangladesh Manpower, Employment, and Training (BMET) states that remittances from manpower exports of 267,667 in 1998 totalled US$ 1599.2 million. To June 1999, the volume of manpower exports was 149,291 who remitted US$ 1017.1 million.¹

- The assumption that situations of high-risk are imported is open to doubt. However, the increased propensity of having sexual relationships with multiple partners confirm that migrant workers are more vulnerable to contracting STD/HIV/AIDS. Therefore, AIDS action programmes are to be integrated into on-going development programmes for potential migrant workers and their families. In addition, pre-departure programmes are required in sending countries together with intensive post-departure programmes in the host country. Such programmes to be based upon peer education in the home and peer education and pressure in the host country.

- Non-governmental organizations (NGOs), national governments, research organizations, clinical and medical service, and behavioural support services are required to undertake collaborative efforts to develop suitable and effective programmes to eliminate the potential for an epidemic of disastrous proportions.

- Suggested action programmes to benefit migrant workers considering the results of the study are:
  1. Pre-departure programmes in home countries
  2. Post-departure programmes in host counties
  3. Integrated programmes within existing development programmes for potential migrants and their families.

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¹. Bangladesh Manpower Employment and Training (BMET), 1999.
Population Mobility in Asia: Implications for HIV/AIDS

Essential steps to reduce the HIV vulnerability of migrant workers include:

- Dissemination of appropriate knowledge and information
- Dissemination of laboratory results and health concerns
- Appropriate IEC material for use in the print media and television broadcasting
- On-going advocacy to implement a suitable policy for testing in host countries
- Raising of awareness on HIV/AIDS transmission and prevention
- Peer education and peer pressure to increase the use of condoms
- Community development models for the education and awareness of families and potential migrant workers

Additionally, aspects relating to the legal, ethical and human rights require attention by the community at large and those involved with the migration process.

Migrant workers have considerable experience and knowledge that will be of benefit in the development of programmes. As a result of efforts by CARAM in Bangladesh during the last two years migrant worker forums have been initiated in nine electoral units, thanas, in Bangladesh. Increased cooperation among NGOs concerned with migrants and health service deliveries is required. Also, appropriate laboratory facilities, counselling, meeting, and other health-related facilities are required to support potential and returning migrant workers.

In association with seven partners in Asia, Coordination on Action Research on AIDS and Mobility (CARAM) Asia is currently focussing on a regional approach to reduce the HIV/AIDS vulnerability of migrant workers. This forum utilises participatory research as an approach to HIV/AIDS and mobility.
VII. Social Context of Women Migrant Worker’s Vulnerability to HIV Infection in Hong Kong, China

Mridula Bandyopadhyay and Joe Thomas *

A. Introduction

Women are becoming increasingly vulnerable to HIV/AIDS infection, as heterosexual transmission is now the dominant mode of transmission in most countries of the world. Their vulnerability is primarily due to a lack of knowledge; limited access to information, economic dependence and in many cases enforced sex, rape, and violence. Women account for 42 per cent of those living with HIV. The increase of HIV in Women reflects a biological vulnerability to the disease. Also, it has resulted from the social aspects of female and male sexuality and the extreme disparities that characterise heterosexual unions.

It is extremely difficult for adult and adolescent women to protect themselves, as they are often coerced into sexual relationships by money or by violence, physical and mental abuse, and rape. Women undertake sexual liaisons as a result of financial constraints, by force or an inability to articulate their own needs and desires. As a result of their weak economic status and dependency on males for their livelihood women are often required to participate in high-risk sexual behaviour. In these circumstances, the use of a condom is rarely initiated and their use is minimal as women often lack control of the situation.

Biologically, women are at a high risk of HIV infection, particularly during unprotected vaginal intercourse, with an HIV occurrence rate two to four times higher than for males. Generally women are at greater risk of HIV infection as they have a larger surface area of secretion during intercourse. Also, semen contains a higher concentration of HIV than vaginal secretions and may remain in the vagina for several hours after intercourse. The disproportionate effects of AIDS on adult and adolescent women and the prevailing biological, social, and economic aspects that contribute to this are considerable. In general, women are disadvantaged, valued less than males, have reduced access to resources, and a lower capacity to realise their health potentials.

* City University of Hong Kong, China.

In 1996, Long and Ankrah observed that many preventive and treatment programmes designed to curb the spread of sexually transmitted diseases, including HIV among women, did not effectively respond to the web of closely inter-related cultural, economic, and structural constraints that impeded women to protect themselves from HIV/AIDS. Women are increasingly becoming exposed to higher risks of HIV resulting from gender inequality, subservient social status, weak sexual negotiating skills, contractual and transactional sex, inequalities in education and employment. Their low socio-economic status caused by poverty, war, and displacement is also a cause of risks.

An urgent need exists to identify and fully comprehend the socio-economic, cultural, and structural factors that enhance and contribute towards increased HIV transmission in women. HIV transmission to women occurs in the context of complex sexual and social relationships within wide structural and environmental settings. Innovative approaches to HIV prevention are required in consideration of the sexual experiences of women and the socio-economic and cultural realities of their lives.\footnote{11}

\section*{B. AIDS, ethnicity and gender}

With the epidemic outbreaks of HIV infections and AIDS, racial and ethnic minority populations, minority women, and children have been disproportionately affected. These populations have also been disproportionately represented in communities with a high incidence of HIV/AIDS infection.\footnote{12} Primarily this has been due to the social and economic factors of poverty, underemployment, and limited access to health care systems. Also, class distinction, racial discrimination and membership of a cultural minority group, has prevented their access to normally available resources and facilities. Negligence of health care support for minority groups may also lead to a disproportionately high incidence of health problems.

\section*{C. Gender specific social determinants of HIV infection}

AIDS poses an enormous threat to women without economic means. In developing countries, 90 per cent of all adults and 98 per cent of all children infected with HIV live.\footnote{13} A United Nations Development Programme (UNDP) report in 1992, estimated that "each day a further three thousand women become infected, and five hundred infected women die. Most are between 15 and 35 years old."\footnote{14} The World Health Organisation (WHO) predicted that, during the course of the 365 days of the year 2000, between six and eight million women will become infected with HIV.\footnote{15}

On women who are addicted, of colour, and living in poverty, Janet Mitchell and others recently noted that "access to care and services has traditionally been marginal for women with any of these three criteria. Any two of these ... essentially put women in the extremely limited access category. Women with all three of these characteristics fall into the no access category."\footnote{16}

Women have been driven into unfavourable sexual and marital unions by poverty and have become vulnerable to AIDS through social processes. These processes are the economic, political, and the cultural forces that shape the dynamics of HIV transmission. All sexually-active women share a biological risk: however, the AIDS pandemic among women is patterned along social, not biological lines. An examination of the precise social mechanisms of poverty, sexism and other forms of discrimination is required to determine their effects and how they become embodied as personal risk. What is the role of inequality...
in promoting HIV transmission\textsuperscript{17} It appears that poverty and gender inequality are strong
teachers to the risk of HIV exposure, yet these aspects tend to be neglected in biomedical
and social science literature.

Risk reduction action programmes to promote consistent condom use and other safer sex
strategies resulted in dramatic behavioural change in specific populations in the United
States of America.\textsuperscript{18} Regrettably, success of similar actions to promote behavioural change
among women is less impressive.\textsuperscript{19} This suggests that well-designed action programmes
have the potential to change behavioural patterns among some women. However, few
sexual risk reduction studies have included a suitable female cohort to examine the effects
of ethnicity.

In 1995, Amaro identified three main model features of sexual behaviour relating to HIV
prevention programmes that limited their applicability to women. Firstly, the models tend to
be individualistic and neglect the broader social and cultural contexts in which sexual
behaviour is embedded. Secondly, they tend to assume that sexual activity is under control
by each individual and ignore the impulsive or coercive nature of sexual encounter
initiation. Finally, they tend to ignore the extent to which sexual behaviour is constrained
by culturally determined factors, including gender roles, sexual values, and the norms that
typically result in inflexible sexual repertoires and create a power differential between males
and females.\textsuperscript{20}

These factors limit the usefulness of the models when explaining the sexual choices of
women and predicting their situations of risk. Considerable evidence is available that
psychosocial variables predicting the sexual behaviour of males have limited predictive value
for females.\textsuperscript{21}

There are two areas that are often ignored by prevention programmes. These are, one, the
only risk faced by women is when they engage in unprotected sexual activity with one
sexual partner, and two, the dynamics of steady relationships differ from casual or new
relationships. A study of housing project data revealed that women with a single partner
were perceived as risky. For example, the women were “sure” or “pretty sure” their sex
partner had other partners or injected drugs. Monogamous women were less likely to report
condom use at last intercourse than those women with multiple partners.\textsuperscript{22} The single
female was also less likely to report talking to partners about condom use than women who
had multiple partners. The two groups expressed similar levels of intention to use condoms,
and had equal perceptions of risk. However, the intentions and perceptions did not
translate for women who were monogamous even if they knew or suspected their partners
were at risk. Finally, and often ignored, is that condom use relies not only on the co-
operation of a male partner and may be difficult to obtain but also prevents conception,
making condom use doubly problematic for many women.\textsuperscript{23}

Of particular relevance to current risk reduction recommendations is that even if they
realise they are vulnerable and wish to change their behaviour, many are unable to
negotiate safer sex with their partners. In addition, the discussion of sexual matters does
not occur because it is not a cultural norm for couples to discuss sexual matters; women
may be reluctant to introduce the topic of condoms or attempt to negotiate safer sex with
partners. A woman’s attempt to discuss HIV prevention in general, and condom use in

\textsuperscript{17} Farmer, et al., 1996.
\textsuperscript{18} Catania, et al., 1991; Ekstrand and Coates, 1990; Kelly, et al., 1989; Silvestre et al., 1993; Stall,
Coates, and Hoff, 1988; Winkelstein et al., 1987.
\textsuperscript{19} Moore, Harrison, and Doll, 1994.
\textsuperscript{20} Amaro, 1995
\textsuperscript{21} Amaro, 1995; Catania, et al., 1992; Moore, Harrison, and Doll, 1994.
\textsuperscript{22} Wagstaff et al., 1995.
\textsuperscript{23} Carovano, 1991; Worth, 1989.
particular, may be seen as inappropriate or disrespectful of the male prerogative to control the couple’s sexual activity, and be taken as evidence for lack of trust.  

Many agree that the complex interplay of economic, cultural, and social forces define the realities of women and present special challenges that risk reduction efforts have yet to achieve. According to a study in 1992, “given the subservient status of the Latino woman, it is difficult to come up with realistic strategies to help her protect herself.” However, there are promising developments in the theoretical and applied literature relating to HIV/AIDS prevention, when considering the prevention needs of women.

D. Acculturation stress and vulnerability to HIV infection

Acculturation is the process whereby migrant populations learn about and adapt to the host culture. Acculturation is significant for discussions relating to HIV/AIDS prevention as it is linked to the risk status in various ways. At the basic level, migrants may be unable to speak the local language and face difficulties in communicating with social service agencies and health care providers. This restricts their access to health services and information. Various studies have reported that the less-acculturated migrant populations have less knowledge of AIDS than the more-acculturated migrants. Also, newly-arrived migrants are often faced with prejudice and discrimination that limit their economic opportunities and increase their stress levels. The acculturation process has been identified as a significant source of stress for individuals and families. Of importance is that the migrant population is exposed to new models of behaviour and situations that may challenge traditional beliefs and norms and cause friction among family members.

E. Violence and risk of HIV infection

HIV and direct violence against women are closely linked. As noted by Zierler “this number, awful as it is, obscures the fact that some women are more at risk than others. For like HIV’s distribution, partner violence against women follows social divisions marked by class position, and race or ethnicity, creating strata of extreme vulnerability to violence victimisation.”

Women who experience or fear abuse are at a high risk of HIV infection for several reasons and will probably lack assertiveness as they are reluctant to risk angering their partner by suggesting the use of condoms. Abuse may take the form of rape or coerced sexual activity that precludes HIV prevention measures. Physical and psychological abuse is also linked to negative outcomes including depression and low self-esteem, passivity and lack of assertion that interfere with female motivations and abilities to protect against HIV. Therefore, women in abusive relationships or who fear negative partner reactions are less able to reduce their risks and may also face physical harm. Social, economic, and cultural realities of the lives of female migrants present serious challenges to risk reduction.

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27. Epstein, et al., 1994; Marin and Marin, 1990; Nyamathi et al., 1993; Rapkin and Erickson, 1990.
29. Zierler, S., 1994b
F. Female migrant workers in Hong Kong, China

Hong Kong, China has approximately 200,000 female migrant workers in the domestic sector. Refer to Table 1 and Figures 1 and 2. As Hong Kong, China is a multiracial and multicultural society, the needs of each racial and cultural minority group are to be assessed as they relate to HIV/AIDS. It is not only restricted to certain “high-risk groups” but is also applicable to the whole population. Health care needs of female migrant workers appear to have been ignored. Their contribution to the economy and the population in general has been substantial. However, education, information, and HIV/AIDS support services have been limited. Research programmes relating to HIV/AIDS and an evaluation of their access to health care are required. Employers are often provided with medical examination results that include HIV testing, before they commence their duties. These results are not provided to the potential employee. This procedure is a breach of confidentiality and potentially infringes on human rights.

Action directed towards the prevention and related education of HIV among migrant women is minimal. Research data are also lacking. Most domestic workers are socially, culturally and economically disadvantaged when compared to their male counterparts. To develop effective strategies for preventing HIV, female participation is necessary and research-based data are necessary. Social, cultural and economic empowerment and increased knowledge and education will provide for increased participation by women in sexual decision-making.

A consultation report recently completed for the Hong Kong, China Advisory Council on AIDS (ACA) focussed on AIDS related programmes in vulnerable communities and suggested a need for community participation in the programme planning process. It provides a contribution towards developing action programmes for female migrant workers as well as assistance in AIDS prevention activities.

Table 1. Female migrant workers, by country of origin, Hong Kong China, July 1998 (by order of majority)

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>141803</td>
</tr>
<tr>
<td>Indonesia</td>
<td>28348</td>
</tr>
<tr>
<td>Thailand</td>
<td>5383</td>
</tr>
<tr>
<td>India</td>
<td>1200</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1172</td>
</tr>
<tr>
<td>Nepal</td>
<td>588</td>
</tr>
<tr>
<td>Others</td>
<td>67</td>
</tr>
<tr>
<td>Pakistan</td>
<td>59</td>
</tr>
<tr>
<td>Malaysia</td>
<td>44</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>33</td>
</tr>
<tr>
<td>Singapore</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>178702</strong></td>
</tr>
</tbody>
</table>

*Source: Immigration Department, Hong Kong, China, 1998.*

---

Figure 1. Female migrant workers, by small groups and country of origin, Hong Kong, China, July 1998

- **Singapore**: 5
- **Bangladesh**: 33
- **Malaysia**: 44
- **Myanmar**: 38
- **Pakistan**: 59
- **Others**: 67
- **Nepal**: 588
G. Objectives

The study focussed on identifying HIV/AIDS related knowledge levels, attitudes, practices, and behavioural patterns of domestic workers. Specifically it discerned on whether gender and other inequalities exist in:

- Health care access
- Health care information and awareness
- Health related communication and education needs and responses
- AIDS related knowledge and awareness
- Level of utilisation of services such as AIDS testing and counselling

H. Methodology

Pre-testing survey questionnaires were administered to approximately 30 female migrant workers with the assistance of the United Filipinos in Hong Kong, China, and the Mission for Filipino Migrant Workers. On receiving responses to the initial survey questions, the questionnaire was adjusted and sent to 2000 women. A convenient sampling procedure was adopted. Thirty incomplete questionnaires were discarded. Completed questionnaires from 1,963 respondents provided the study data. Confidentiality and anonymity were assured and maintained, and prior informed consent was received.

The questionnaire was divided into four sections.

1. Demographic and background information relating to age, sex, educational levels achieved, marital status, and socio-economic background.

2. Knowledge, awareness, and attitudes related to HIV/AIDS.

3. Behavioural practices and capacity to negotiate for safer sex, occurrences of violence, in the form of rape, or physical abuse by boyfriends, husbands, or employers.

1. Data analysis

Descriptive statistics are presented, as the data collected was nominal. Relationships and associations between variables are presented. The chi-square test was used to determine the significance of univariate associations. Correlation coefficient tests were conducted to define the relationships between variables. Data analysis was completed with the use of SPSS software.

2. Analysis

Foreign domestic workers are a part of the normal scene although their demographic profile was unknown. This study provides an indication of this profile. The HIV/AIDS knowledge levels and access to information, related support services, and inter-related health services were examined. Perceptions of their vulnerability, experiences of sexual and physical violence, and discrimination were analysed.

3. Demographic profiles

The majority, 80.8 per cent, were in the 25 to 44 age groups. Approximately, half were married (49.7%), and one-third (38.5%) were single. The balance was divorced, separated, or widowed. Approximately two-thirds (67.4%) were from the Philippines. Other groups originated from Indonesia (15.6%), Thailand (12.7%), and South Asia (4.3%). Three-quarters (72.2%) had a high school or university degree. A small segment, 0.4 per cent, had not received any formal education.

Over 63 per cent had been resident for periods between four and ten years or more. Approximately ten per cent were new arrivals and resident for less than one year. One quarter, 25.6 per cent, had been resident for periods between one and three years. More than one-third (67.2%), visit families or travel overseas once every two years. Most worked long hours with three-quarters (72.3%) reporting daily work hours of between 11 and 16. Refer to Table 2.

| Table 2. Demographic profile of migrant workers, Hong Kong, China, 1999 (values in percentages) |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Age group | 15-24 | 25-34 | 35-44 | 45-54 | 55+ |
| Married status | Single | Married | Divorced | Separated | Widow |
| Nationality | Philippines | Indonesia | Thailand | Nepal | Sri Lanka | India |
| Education | Primary | Secondary | Higher Sec. | University | None |
| Length of stay | <1 Yr. | 1-3 Yr. | 4-6 Yr. | 7-9 Yr. | 10+ Yr. |
| Travel out | Once a Yr. | Each 2 Yr. | Others |
| Daily work hours | 6-7 hours | 8-10 hours | 11-16 hours | 16+ hours |
| Reading proficiency | Fluent | Good | Poor | Don't Know |
| English | 28.4 | 48.3 | 18.5 | 0.2 |
| Chinese | 1.2 | 17.3 | 17.3 | 40.5 |
| Others | 26.4 | 29.6 | 6.0 | 0.1 |
| Writing proficiency | English | Chinese | Others |
| English | 27.7 | 48.5 | 18.2 | 0.2 |
| Chinese | 0.2 | 1.7 | 14.8 | 42.0 |
| Others | 25.4 | 28.6 | 4.8 | 0.0 |
4. Health insurance

Two-thirds (66.3%) had medical insurance as part of their employment. Only 48.1 per cent had seen their medical insurance documentation as it is normally given to the employer and not the employee. Approximately 84.5 per cent had undergone a medical check-up as part of their employment contract and 66.2 per cent had seen the results. Nearly three-quarters (74.5%), were aware of the medical tests and examinations taken prior to employment. Over 60 per cent reported that they had been tested for pregnancy; 55.2 per cent for HIV/AIDS; and 43.1 per cent for other diseases in addition to normal tests and examinations. Medical test results were given directly to workers in 44.7 per cent of the cases and 35.3 per cent directly to the employers. See Table 3.

| Table 3. Health insurance of migrant workers, Hong Kong, China, 1999 (values in percentages) |
|-----------------------------------------------|-----------------|------------------|
| Any medical insurance as part of employment | Yes | No | Don’t Know |
| Have you seen it                               | 66.3 | 21.3 | 11.2 |
| Underwent medical check-up as part of employment in Hong Kong, China | 84.5 | 14.4 |
| Did you see a copy of the medical tests         | 66.2 | 32.4 |
| How many times had a medical check-up in Hong Kong, China, prior to employment | Once | Twice | 3+ times |
| Did you know what medical tests & examinations were conducted | Yes | No | N/A |
| Pregnancy                                      | 74.5 | 9.1 | 14.1 |
| HIV/AIDS                                       | 60.5 | 10.2 | 23.3 |
| Others                                         | 55.2 | 14.8 | 21.7 |
| Me Employer                                    | 43.1 | 19.5 | 21.7 |
| Result of the tests given to you or your employer | 44.7 | 35.3 | N/A |

5. HIV/AIDS knowledge

Although the general knowledge level of HIV/AIDS was inadequate many were aware of the usual HIV transmission route. However, many had misconceptions and misgivings. More than half (54.9%) reported that donating blood caused HIV infection. Kissing was reported by 40.4 per cent as being a source of HIV. Over one-third (37.9%) thought that mosquito bites spread HIV infections. Most reported that all people are susceptible to HIV irrespective of class or creed. Refer to Table 4.

6. Knowledge of AIDS related support services

When knowledge of AIDS related support services availability was tested with the duration of stay the correlation coefficient was found to be negative. The length of stay is not directly related to any awareness and knowledge of the availability of AIDS related information and education, and services such as the AIDS-Hotline \((r = -0.219, P \leq 0.01)\). Although some workers had been resident for over seven years they had minimal HIV/AIDS knowledge or information and did not know where to obtain it \((r = -0.217, P \leq 0.01)\). Few were aware of the available AIDS related support services.
Table 4. Levels of HIV/AIDS knowledge in female migrant workers
Hong Kong, China, 1999

<table>
<thead>
<tr>
<th>Do you think HIV/AIDS can be transmitted by:</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant HIV positive mothers to the unborn baby</td>
<td>82.9</td>
<td>5.7</td>
<td>10.2</td>
</tr>
<tr>
<td>Casual sex</td>
<td>82.8</td>
<td>9.4</td>
<td>6.6</td>
</tr>
<tr>
<td>Syringe and needles</td>
<td>77.9</td>
<td>10.3</td>
<td>10.9</td>
</tr>
<tr>
<td>Sharing clothing</td>
<td>5.6</td>
<td>86.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Sneezing</td>
<td>7.6</td>
<td>80.8</td>
<td>9.7</td>
</tr>
<tr>
<td>Coughing</td>
<td>7.3</td>
<td>80.8</td>
<td>10.0</td>
</tr>
<tr>
<td>Using toilet seats</td>
<td>15.3</td>
<td>71.2</td>
<td>11.6</td>
</tr>
<tr>
<td>Donating/giving blood</td>
<td>54.9</td>
<td>27.6</td>
<td>16.7</td>
</tr>
<tr>
<td>Kissing</td>
<td>40.4</td>
<td>44.8</td>
<td>13.0</td>
</tr>
<tr>
<td>Mosquito bites</td>
<td>37.9</td>
<td>42.2</td>
<td>18.1</td>
</tr>
<tr>
<td>Swimming</td>
<td>6.2</td>
<td>83.4</td>
<td>8.4</td>
</tr>
<tr>
<td>Sharing chopsticks/eating utensils</td>
<td>7.5</td>
<td>82.7</td>
<td>8.4</td>
</tr>
<tr>
<td>Shaking hands</td>
<td>5.0</td>
<td>87.7</td>
<td>7.0</td>
</tr>
<tr>
<td>Receiving blood transfusion</td>
<td>84.6</td>
<td>6.2</td>
<td>8.0</td>
</tr>
<tr>
<td>Do you think only the following people can get HIV/AIDS?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexuals</td>
<td>77.6</td>
<td>11.9</td>
<td>8.0</td>
</tr>
<tr>
<td>Commercial sex workers</td>
<td>80.2</td>
<td>12.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Injecting drug addicts</td>
<td>69.8</td>
<td>14.0</td>
<td>13.5</td>
</tr>
<tr>
<td>Heterosexuals</td>
<td>59.1</td>
<td>16.4</td>
<td>21.6</td>
</tr>
<tr>
<td>Married couples</td>
<td>63.5</td>
<td>23.1</td>
<td>10.5</td>
</tr>
</tbody>
</table>

Knowledge of AIDS counselling facilities was minimal, although 63.6 per cent had been resident for long periods ($r = -0.108, P \leq 0.01$). The correlation coefficient test discerned that the length of stay and knowledge of where to be AIDS tested was positively correlated ($r = 0.052, P \leq 0.05$). See Table 5. This may be attributed to:

- Earlier testing prior to signing a contract with their employers
- Assumption that public sector hospitals offer HIV/AIDS testing

Table 5: Knowledge levels of AIDS related support services in female migrant workers, Hong Kong, China, 1999
(values in percentages)

<table>
<thead>
<tr>
<th>Do you know/or are you aware of the AIDS hotline in Hong Kong, China?</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know where to get AIDS related information if you want to find out more about it?</td>
<td>18.4</td>
<td>61.4</td>
<td>18.0</td>
</tr>
<tr>
<td>Do you know where to get AIDS related counselling?</td>
<td>11.7</td>
<td>66.7</td>
<td>19.6</td>
</tr>
<tr>
<td>Do you know where to find an AIDS testing facility?</td>
<td>8.3</td>
<td>70.1</td>
<td>19.5</td>
</tr>
</tbody>
</table>

The minimal knowledge of existing AIDS related support facilities is a cause for concern. This minimal knowledge and awareness is presumed to have been acquired at home or from friends and colleagues after arrival. Most undergo a health orientation camp before departure where some knowledge of HIV/AIDS was possibly received. New or additional knowledge has not been gained since their arrival as they have been excluded from Information, Education, and Communication (IEC) campaigns.

7. Perceptions of vulnerability

A chi-square ($\chi^2$) test revealed that the relationship between age and negotiating skills used with partners for condom use during sexual encounters is significantly related. It also indicated that those in the 25 to 44 age group are able to negotiate condom use.
Presumably, this is due to their being employed, economically independent and have been resident for periods of four to ten years or more. They may be the family breadwinner ($\chi^2 = 50.43, P \leq 0.01, df = 6$). This probably provides them with more improved negotiating skills than those in the younger or older age groups who are dependent on partners. See Table 6.

| Perceptions of vulnerability in female migrant workers, Hong Kong, China, 1999 (values in percentages) |
|-------------------------------------------------|----------------|----------------|----------------|
| Do you think that the migrant women workers in Hong Kong, China should be concerned about HIV/AIDS? | 83.9 | 3.2 | 12.2 |
| Do you think you may be able to negotiate with your partners to use condom? | 47.8 | 24.4 | 24.8 |
| During your last sexual experience did you or your partner use a condom? | 26.3 | 38.1 | 18.4 |
| Do you think you are vulnerable to HIV infection because you are a female? | 54 | 18.6 | 21.3 |
| Do you think you have adequate knowledge about HIV/AIDS to protect yourself from HIV infection? | 23.3 | 62.2 | 12.8 |
| Are you at the risk of HIV infection? | 10.4 | 63.3 | 26.2 |

Marital status and negotiating condom use are also significantly related. Those who are married, working, and resident for more than ten years possess greater negotiating skills ($\chi^2 = 202.6, P \leq 0.01, df = 8$), than for those who are single, divorced or separated.

Similarly, the $\chi^2$ test revealed that female migrant workers from the Philippines had stronger condom use negotiating skills than others. This may be attributed to their completion of higher secondary or university education (58.3%). In addition, they are gainfully employed and economically independent from their spouse or sexual partner, have been resident longer than other migrant groups ($\chi^2 = 179.66, P \leq 0.01, df = 6$), and are often the sole providers for the family.

Although 47.8 per cent reported their ability to negotiate condom use only one-quarter had used a condom during their last sexual experience. One-third of those in the 25 to 44 age groups had used a condom during their last sexual experience. Approximately, 30 per cent of those married and seven per cent of those unmarried had used a condom during their last sexual experience ($\chi^2 = 11.84, P \leq 0.05, df = 4$). Of those using a condom during their last sexual intercourse, a predominant use was by those from the Philippines ($\chi^2 = 31.94, P \leq 0.01, df = 3$). This indicates that the intention to use a condom is not always translated into behaviour and practice. The intention to use and perceptions of risk do not always alter behaviour.

When a correlation coefficient test was conducted to identify a relationship between initiating negotiation for condom use and actual use during the last sexual encounter, it showed that the two variables were positively correlated. If the possibility to negotiate condom use exists, there is an increasing probability of using a condom during the last sexual encounter ($r = 0.464, P \leq 0.01$). When negotiation skills are high, condom use rises. Approximately, 32 per cent, reported sexual encounters in the previous 12 months. One-quarter (24.4%) had used a condom in the previous 12 months ($\chi^2 = 51.86, P \leq 0.01, df = 1$).

Tests were undertaken to identify the relationship between perception of HIV vulnerability and age. The chi-square ($\chi^2$) test revealed that approximately 10.4 per cent perceived themselves to be vulnerable or at risk. Twenty-six per cent were unsure and were unable to state whether they were vulnerable or at risk ($\chi^2 = 12.98, P \leq 0.05, df = 6$). Approximately, 63 per cent perceived themselves to be not at risk. This perception is rather dubious, as only one quarter had used a condom during their last sexual experience. Those with one partner who they perceive as risky are less likely to use a condom at the last intercourse than those
with multiple partners. Monogamous women are less likely to talk to their partners about condom use than those having multiple partners.\textsuperscript{33} Intentions to use condoms may be expressed and risk perceptions are present. However, these do not translate into the behaviour of monogamous women even when partners were suspect or at risk. This may be due to condom use that relies on the co-operation of a male partner and data may be difficult to obtain. Use also prevents conception, which is doubly problematic for many.\textsuperscript{34}

Data also indicated that those from the Philippines are at greater risk than other groups and this is attributed to their composition, 67.4 per cent, of the sample group. Seven per cent of this group perceived a vulnerability to HIV infection followed by 3.1 per cent of those from Indonesia, Thailand and South Asia ($\chi^2 = 26, P \leq 0.01, df = 6$).

\section*{8. Access to HIV/AIDS related information}

Some respondents who had seen AIDS related information in their own language had obtained newspapers and magazines from their home countries or from friends or returnees. Some had obtained some minimal information from various organizations. See Table 7.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|}
\hline
Have you ever seen AIDS related information in your language in Hong Kong, China & Yes & No & Don't Know \\
\hline
10.6 & 79.3 & 6.6 \\
\hline
\end{tabular}
\caption{Access levels to HIV/AIDS related information by female migrant workers, Hong Kong, China, 1999 (values in percentages)}
\end{table}

\section*{9. Discrimination and access to health care}

Two-thirds of the respondents were conscious of potential discrimination due to their nationality, particularly when seeking medical care. However, 26.3 per cent reported that they were unsure as to whether they would face discrimination when seeking medical attention. Approximately 23.1 per cent did not expect discrimination when seeking medical care ($\chi^2 = 82.17, P \leq 0.01, df = 6$). To isolate the relationship between the two variables, a correlation coefficient test was conducted. This indicates that discrimination will occur when seeking any medical care ($r = 0.293, P \leq 0.010$). If general discrimination increases then inevitably discrimination when seeking medical care will also rise. Similarly, the correlation coefficient test revealed that even when seeking medical care they will face discrimination based on their nationality and occupation ($r = 0.223, P \leq 0.01$). As discrimination increases when seeking medical care, the quality of care received may be sub-standard. Table 8 displays the frequency distribution relating to health care access. Details of discrimination faced are shown in Table 9.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|}
\hline
Have you ever been ill while you were in Hong Kong, China? & Yes & No & Don't Know \\
\hline
43 & 56 & \\
\hline
Have you ever been to a medical facility (private or public) in Hong Kong, China? & 57.0 & 41.1 & \\
\hline
Do you think, if you need, you may get adequate medical care in Hong Kong, China? & 48.6 & 23.1 & 26.3 \\
\hline
\end{tabular}
\caption{Access levels to health care resources of female migrant workers, Hong Kong, China, 1999 (values in percentages)}
\end{table}

\textsuperscript{33} Carovano, 1991; Worth, 1989
Table 9. Experiences of violence and discrimination by female migrant workers, Hong Kong, China, 1999
(values in percentages)

<table>
<thead>
<tr>
<th>Experience</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever experienced physical violence?</td>
<td>14.1</td>
<td>84.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Any of your friends subjected to physical violence?</td>
<td>39.1</td>
<td>56.4</td>
<td>4.5</td>
</tr>
<tr>
<td>Have you ever been subjected to sexual violence?</td>
<td>8.5</td>
<td>89.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Any of your friends being subjected to sexual violence?</td>
<td>33.7</td>
<td>59.5</td>
<td>4.8</td>
</tr>
<tr>
<td>Have you ever felt discriminated in Hong Kong, China?</td>
<td>69.5</td>
<td>22.1</td>
<td>4.9*</td>
</tr>
<tr>
<td>Felt discriminated at:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restaurants/Hotels/Pubs/Bars</td>
<td>47.6</td>
<td>18.8</td>
<td>3.2*</td>
</tr>
<tr>
<td>Supermarkets/Markets</td>
<td>43.3</td>
<td>23.6</td>
<td>2.6*</td>
</tr>
<tr>
<td>Public Transportation</td>
<td>41.1</td>
<td>26.0</td>
<td>2.1*</td>
</tr>
<tr>
<td>Hospitals</td>
<td>42.3</td>
<td>22.3</td>
<td>4.1*</td>
</tr>
<tr>
<td>Government Offices</td>
<td>56.1</td>
<td>12.7</td>
<td>1.1*</td>
</tr>
<tr>
<td>Any of your friends were discriminated in Hong Kong, China?</td>
<td>73.9</td>
<td>16.7</td>
<td>7.0</td>
</tr>
<tr>
<td>Do you think you will be discriminated if you seek medical care in Hong Kong, China?</td>
<td>50.5</td>
<td>24.9</td>
<td>22.0</td>
</tr>
<tr>
<td>Any of your friends were discriminated in Hong Kong, China hospitals?</td>
<td>48.1</td>
<td>35.7</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Note: * = no response.

Those who experienced sexual violence (8.5%), perceive themselves to be at risk of HIV infection \((r = 0.093, P ≤ 0.01)\). As sexual violence incidents against women rises there is an increased likelihood that they may contract HIV infection as a consequence of the abuse. Present findings corroborate earlier studies that suggest that vulnerability to HIV/AIDS in women is primarily due to:

- Lack of knowledge or access to information.
- Economic dependence.
- Forced sex, rape and violence or a combination of all.  

Sexual violence was reported at 4 per cent for those from the Philippines, 2.4 per cent from Indonesia, 0.6 per cent from Thailand and 0.1 per cent from South Asia \((\chi^2 = 41.66, P ≤ 0.01, df = 3)\).

10. Situations of risk

Although the majority stated their intention to use condoms in the previous 12 months only one-quarter had done so. Some 45.8 per cent reported that using a condom was the best protection for safe sex, however, 65.5 per cent stated that they were not always used. It appears that a wide gulf exists between the perception of safety and reality. See Tables 10 and 11.

I. Prevention strategies

Continuous education and discussion of HIV/AIDS, with increased information available from television and radio broadcasting was suggested as an appropriate AIDS prevention strategy. Celibacy and condom uses were also stated as appropriate. Others considered that multiple sexual partners created a situation of risk, and relationships should be monogamous or restricted to spouses. Medical check-ups and counselling services should be available at all time. Some suggested a monthly bilingual newsletter, seminars, regular discussion sessions, and lectures focussed on their group to create increased awareness. Others remained sceptical and had misconceptions. They stated that HIV infected persons should be ignored, public toilets should not be used, and spermicidal jellies and contraceptives used.

Table 10. Situations of risk of female migrant workers, Hong Kong, China, 1999 (values in percentages)

<table>
<thead>
<tr>
<th>During the past 12 months, have you had sex?</th>
<th>Yes 32.0</th>
<th>No 57.2</th>
<th>No response 5.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the past 12 months, with how many people have you had sex?</td>
<td>Number</td>
<td>Don’t Know/Not Sure</td>
<td>N/A</td>
</tr>
<tr>
<td>1 = 23.9</td>
<td>1.8</td>
<td>4.7</td>
<td>65.4</td>
</tr>
<tr>
<td>2 = 0.6</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 = 0.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 = 0.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 = 0.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the past 12 months, have you had sex with only males, only women, or with both males and women.</td>
<td>Only male(s) 24.9</td>
<td>Only female(s) 1.6</td>
<td>Both male(s) &amp; female(s) .8</td>
</tr>
<tr>
<td>The last time you had sex did you or your partner use a condom?</td>
<td>Yes 24.0</td>
<td>No 36.6</td>
<td>No response 21.1</td>
</tr>
</tbody>
</table>

Table 11. Knowledge levels of situations of risk of female migrant workers, Hong Kong, China, 1999 (values in percentages)

<table>
<thead>
<tr>
<th>What do you understand by Safe Sex?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using a Condom</td>
<td>45.8</td>
</tr>
<tr>
<td>Using Birth Control Pills</td>
<td>9.0</td>
</tr>
<tr>
<td>Having only Oral Sex</td>
<td>2.6</td>
</tr>
<tr>
<td>Total Abstinence/Celibacy</td>
<td>11.3</td>
</tr>
<tr>
<td>Having multiple partners</td>
<td>2.0</td>
</tr>
<tr>
<td>Having only one partner</td>
<td>40.0</td>
</tr>
<tr>
<td>No response</td>
<td>9.7</td>
</tr>
<tr>
<td>How do you safeguard yourself?</td>
<td>No</td>
</tr>
<tr>
<td>By being Celibate</td>
<td>80.6</td>
</tr>
<tr>
<td>By Using Birth Control Pills</td>
<td>80.1</td>
</tr>
<tr>
<td>By having only Oral Sex</td>
<td>85.5</td>
</tr>
<tr>
<td>By having only Anal Sex</td>
<td>85.1</td>
</tr>
<tr>
<td>By Always Using Condoms</td>
<td>65.5</td>
</tr>
<tr>
<td>By Changing partners frequently</td>
<td>85.2</td>
</tr>
<tr>
<td>By having only one partner</td>
<td>41.4</td>
</tr>
<tr>
<td>No response</td>
<td>66.2</td>
</tr>
</tbody>
</table>

J. Recommendations

- AIDS related IEC needs require an immediate response.
- HIV prevention and care requires an effective response to reduce long-term social and economic consequences.
- IEC programmes require initiation.
- Initiatives are required to reduce occurrences of discrimination.
- Behavioural changes in perception are required.
- Efforts are needed to facilitate access to adequate medical services and treatment by the reduction and removal of discrimination.
Medical confidentiality is to be assured.

Confidential HIV testing and counselling services are required.

Sexual violence and its implication for HIV transmission to be carefully monitored and post exposure prophylaxis (PEP) explored.

A drop-in-counselling centre operated by trained female migrant workers would offer effective support.

A peer out-reach programme requires initiation.

K. Conclusions

Knowledge of HIV/AIDS and transmission routes is inadequate. Many had misconceptions and misgivings of HIV and AIDS and consider that HIV positive persons should be avoided. A dearth of information precludes a raising of awareness and prevention controls. Minimal knowledge, information, and awareness were included in health orientation programmes of sending countries. Some additional information is received from friends, newspapers, and magazines.

Although a majority considered that they were able to negotiate condom use, the study determined that only one-quarter had used condoms during their last sexual experience. This possibly results from a difficulty in articulating personal needs and desires. Married women generally require that a condom be used. Condom use among single, divorced and separated women was minimal. Approximately two-thirds perceived themselves to be ‘not at risk’ of HIV infection. This result is dubious as most had sexual relations during the previous 12 months without condoms.

In excess of ten per cent perceived themselves to be ‘at risk’ of HIV infection. Over one-quarter stated they were not sure if they were ‘at risk’. For most the only risk is unprotected sexual activity with one partner. Those with single partners are less likely to use a condom than those having multiple partners, although they perceive their partner to be risky. Women having a single partner are less likely to discuss condom use than those having multiple sexual partners. This is an area of concern as most have minimal knowledge of HIV/AIDS, and access to correct information is severely limited.

Many expressed that adequate medical treatment is not available due to their position in society and prevailing discriminations relating to nationality and occupation.

More than one-third reported that their medical records are provided directly to their employers and they are themselves unaware of the contents.

Present findings substantiate those of earlier studies indicating that vulnerability to HIV/AIDS is due to limited knowledge and access to information, sexual abuse, rape, violence, and discrimination. Health promotion and action programmes to effectively respond to the needs identified in this study are imperative.

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Population Mobility in Asia: Implications for HIV/AIDS


VIII. HIV Infection and Female Commercial Sex Workers: Their Work or Personal Feelings?

Ivan Wolffers, Walter Deville, Rika Subarniati Triyoga, Rachmat Hargono; Endang Basuki, Didik Yudhi and Sylvia Tiwon *

Action programmes that target female commercial sex workers usually approach them in their professional status and as persons with one dimension. Commercial sex workers are more than this and have personalities of multiple identities. These identities are carefully separated by themselves. Those working in Indonesia are influenced by many factors, including the national ideology of the good mother and wife ('ibuism'). In daily life females who trade in sex move between the identity of a professional sex worker and that of a good female, with emotional relationships. It is within these emotional relationships that females have less control and negotiation possibilities and where they are at a higher HIV risk than in their professional lives.

A. Introduction

Commercial sex workers, subsequently referred to as workers, and their clients have been identified as populations that require targeting to decrease the dissemination of HIV. Campaigns have focused on:

- Education.¹
- Condom promotion.²
- Sexually Transmitted Infection (STI) services.³

An underlying characteristic in earlier research considered that commercial sex workers are a potential hazard to society and are multipliers of HIV infection.⁴ This has resulted in one-dimensional action programmes. Workers are seen in the context of frequent sex partners that contributes to HIV transmission.⁵ This reinforces an attitude of protecting males from HIV infection whereas female workers are more vulnerable to HIV-infection.⁶

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⁴. Lawless, Kippax and Crawford, 1996.
⁵. Wawer et al., 1996.
dimension of males and females that are involved in commercial sex activity, concurrently ignoring that they also interact with others. Some researchers have suggested that other relationships of workers, particularly those with their partners and husbands, may have considerable risk that is possibly greater than with their professional contacts. To fully understand this, research approaches are required to be holistic and not limited to the contacts with clients.

Minimal research has been conducted on the concept of sex as work rather than prostitution. A broad range of associated topics require additional understanding and include the conditions of prostitution, the way workers think about their work, how they survive, and give meaning to their daily activities and how they view themselves and their partners. Earls and David claim that literature prepared to date is of limited value and only useful in reaching a general understanding of prostitution or to guide social policy.

De Zalduondo stressed the importance of considering the many different workers and to understand the differences and details of working in commercial sex activities. This provides a need to focus upon a fundamental approach to research on prostitution. In addition, de Zalduondo emphasized the “value of a holistic, ethnographic view of the cultural and economic context of gender relations for understanding sexual behaviour and to depict the interlocking system of learned values and beliefs, and the opportunities and constraints.”

This study examines and describes the various relationships of female workers: the meaning that is given to them, how the national ideology, *ibuism*, influences their self image, how the relationships are distinguished from each other, and the relationships in which they have greater control and impacts on their vulnerability to STIs and HIV. To achieve a successful study it was necessary to adjust the parameters of conventional public health research. Recently, attention has gradually moved from sexual actions to the cultural and social context in which they take place. While medical epidemiology is still enmeshed in its quantitative quest for description of the sexual act of workers: with whom, how often, and how?

In this way it removes sex from its context, in this case prostitution, while creating a stereotype for sex workers by focusing only on one dimension of their identities. It is practical for a public health professional to use terms such as sex worker, as it suggests a certain control. However, many exchanges of tenderness, warmth, sex, and financial support are possible and distinguishing between them may be difficult. Altman discusses the social construction of the worker identity and observes, “The relationship between money and sex is complex and fluid and the demarcation of prostitution correspondingly vague.”

Considering these aspects it is essential to differentiate between the way sex workers define their identity and how others perceive them. The independent young woman visiting a bar to select a man that she likes to support her with the costs of daily life does not consider herself to be a sex worker. An epidemiologist will, however, place her in that category to suit research and study. This implies a conflict between self-defined identity and her identities in others. Internalisation of social ideas relating to sexuality and the roles of females contribute to the way sex workers respond to their own needs and the expectation of others that will partly define their self-esteem.

### B. Gender, *ibuism* and commercial sex in Indonesia

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Many types of workers operate in Indonesia. Prostitution is not permitted and those convicted of soliciting may be sent to a rehabilitation camp. In certain areas of some large cities, brothels (lokalisasi) are tolerated. In Jakarta they are in the harbour area of Tanjung Priok, in Surabaya, the largest port, among others in Tambak Asri and Bangunsari. Authorities regulate commercial sex activities in these areas, including the health facilities and imposition of restrictions during religious events.

Prostitution is seen as being a negative aspect of society and many insist that it is not part of the national culture and is a result of modernization and westernization. This negative conception is expressed in the local term used for a worker. This term wanita tampah susila translates to a woman without morality. The root being Sanskrit based euphemism and belongs in the same category as tunawisma, homeless, and tunanetra meaning blind. Another word that is used is pelacur, meaning selling the self. This is also used for a person who sells their principles and it conveys an idea of socially deviant sexual behaviour.

Stigmatisation of workers may not be viewed separately from the current status of females in the country. During one particular period, the status of females underwent a serious decline from an earlier era when they had formed strong mass-based organisations, and a political party, and had achieved senior ministerial positions. In one period a rigid and regimented female hierarchy in society was established. This intensive social adjustment on the basis of gender is now referred to as Ibuism, which implies that females are defined according to their role as sexual partner, isteri, and reproducer, ibu.

At the same time, unmarried and uneducated females from rural areas were encouraged to contribute to national development plans and were internationally marketed as obedient, patient, nimble-fingered workers to attract capital investments in the drive towards industrialisation. As such they would be satisfied with lower wages and non-career employment as they were expected to subsequently marry and become housewives. Marriage law of 1974, declared that husbands were household heads, kepala rumah tangga, with wives as mothers of the household, ibu rumah tangga. Females became domesticated and subordinated by this with an identity of being just mothers with limited legal rights. In the early 1970s the family planning movement was initiated placing additional burdens on females. National development strategies in the same period were influenced by a green revolution in which rural females lost their traditional roles in the harvesting, hulling, and marketing of rice.

Modernisation of market mechanisms and structures further weakened the economic position of females when they lost their traditional position in the marketplace with many young females recruited as factory workers and domestic helper. The number of workers also increased significantly. In common with other countries of the region the commercial sex industry has become a significant economic activity. The large movement of single young females into urban areas who were not protected became particularly vulnerable to violence.

Changes in national policies in 1998 have improved the status of females. There have also been demands for the closing of brothels. Concurrently, the industrial sector significantly reduced production and created a large number of unemployed females. In Jakarta, it was reported that approximately 11,000 females previously employed as factory workers have entered into prostitution.

The concepts of ibuism, the good female, conflicts with an identity as a sex worker but both are part the complete identity of a worker. These workers have various relationships, which are defined by their context and imply different roles to play and differing identities. An earlier concept of multiple identities as introduced by post-structuralism and post-modern anthropologists and feminists appear to be useful in the analysis of workers behaviour. Moore describes it as: “Individuals are multiple constituted subjects, and they can, and do, take up multiple subject positions within a range of discourses and social practices. Some of these

subject positions will be contradictory and will conflict with each other. This set of multiple and contradictory positionings and subjectivity is held together by “the subjective experience of identity, the physical fact of being an embodied subject and the historical continuity of the subject.”

The emphasis being that multiple identities are defined by the context and that these identities are not always shared, but may exist in competition, as the person has competing loyalties. This indicates that identities are shaped and reshaped by external forces with their own agendas. Papanek provides three examples of how “certain ideals of womanhood are propagated as indispensable to the attainment of an ideal society. These ideals apply to women’s personal behaviour, dress, sexual activity, choice of partner and reproductive options.”

Creation of an identity is to be seen as the process of understanding the limitations and defining self and the other(s). A result is not a fixed and unchangeable identity but a reflexive project made and remade by the person according to biographical experiences. To emphasize the dynamics it may be suitable to use flexible terms to describe multiple identities: identification and differentiation. The proposed approach clarifies the competition between values, the domination of certain ideologies in a society and assists in the understanding of how effective the identities are in maintaining self-esteem and reaching personal goals. Weeks states that sexuality is woven into the web of all our identities. Workers move from one identity to another and are supported by certain rituals and codes in the process. Dress and make-up indicate the changes in roles from mothers, sisters, and wives to sex workers. The importance of these rituals is the need to maintain self-esteem through defining and identifying oneself contrary to others doing so.

C. Methodology

Two research projects, Support for STD and HIV/AIDS Control and Prevention Among High Risk Populations in Jakarta, Surabaya, and Bandung, and the Community Intervention Study on Female Commercial Sex Workers in Surabaya were based on exploratory and descriptive research. They were also expected to develop action programmes to improve the protection of female workers and their clients from Sexually Transmitted Infections (STIs) and HIV.

The cohorts selected were female workers in brothels and massage parlours of Jakarta, 501; Bandung, 342; and Surabaya, 623; to improve the understanding of HIV among them. Each person was tested bi-monthly for clinical and laboratory signs of STIs and every six months for HIV infection. During the research HIV infection was not found. In addition to the clinical data, socio-economic data was collected by social scientists. Instruments used were quantitative data collection relating to situations of risk and sexuality (Knowledge, Attitudes, Beliefs, and Practices [KABPs] and condom diaries) and qualitative data collection through focus groups, discussions, and life histories on the reasons for certain behaviour and choice of work. In Surabaya, research was undertaken to identify the potential and constraints of peer education. Qualitative research was also completed in 1998. In 1999, an assessment of the reproductive health needs of marginalised females was completed.

19. Wolffers, 1997
22. leven et al., 1997.
This study focuses on the qualitative research from Jakarta and Surabaya, with data collected through KABPs included where appropriate. The KABPs were completed for those working in brothels with in-depth interviews that included other categories of workers.

D. Results

1. Demographic results

Mean age of the cohort surveyed in Surabaya was 27.58 (Standard Deviation [SD] 5.52) and in Jakarta 23.86 (SD 5.3). The mean age of commencing commercial sex activities was 25.63 (SD 5.20) and 22.1 (SD 5.1) respectively. For Surabaya the mean age was older than for Jakarta as they tend to remain living in brothels for extended periods.

Those without education formed 22.0 per cent of the cohort in Surabaya and 9.7 per cent in Jakarta. Primary education, sekolah dasar, was commenced but not completed by 34.5 per cent in Surabaya and 38.1 per cent in Jakarta. Completion of primary education was reported by 30.1 per cent in Surabaya and 39.7 per cent in Jakarta. Beyond a primary level attainment was reported by 9.6 per cent in Surabaya, and 10.4 per cent in Jakarta. Either married or previously married were 85.5 per cent in Surabaya and 87.4 per cent in Jakarta. Of those married or previously married 73.5 per cent had children. Seventy-one per cent of those unmarried had children. The mean number of children was 1.09 (SD 1.05).

2. Identity

The process of worker recruitment and the process of accepting this new identity were described by Wolffers et al., in 1999. As their new identity conflicted with the concept of ibuism most denied that they were workers. Some females working in the massage parlours, lokalisasi, accept the worker identity. Though most accept this identity, they consider that they are not so for 24 hours a day. The mother identity is important to separate the different identities.

Many of the workers live quite separate identities in their home and communities and often do not disclose their occupation to their children or neighbours. Relationships to males impact on their position and negotiation skills.

3. The ‘tamu’

A client is called a tamu; a guest or visitor and emotional relationships do not exist as the interactions are characterised by behaviour that stresses this emotional distance. As the visitor is potentially kotor, dirty, washing is insisted upon before any sexual activity occurs. This indicates a certain level of negotiating skill by the female; however, this may be weakened by an urgent need for money. The kotor concept extends to the time when the client leaves, as the worker will then also carefully wash.

Condom use is a behaviour that may help to maintain the emotional distances. The use of condoms is minimal and although most workers attempt to negotiate their use the potential loss of money may inhibit this preference. In some instances the use of condoms is conditioned by factors dependent on the characteristics of a particular client or situation. In general, most realise the importance of condom use to prevent STIs and to aid in maintaining cleanliness.

4. Langganan or pelanggan

Regular clients are referred to as langganan or pelanggan. During their workdays their social contacts are limited to clients, pimps and their acquaintances, and other workers in the brothel. Those working in Surabaya reported that 52.5 per cent of their clients were regulars. Of these, 19.9 per cent reported one; 10.0 per cent, two; 8.7 per cent, three; and 13.9 per cent more than one. The remainder of 47.5 per cent reported that they did not have regular clients. During KABP interviews, 26.1 per cent in Surabaya reported that on the previous night they had received a regular client.
When a client visits frequently they become a regular client. In this process they become less kotor or dirty. The worker will not discuss condom use with this client and will leave the choice to him, as their identities as friends become more important. It would appear at this time that the female becomes submissive and willing to adapt to the expected subordinate behaviour of other females in society, as a 'good mate', isteri. Some will request a new client to use a condom, but if the client is known then condom use is unlikely. This type of relationship is often more emotional and is less likely to be defined as a commercial transaction. The worker may then change from the identity of being professional to one who becomes personally involved to meet her needs as an Indonesian female.

Most workers claim they do not offer condoms to boyfriends, close friends, or regular clients. The rationale being that they had not been previously infected with these partners and diseases had not been contracted from them.

5. When a tamu becomes a pacar

To become a complete female in society each female is required to form a permanent relationship with a male, a pacar, or lover. A worker may start an emotional relationship with the client. The consequence of an emotional relationship is that the negotiating power of the female is weakened and impacts negatively on their potential for autonomous decision-making. Most workers have relationships with pacars or kiwirs (Javanese). Traditional values for females include pleasing and finding a permanent partner. If by the age of twenty-three or twenty-four she has not succeeded she is in danger of becoming a perawan tua or old spinster. Status of females, according to traditional values, is strongly related to having a partner and in relation to that, having children. In modern societies, particularly in cities, this is changing. Often the first question asked of young females is whether they have a boyfriend. These values are also important for workers. Some save money to subsequently buy and maintain a lover that can be a father for their children that may be residing with their grand parents.

Of the 150 females with partners, 90 reported sexual activity with them on the previous night and 116 during the previous seven days. A pacar is not considered to be kotor and is tampak kotor, without dirt, therefore condom use is usually not considered.

Two categories of steady relationships exist. Young and attractive workers emotionally require a pacar, to make them feel comfortable and to satisfy their own feelings. Personal problems are discussed with him, as they live away from home and need a person to rely upon. Sometimes, when money is needed she may borrow from him. They will go shopping together and will spend part of their free time together. Though the worker has a steady relationship she will continue to work and see many clients to earn money for the both of them. Some of the younger females do not wish to have a partner as they consider that time spent with a partner is wasted and earning opportunities are being lost.

The older workers will attempt to create a situation whereby they will only serve a few regular clients. Such a relationship with a regular client may eventually develop into the female becoming an isteri simpanan, a female at the side, or mistress. As a mistress, she will continue to live at the brothel, but will not serve other clients. This is considered as being an ideal situation when a regular marriage is not possible. A regular, but small income is achieved that is sufficient for daily expenses. When she wishes to visit her children, she may ask for additional money. As she only has one relationship she feels safe with respect to Sexually Transmitted Infections (STIs) and HIV/AIDS. Also, she does not have to work so hard and may join the Women’s Organization for Family Welfare and Education (PKK). As a mistress she has the opportunity to participate in community activities such as visits to orphanages, religious gatherings, joining arisans, lottery to save money for social activities, and will have a certain status in the community. During interviews the workers mentioned that this allows them to be a normal housewife and to save money for their old age.
Population Mobility in Asia: Implications for HIV/AIDS

E. Conclusions

- Control of sexual interactions depends on the role played in the relationship. This role will depend on which of the multiple identities are involved in the particular situation. The sexual identity of workers particularly those working in brothel are to be understood in relation to their different roles and expected behaviours. Part of the professional attitude of the worker is based on keeping their different identities strictly separated. To do this workers follow rules of behaviour that help them to draw lines between the identities. Dress, make-up, gestures, and mimics help them move from one identity to another.

- Condom use is an important ritual in separating the identities. Unless there are specific reasons that may prevent receiving payment condom use is preferred. When not used it is because most males prefer not to use them or lack of negotiating skill due to an urgent need for money. Emotional closeness also weakens these skills. As most females seek emotional relationships they are influenced by the internalised ideas of the national good woman concept of ibuism. With their lovers or regular clients with whom they have developed a form of emotional relationship workers do not consider using a condom as the relationship belongs to a personal life and the partners as non-kotor and belonging to their own world. As the relationship becomes non-commercial the workers ignore their professional attitudes and control. This seems to be the moment when the payment for services becomes a gift. Unlike money there is no control over gifts and favours and they cannot be demanded, bargained for or refused.

- Beyer describes a worker in Thailand who was always tough when negotiating condom use as a professional.\textsuperscript{25} With clients she insisted on condom use without exception. Eventually, her boyfriend who had other relationships with several females infected her. Workers may have a professional attitude and try to convince their clients, but in their personal lives they are extremely vulnerable and become infected because of their emotional involvement with certain males.

- Information and awareness campaigns for commercial sex workers to provide them with the tools to protect themselves should focus on their various identities. In their identity as a commercial sex worker, they tend to maintain professional standards and condom requirements. A focus on multiple identities is likely to be valid in other countries also. Additional research that extends beyond interactions between workers and casual clients is required to develop a greater understanding of the various roles played and the tools used to maintain self esteem and cope with their stigmatisation by society.

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HIV Infection


IX. Population Mobility in Asia and the Implications for HIV/AIDS

Philip Guest *

A. Introduction

Population movement in all forms, including international and internal migration, and tourism, may contribute to the transmission and spread of communicable diseases. Currently, of major concern in Asia is the spread of sexually transmitted infections (STIs), including HIV. Sexually transmitted infections do not require a non-human vector and migrants present a direct transmission risk when a disease is not endemic in a recipient population. Migrants also may contract the disease on entry to a population where the disease occurs and if they engage in high-risk behaviour. Some migrants may also be particularly vulnerable to HIV/AIDS due to their marginal position in a host community.

Although increasing attention is being given to mobile populations in relation to HIV/AIDS, especially as they relate to the vulnerability of migrants, the dynamics of population mobility are often ignored or treated as self-evident. Population mobility, however, is a complex phenomenon and the size and structure of this mobility have direct implications that relate to HIV/AIDS and requires close study and analysis.

Suggested programmatic responses resulting from a study of population mobility and HIV/AIDS is the focus of this document. Its objectives are achieved through the process of identifying the levels and trends of population mobility in the region. A description of the selectivity processes underlying migration in the region then follows. Migration patterns, including levels and trends as they relate to HIV/AIDS are examined. In conclusion, policy related recommendations are made.

B. Levels and trends of population mobility

Population mobility occurs in a continuum with several dimensions. Time and space are most frequently used to delineate forms of movement. For an analysis of mobility other dimensions such as the direction and the reason for movement may also be important. With reference to time, the mobility continuum may take the form of daily commuting to absences of several years. Within the two extremes are tourism, seasonal movement, and other temporary forms of mobility. The space dimension may involve short distances, for example, between adjacent villages, or longer distances between regions within countries, or between countries. Movement may occur between rural areas and urban areas, or movement between both. Location of movement in this complex continuum is important as various forms of mobility involve people possessing differing characteristics and with a variety of experiences.

The complexity of the mobility process, however, may lead to a paralysis in the analysis. Mobility requires generalisation to highlight potential links between mobility and HIV/AIDS. In this presentation a distinction is made between the mobility that occurs within the borders of a country, internal migration, and the migration that occurs across national borders being international migration. The crucial factor is how movement affects normal human interaction patterns. For example, international movement, even for a short time may be important when considering aspects as they relate to HIV/AIDS with longer-term migration between rural areas of the same country being of lower importance.

The most common form of population mobility within Asia is the movement within countries. Disregarding short-term movements, the scale of mobility is impressive. Most censuses conducted in the region containing internal migration estimates show that between 5 and 10 per cent of the population migrate over a five-year period. Results of the 1981 census in India, showed that in excess of 50 million people aged 5 and over migrated in the five-year period prior to the census.

Census estimates of migration, however, often under enumerate the volume of internal migration, as they do not include short-term movements, or movements not officially classified as migration. The 1990 census in Thailand reported that approximately 4 million (8%) of the population moved between 1985 and 1990. A national migration survey conducted in 1992 reported that 25 per cent of the population aged 5 and above, approximately 12 million persons had moved for a period of at least one month during the five-year period before the survey. In China, it was reported that over 100 million persons form a floating population. Primarily this population is composed of internal migrants moving to larger cities without the right of registration in destination areas. They outnumber registered migrants by a ratio of 4 to 1.

When the full range of migration within countries is considered, an indication of the wide diversity of movement becomes apparent. In Thailand the migration survey reported that approximately one third of the movements were short-term in nature. One half of the movement was reported as seasonal in nature with a further half devoted to repeated short-duration movements. High levels of short-duration moves were also identified in other countries of Asia, although special surveys are often required to document this movement.

A large proportion of the seasonal migration is focussed on urban areas particularly to larger cities. Fluctuations in seasonal demands for agricultural labour, combined with booming urban economies, also contributed to the ebb and flow of rural workers to urban areas. The magnitude of these flows requires special consideration. One study estimated the variance between wet and dry season populations of Bangkok is approximately 10 per cent, a difference of approximately one million persons.

Most mega-cities of the world are sited in Asia, yet the region has a comparatively low level of urbanisation. Therefore, most internal movement occurs between the rural areas, although migration rates are higher for urban than for rural areas. In the 1981 census of India, almost 56 per cent of the reported internal migration occurred between rural areas, a low 20 per cent from rural to urban areas and 16 per cent between urban areas. Although only 23 per cent of the country was classified as urban, approximately 35 per cent of

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5. Chamratrithirong et al., 1995.
migrant flow was to urban areas. In India, as in most countries of Asia, the share of rural to urban migration as a total of internal movement is increasing. An analysis by the United Nations in 1996, indicated that in the decade of the 1980s, migration contributed approximately one-half of the urban growth in Asia. The contribution of migration and reclassification to urban growth was generally lower in South and West Asia when compared to East and South East Asia. The significant contribution of migration to urban growth in East and South-East Asia during the 1970s and 1980s may be a result of the economic dynamism of the sub-regions, with most centred on the larger cities. The attractiveness of city life to rural dwellers is also a consideration.

The broad features of international labour migration in Asia are well documented. Although movements across international borders are smaller than internal movements it involves a significant and increasing number of people. An increasing proportion of this movement is occurring between countries of Asia region. Most countries of East and West Asia are receiving countries. Countries of the Central, South, and South East Asia are generally the exporters of labour. Most Pacific Island countries are labour exporters, with most migrants travelling to North America, Australia, and New Zealand.

Within Asia it is necessary to distinguish between legal and illegal migration, long-term and contract and other labour migration, and refugee movements. A considerable proportion of long-term migration from the region is by migrants leaving for settlement in Australia, Canada and the United States of America. These migration streams include a significant number of migrants from Hong Kong, Malaysia, the Philippines, Singapore, and the Pacific Island nations. Substantial numbers of students also travel out of the region for study. However, it is labour migration with short-term contracts and the undocumented migrants that form the main flow of migrant movements.

Historically, contract labour migration from the region was to the countries of West Asia. The major exception to this was Viet Nam, when large numbers of contract workers were employed in the former Union of Soviet Socialist Republics (USSR) and Eastern Europe during the 1980s. During the late 1980s and early 1990s over 4 million contract workers from Asia were employed in the Middle East. Those from India formed the largest volume with others, in order of majority, from Bangladesh, Pakistan, Sri Lanka, the Philippines, and Indonesia forming the balance. Commencing in the 1980s, and increasing at the start of the 1990s, a shift in countries of destination was seen. The rapidly developing countries of East and South-East Asia such as Brunei, Japan, Singapore, and Taiwan Republic of China then became major destinations.

Estimated averages of annual numbers of contract migrants workers for the periods 1985-1989 and 1990-1994 for major labour exporting countries in Asia are displayed in Table 1. The volumes shown in the table relate to the annual flows of migrants. Migrant workers already overseas are expected to be considerably higher than the annual flows. In 1997, Hugo estimated that the total number of migrant workers from Asia in the period from the 1970s to the mid-1990s was approximately 16 million, with 4 million migrating from just the Philippines.

Of considerable concern to the governments of importing countries is the flow of undocumented workers. The number of persons in this category is difficult to quantify. Martin in 1996, noted that although the number of undocumented workers in Japan,
Population Mobility in Asia

Republic of Korea, and Taiwan are high, the numbers in Malaysia and Thailand are considerably more. Estimates for 1997 suggest that there were approximately one million undocumented foreign workers, mainly from Indonesia working in Malaysia.

### Table 1. Average annual number of contract migrants workers for the periods 1985-1989 and 1990-1994: Major labour exporting countries of Asia

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>78000</td>
<td>174100</td>
</tr>
<tr>
<td>China</td>
<td>61000</td>
<td>135000</td>
</tr>
<tr>
<td>India</td>
<td>139800</td>
<td>297225</td>
</tr>
<tr>
<td>Indonesia</td>
<td>63500</td>
<td>118000</td>
</tr>
<tr>
<td>Myanmar</td>
<td>8100</td>
<td>9000</td>
</tr>
<tr>
<td>Pakistan</td>
<td>76800</td>
<td>143000</td>
</tr>
<tr>
<td>Philippines</td>
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<td>471000</td>
</tr>
<tr>
<td>Republic of Korea</td>
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<td>20218</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>18900</td>
<td>52300</td>
</tr>
<tr>
<td>Thailand</td>
<td>89600</td>
<td>86800</td>
</tr>
</tbody>
</table>

*Source: Zlotnik (1998)*

Estimates for Thailand are approximately one million, with the majority of the illegal workers coming from Myanmar. A 1999 report by Battistella and Skeldon estimated that approximately 500,000 of 2.5 million international migrants in East Asia are undocumented with 2 million of approximately 4 million international migrants in South East Asia being undocumented. Considerable undocumented migration exists between countries of Asia. For example, the considerable two-way flows between Nepal and India. In 1999, Archavantikul and Guest using various sources noted that the volume of undocumented migrants in some countries of South Asia is extremely high with an estimated number of 10 million in India. From a regional perspective it is estimated that undocumented migrants exceed the volume of documented migrants.

Smuggling of workers across borders in Asia is a thriving industry. A report by Martin states that potential migrants from Asia are willing to pay the highest fees of all migrants to be smuggled into various selected countries. The report also includes estimates that indicate that approximately one-half of the US$ 5 million to US$ 7 billion industry of illegal migrant smuggling is generated in Asia. The volume of such activities of trafficking is extremely large. In a 1998, report by Skeldon, he cited estimates that throughout the world up to 4 million persons a year are trafficked with the majority being females and children. Many of these flows occur in Asia and involve prostitution.

Since 1950, the Asia region has experienced a large number of involuntary movements. Some of this has resulted from the movement of refugees. It is noted that some host governments have restricted and severely limited the interaction between refugees and local populations. For example, the migrant flow from Viet Nam in the 1970s and 1980s

and from Cambodia during the 1980s was clearly refugee movements. Undoubtedly these flows also contained persons migrating for economic reasons. Other large-scale displacements, such as those from China into Hong Kong, China, from the Lao People’s Democratic Republic into Thailand, and from Myanmar into Thailand often combine the features of both labour migration and refugee movements. Recent conflicts in West and Central Asia have added more refugees to the total living in Asia. In the mid-1990s approximately 2 million refugees from Afghanistan were living in Pakistan. Similarly, the International Organization for Migration (IOM) estimated that 1 in 12 of the population of Central Asia has moved, primarily due to armed conflicts. Also there were significant numbers of refugees in India from Bhutan, China and Nepal. In 1996, one-third of the estimated global total of 13.2 million refugees were living in Asia.

In addition to those moving for long periods of time, there is also a considerable temporary cross-border movement. This movement, mainly for trading, may occur on a daily basis or for longer periods. Although it is not possible to determine the exact numbers, most of the existing borders are porous and populations living on both sides of a border are often culturally similar and hence there is often the potential for considerable movement. Although not seen as a form of population mobility, international tourism involves the movement of large numbers of people, as seen in Thailand with more than 6 million annual international tourist arrivals.

C. Characteristics of Migrants

Migration is not random behaviour. Selectivity exists in any movement, with persons with certain characteristics more likely to migrate than those with other characteristics. Some of this selectivity results from economic structures, and various demand levels for specific forms of labour. Migration selectivity is also related to various levels of integration into social networks and by cultural restrictions or encouragement to members of certain groups.

The most consistent selectivity patterns are observed for age. Young adults in the 15-29 age group have the highest migration rate. Most migrants especially those moving to urban areas are single. Males are the most likely to move, although there is a considerable variation among countries and forms of movement in the sex selectivity of migration.

When comparing countries of East and South East Asian to those of West and South Asia the cultural norms and patterns of economic development are associated with relatively high levels of female mobility, especially in the younger age groups. For East and South East Asia the age patterns of female migration are similar to those for males. In many countries of these latter regions, females dominate the migration streams to urban areas.

Age-sex patterns of migration of South and West Asian countries, particularly the countries with predominantly Islamic populations, is quite different from that in East and South East Asia. Migration rates for young adult females are one-half or less than for males. Females, in their thirties, exhibit migration rates similar to those for males of the same age. The patterns relate to the migration of females occurring within the context of family movements. For males, considerable migration is within the single and younger age

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groups. Within South Asia, increased female mobility has been observed over recent years, particularly of young unmarried females. Based on census data, Pathak and Mehta in 1995, described the increasing proportion of single female migrants in internal migration streams in India and noted that most of the increase was focussed on movements to large urban centres.

A major contributor to the rise in female migration was the transformation of the labour force structure in East and South East as a result of government policies that promoted export-led development. These policies centred on the establishment of free-trade zones, encouragement of foreign investment, investment in human resource development and the considerable efforts devoted to maintaining a labour environment free of industrial activity. Many of these economic policies are conducive to high levels of female labour force participation. In several countries of South East Asia more than 80 per cent of the labour force in companies established in free-trade zones are female.\(^\text{15}\)

The development of the tourism industry has also brought an expansion of employment in the service sector. In Thailand, tourism is a major earner of foreign exchange. The industry also provides many employment opportunities in the hotel and restaurant sector and commercial sex sector. Seasonal migrants whose rapid job turnover discourages employers to invest in the training of workers hold many of these jobs.\(^\text{16}\) Migrant labour is particularly attractive as it provides employers the opportunity to exert greater control over activities of workers when they are separated from their families and communities.

A variation also exists in migrant selectivity across migration types. For example, temporary migrants when compared to the more permanent migrants are more likely to be older: male, poorly educated, married, living apart from their families (who remain in the area of origin) living in poor conditions and remitting most of their income. The main reason for migration being to earn money to support their rural-based households.

The age patterns for inward and outward migration show that migration is a major contributor to changes in the age structure of rural and urban areas. Rural to urban population shifts resulting from migration increase the numbers of young adults in the urban population and depletes rural populations of persons at younger ages. Demographically the effects of age-selectivity of rural to urban migration are significant. These selectivity patterns also vary the sex composition of urban and rural areas. In East and South-East Asia, the trend has been for urban areas to contain an increasing proportion of young, usually single, females, with a corresponding over-representation of young males in rural populations. In contrast, in South and West Asia the opposite trend has occurred. The result for all countries in Asia has been the same, an unbalanced sex composition in both urban and rural areas. As the size of urban populations in most countries of Asia is smaller than the rural populations the magnitude of differences is greater for urban than for rural areas.

Males generally dominate international migration flows in Asia.\(^\text{17}\) However, some exceptions exist. For example, migration of contract labour from Indonesia and the Philippines consists of as many or more females than males.\(^\text{18}\) Most females work in the domestic sector. A large number of females from the Philippines work in the entertainment industry. The emergence of the countries of East and South East Asia as migrant destinations also contributed to an increasing proportion of female international migrants.

\(^{15}\) Simmons, 1993.
\(^{16}\) Phongpaichit, 1991.
\(^{17}\) See Skeldon, 1998.
\(^{18}\) See Gulati, 1993.
Further development of migration networks will reduce risks of migration and may be expected to contribute to increased levels of female international migration.

An important feature of international labour movement is that although many migrants are married, most labour importing countries have regulations that prohibit family members from moving with the migrant. Although the purposes of such regulations are to reduce migrant integration into the host society, and staying beyond the length of their contract, the result is that sexually active adults are removed from their normal sexual networks for extended periods of time. Undocumented migrants, because of the risks involved in movement often move alone or in same-sex groups.

D. Population mobility and HIV/AIDS

To identify the relationships between migration and health, it is necessary to examine the variations between migrants and non-migrants on HIV/AIDS related aspects. First, it is necessary to examine whether migrants are a selective component of the population. When migrants are selected on the characteristics relating to a low or high exposure to HIV/AIDS, differences will occur between migrants and non-migrants on HIV prevalence. These differences however, are not related to being a migrant: they result from a compositional difference, resulting in more migrants than non-migrants being selected on the basis of a certain characteristic. For example, migrant populations often contain a higher proportion of those living at minimal income levels than for the non-migrant populations. Minimal income levels are usually associated with high vulnerability to diseases, including HIV/AIDS. Are higher rates of a disease in migrant groups a result of their migrant status, or their income level? Similarly, higher rates of HIV/AIDS among migrants may occur due to the concentration of migrants in the ages of high risk. It is important to define carefully any relationships that may exist between migration and HIV as they may result from selectivity patterns.

Selectivity factors related to migration are not necessarily related to casual relationships between migration and HIV/AIDS. However, selectivity may interact with mobility features to heighten the vulnerability to risk. In many countries, a high proportion of migrants moving to urban areas are young and single. They are separated from social networks that traditionally limit exposure to high-risk behaviour, such as sex with multiple partners. Also, they often have increased economic resources that allow them to engage in potentially unsafe behaviours. Many married temporary migrants who move without their spouses are similarly removed from the social networks that regulate sexual and other risk behaviours.

Migrant status may also lead to an increased exposure to HIV/AIDS vulnerability. For example, in 1994, Long outlined a series of circumstances that may place female refugees in a position of high risk.

These may include:

- During flight and in camps, they often face the high risks of rape by males with high-risk levels of sexual behaviour.

- To ensure the survival of themselves and their families, they may be pressed into providing sexual services.

- Health services to combat the cofactors of HIV, such as STIs, or of Information, Education, and Communications (IEC) campaigns to promote understanding of HIV, are not always available.
A lack of knowledge or non-access to health and other services, resulting from their status as migrants may also increase their vulnerability to HIV. Often migrants lack information on services, as they are not closely linked to local social networks. When migrants know of the services they are often unable to access the services due to a limitation in legal rights. For example, in many countries only residents may use medical services, which exclude their use by temporary and international migrants. Where efforts exist to provide services to mobile populations it may be difficult to identify and contact them. Mobility rarely occurs once, and repeated moves are usually a normal event. When services are provided, discrimination or lack of understanding by providers may limit their use.

Special migration patterns may also place particular groups at risk, particularly when they relate to the cultural or social context. Kunstatdtter in 1994, noted that members of hill tribes in northern Thailand are at a heightened risk of contracting HIV/AIDS due to their migration patterns linking them to the lowlands, poor health services, and the presence of co-factors such as tuberculosis.

Locations with large numbers of migrants, such as border towns, and centres of trade often experience higher HIV/AIDS prevalence rates than areas with smaller migratory populations. Seroprevalence data from Cambodia, Myanmar, and Thailand, indicate that populations in provinces with international border crossings have higher levels of HIV infection than the populations living further away from the borders. Communities near border crossings are in higher risk environments due to remoteness from normal legal and cultural restrictions. This encourages visitors to engage in risk behaviour that is not usually practised within their home communities. In addition, among the travellers, males greatly outnumber females in communities close to border crossings. This gender disparity creates an unusually high demand for commercial sex. Moreover, females who live at cross-border locations are at a significantly higher risk of HIV as they are more likely to have sex partners who are mobile males who, in turn, are at high risk of carrying HIV. Whether people on the move pose a potential threat for the spread of HIV depends upon their risk behaviour and the environments that they encounter.

International tourism has also been associated with the transmission of STIs, including HIV. Several studies have indicated that although a tourist's knowledge of HIV was high the perceived personal risk and intention to use condoms was low. This indicates that a change of context means that the normal precautions are considered as being unnecessary.

Increased trade and commerce along the borders of Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam has facilitated the rising transmission of AIDS that accompanies intravenous narcotic use. This has become a concern for the Yunnan Province of China as it forms an integral section of the overland route for heroin trading as it travels from the poppy fields to coastal ports.

The rapid spread of HIV by heterosexual contact associated with workers in all countries of the region is ominous. As countries of Cambodia, Lao People’s Democratic Republic, Myanmar and Viet Nam increase their supply of commercial sex workers to South-East and East Asia, and severe constraints exist in the communication of health information to those migrating to cultures different from their own, the risk of an expansion of HIV is greatly increased.

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Some researchers suggest that economic and gender inequalities contribute to the high rate of STIs in workers and the rapid increase in HIV infection and AIDS among female migrants. They are at risk of being sexually exploited as some are pushed or lured into sex work, the occupation that provides them with money to send home. In general, it may be suggested that sexual relations, as with any other form of behaviour, involves a complex set of interactions governed by a web of individual, family and societal values. When individuals are removed from this web of relationships by migration movements they are faced, either through their own or by others actions with increased vulnerability to HIV/AIDS. For example, in 1994 Singhanetra and Renard suggested that rural-urban migrants in Thailand experience more than just a change of geographical context, but also a change in forms of their relationships. In rural Thailand social relations are likely to be expressed in terms of family relations whereas in urban Thailand, for migrant females, social relationships are more contractual and more likely to involve sexual relations as a mechanism for social mobility.
E. Conclusions

- At the program level, mobile populations are recognized as important links in the geographic spread of HIV. Throughout Africa and Asia, highly mobile populations such as truck drivers have been the focus of HIV prevention efforts. The reasons for this focus are that these groups by nature of their work are exposed to a high risk of contracting HIV and also act as links in the spread of HIV into geographically dispersed populations.

- In addition to transport workers and traders, who are constantly moving, limited attention has been focussed on the more settled migrant populations who are often placed into situations where they become extremely vulnerable to contracting HIV. During recent years the attention to the problems of migrant populations has been directed towards international movements. Action programmes that generally involve the provision of IEC to migrants have commenced in several countries of Africa and Asia. Minimal attention, however, has been focussed on migrants who move within countries, although internal migrants outnumber international migrants in many countries and have similar levels of vulnerability.

- A difficulty in targeting internal migrant populations is identifying them within the general population. Prevention efforts that attempt to target migrants may experience constraints as access is usually through the general population. An alternative approach is the provision of information at the workplace as migrants are often concentrated within a few occupations. In many instances, for example, in the construction industry, they may live and work at the same site. By focusing behavioural change efforts at the workplace it may be possible to reach a large migrant audience. In Viet Nam, the Ho Chi Minh City Provincial AIDS Committee is supporting AIDS programmes at workplaces with mobile populations, such as construction workers.

- Mobile populations are an important target group for programmes attempting to reduce the spread of HIV/AIDS. However, not all mobile populations are at equal risk, and in some groups apparent heightened risk may be related to the composition of the migrant population rather than relating to migration. Careful assessment of the needs related to the migration status is required before planning action programmes.

- Increased programming attention needs to be directed towards in-country movements, the predominant form of necessary movement, and to short-term movement, both internal and international.

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Population Mobility in Asia: Implications for HIV/AIDS

References


X. Promoting and Protecting Human Rights to Reduce the HIV Vulnerability of Migrant Workers

Sharuna Verghis *

A. Introduction

All human rights are universal, indivisible, and interdependent and interrelated. While the significance of national and regional backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.¹

Most governments in Asia, including the Association of South East Asian Nations (ASEAN) have adopted this principle. However, delays to full implementation have been experienced due to existing diverse politico-economic and socio-cultural realities. Certain reservations have also been expressed that individual rights may not be compatible with community rights. This may also relate to matters of public health.

B. Human rights, public health and development

Protection of individual human rights is consistent with national aspirations for growth and progress especially for public health as it relates to development. Experiences related to the HIV pandemic have clearly shown the powerful relationships between human rights, public health, and development. The significant cost to social and economic development of HIV infection is clear. National human capacities are minimized, increased deaths occur, and human capacities are reduced. Public health is an important component of development activity, as improved health contributes to sustainable development. Considering national resource levels the sustainability of development directly relates to an effective balance of preventive and active public health policies and strategies. In addition, close adherence to principles of human rights is required. This implies that public health and human rights are complementary and interlinked. Integration of both is crucial for the promotion of health in harmony with sustained development.

Within the context of HIV/AIDS, effective public health policies that fully recognise the protection of human rights are required. Human rights protection reduces individual and societal HIV risk caused by negative economic, social, political and legal impacts on vulnerable members of the population.

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* Co-ordinator, CARAM Asia

Protection of human rights creates an enabling environment to empower the population against the HIV infection. When this supportive environment is not present the impact of the HIV pandemic increases.

Global statistics relating to AIDS have indicated higher rates of HIV infection in countries that are economically less developed. Such countries will also experience a retrograde impact of the epidemic more severely due to increased rates of HIV infection. Restricted or reduced access to health information and services also inhibits reduced HIV infection. Limited access to legal protection of undocumented migrant workers, restrictive inheritance, and family laws relating to female and the criminalisation of sex workers are also important concerns. Legal environments without protective mechanisms also impact negatively on the health of a population. When individual human rights are neglected and disregarded, the development of an enabling environment is negated and decreases the opportunity for the population to exert control upon their lives and reduce HIV infection risk and national efforts to secure long-term sustainable development are jeopardised.

It is apparent that when individual human rights are not respected the health of the population and the nation are at risk.

C. Human rights and HIV vulnerability of migrant workers

Migrant workers need full human rights protections to reduce their HIV vulnerability. To promote and protect the rights of migrant workers are compelling needs, as often they have diminished control on their lives being non-nationals in the destination countries. In addition, in some countries, AIDS is viewed as a disease brought in by outsiders and such misguided and easy associations between migrant workers and AIDS add to increased discrimination.

Various factors occurring during the various stages of the migration process reduce the rights of migrant workers and predispose them to acquiring HIV. To fully develop a supportive environment that is fully conscious of the rights of migrant workers and reduce HIV vulnerability, it is necessary to examine each stage in the migration process.

The stages of the migration process include pre-departure, transit, arrival, working and living in the new location, and return to the home country. At each stage violations to human rights may occur that subsequently impact negatively on health and increase susceptibility to HIV infection.

D. Pre-departure human rights violations

1. Socio-economic conditions in the home country

Potential migrant workers face situations of risk to acquiring HIV in their home country. Numerous such situations prevail that include being forced out from lands and homes by poverty and absence of employment, arising from zero or limited access to land and natural resources, knowledge, information, services, and credit. Such unfulfilled human rights to work and enjoy a minimum standard of living and participate in the socio-cultural and political processes of their home country lead to a violation of rights during migration. It is observed that the greater the level of disempowerment, the greater the vulnerability to fraud, abuse and violation by unscrupulous recruiting agents, intermediaries and potential employers. The migration risks are also accompanied by violations to health and other human rights.

2. Availability and access to information before departure

Many countries actively promote the export of labour to finance economic growth and meet foreign debt obligations. However, limited pre-departure preparation for potential migrant workers is undertaken. Remittances received from migrant workers from Bangladesh are
significant. See Table 1. However, the draft, Protection and Welfare of Migrant Workers Act, 1999, still remains to address health and HIV vulnerability aspects for emigrating workers. A review of the health and HIV information actions reveals that although several efforts by the government and non-governmental organizations (NGOs) are being undertaken to disseminate related information through posters, billboards, television, and radio, attention to the needs of particular segments of the society, such as migrant workers is ignored. Research conducted by Co-ordination of Action Research on AIDS and Mobility (CARAM), Malaysia that focussed on migrant workers from Bangladesh to Malaysia, showed that 91 per cent of the respondents did not receive orientation or training relating to HIV or AIDS before leaving their home country.

<table>
<thead>
<tr>
<th>Year</th>
<th>Manpower exported</th>
<th>Incoming remittances (value in millions of US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>381,077</td>
<td>1,525.03</td>
</tr>
<tr>
<td>1998</td>
<td>267,667</td>
<td>1,599.24</td>
</tr>
<tr>
<td>1999 (to June)</td>
<td>149,291</td>
<td>1,017.04</td>
</tr>
</tbody>
</table>

*Source: Bangladesh Manpower Employment Training (BMET)*

Currently, the Philippines has an organized pre-departure programme for emigrating persons. However, additional information relating to health, HIV, and STIs is to be provided to potential migrant workers and the format and structure of the orientation adjusted.

In Cambodia, a pre-departure orientation programme for overseas migrant workers is restricted to health, HIV, STIs, and AIDS. The information provided is insufficient to empower the workers against HIV and other health risks. It is suggested that domestic workers from Cambodia migrating to Malaysia be informed that domestic work is not covered under the Employment Act 1955, of Malaysia. Information relating to labour and immigration laws of host countries is important for migrant workers. Social, legal, and cultural aspects of the host country impact on HIV vulnerability are also important. When correct and appropriate information is disseminated human rights protection increases and HIV vulnerability reduces.

A migrant’s right to information before departure include the level of sharing, its form, and content. Currently, suitable and appropriate information is often unavailable due to a lack of pre-departure orientation programmes, for example, in India, Pakistan, and Viet Nam. In the Philippines the required information remains to be fully integrated into the pre-departure programme. At present, the information available in Cambodia is inadequate. In all countries in the South East Asia, South Asia, and Indo China regions general public health information relating to HIV/AIDS is disseminated. However, for various reasons, the needs of the special and vulnerable groups remain to be fully addressed.

Other socio-cultural factors restrict the access to information of migrant workers before departure. In some societies, it is considered unsuitable or immoral for female to work outside the home or to travel overseas to work. This has been the experience of the National Forum on Migration in India where the supply of domestic workers to Europe, Hong Kong, and the Middle East takes place stealthily. This severely restricts the access to information before migration occurs.


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3. Other considerations

- Minimal recognition of health as a right is apparent due to the emphasis on the economic value of migrant workers. This results in limited health information dissemination designed to protect the overall health of a population.

- The right to information and the right to health are dependent on the fulfilment of the socio-economic rights of migrant workers. This may also have the potential to raise barriers to the availability and accessibility of information and health. Efforts to reduce HIV vulnerability (by facilitating the individual levels of knowledge relating to HIV, STIs, and AIDS) are to be based on the fundamental rights of the migrant worker to good health in harmony with all other aspects of human rights. Denying or restricting information to potential migrant workers increases the risks to health and HIV infection.

- Research by CARAM and experiences of other NGOs in the region with migrant workers from Indonesia, Philippines, and Vietnam indicates that some female choose to migrate to escape from situations of domestic violence and other abuses.

Many factors contribute to HIV vulnerability of migrant workers that arise from the inability to exercise economic, social, civil, political and cultural rights in their home countries. Some include the structural causes of inappropriate development and the socio-cultural subordination of the female population. Promotion of the human rights of migrant workers to reduce HIV vulnerability is also to consider the structural causes. Some structural problems relate to a particular country whilst others are of regional and global concern.

E. Human rights violations during transit

At the important transit stage the rights of migrant workers are often violated by recruiting agents and other intermediaries, that places the health and lives of the migrant workers into jeopardy. Extremely poor living conditions, threat of abuse, limited sanitation, and denial of access to medical care, faced female migrant workers housed in overcrowded houses for long periods of time, up to one year; during their transit is an example of increased HIV vulnerability.

Working conditions were also poor during the period waiting for overseas employment opportunities. Mobility was also restricted. This practice of restricting potential migrant workers to long periods of stay in hostels also occurs in Cambodia. Such situations can increase HIV vulnerability of migrant workers through exposure to rape and sexual violence, adversely affecting general health and compromising of immune systems.

Undocumented migrant workers, particularly female, who are without legal identities, are more vulnerable to abuse by recruiting agents, and enforcement and border officials. Often the migrant workers undertake dangerous journeys and live precariously in forests and other places without sustenance or access to medical care that intensifies their health risks. When additional risks occur such as the trafficking of sex workers, forced labour, rape and sexual abuse, the threat of HIV infection is even greater.

Examination of occurrences at the transit stage indicates that most human rights violations that contribute to an increased HIV vulnerability arise from irregular migration and other irregularities in the migration process. Some occurrences such as prolonged stays in agency houses may be rectified with effective political and bureaucratic will. Violation of their rights to information, freedom of movement, protection of the law, and health care services increase the vulnerability to HIV infection of migrant workers.

CARAM, Philippines and Viet Nam, 1999.
As experienced by: Solidaritas Perempuan, UCM-CIMW and Yayasan Panca Karsa NGOs, Indonesia and Tenaganita NGO, Kuala Lumpur.
A Modern Form of Slavery - Trafficking of Burmese (Myanmar) Female and Girls into Brothels in Thailand, in Asia Watch, 1993.
F. Human rights violations in destination countries

Although the violation of human rights that impact negatively on health and increase the risk of contracting the HIV infection is ever present in the home countries, most violations to the human rights of migrant workers occur in destination countries. Undocumented migrant workers are often faced with more severe violations of their rights.

1. Mandatory HIV testing, notification and deportation relating to migrant workers

Most host countries in the Far East, Middle East, and South East Asia require that potential migrant workers undergo mandatory testing for HIV and other infectious diseases. In addition to the discriminatory nature of the mandatory testing it is often undertaken in an insensitive and irresponsible manner. Although the Government of Bangladesh signed a strategic plan in 1997, that condemned mandatory HIV testing, emigrating workers are still required to undergo testing prior to departure.

Research by CARAM of migrant workers from Bangladesh in Malaysia identified the following:

- Pre-departure medical tests were completed by 83 per cent.
- Forty-eight (65.8%) were aware that they were undertaking HIV testing.
- Of the 48, only 3 who knew that they had been tested for HIV received pre- and post-test counselling for HIV.

Malaysian law requires migrant workers to undertake medical testing for hepatitis, HIV, AIDS, tuberculosis, and STIs after arrival. Periodic tests are required for renewal of work permits. CARAM research also identified the following:

- Ninety of the 148 arrivals from Bangladesh were aware that they had been tested for HIV/AIDS after arrival.
- Seven, of approximately 90, stated that they had received pre- and post-test counselling.

A similar situation was found in the Philippines. Many migrant workers from the Philippines are unaware that they are tested for HIV. Subsequent pre- and post-test counselling requires extensive improvement. Sending and host countries may pay little attention to pre-test counselling for HIV/AIDS tests that are mandatory before departure and on arrival for migrant workers. In addition, the methods by which these tests are conducted often breach the universally recognized principles and procedures for HIV testing.

Mandatory testing of migrant workers for HIV raises several concerns. The first concern relates to the rights of the migrant workers. Secondly, the use of mandatory HIV testing for migrant workers as a strategy to manage the HIV epidemic is questionable. In assessing the logic and ethics of mandatory HIV testing of migrant workers as a strategy to manage the HIV epidemic it is necessary to examine aspects of notification and deportation of those who test positive.

(a) Notification and deportation

In most of the host countries, mandatory testing of migrant workers for HIV operates in parallel with notification and deportation. In Malaysia, the privatized consortium of Fomema (Foreign Workers Medical Examination Monitoring Agency), conducts the mandatory medical examination prior to the renewal of work permits. This agency is directly connected to the Ministry of Health and the Department of Immigration. Results of medical examinations are immediately transmitted to them. If, the migrant worker tests positive for any one of the many infectious diseases identified by the government including HIV, deportation immediately occurs.

Prevention and Control of Infectious Diseases Act requires notification of the presence of an infectious disease. The Immigration Act 159 of 1963 controls the deportation of migrant workers with HIV and requires a medical examination when necessary. In 1998, several media reports referred to the deportation of migrant workers from the United Arab Emirates, Saudi Arabia, Singapore, and Malaysia for testing positive for HIV.

What are the effects of mandatory HIV testing and deportation for migrant workers and for the management of HIV infection as public health and developmental concerns?

For the migrant worker, mandatory HIV testing and deportation creates severe effects particularly by the manner in which tests are conducted. An HIV positive result effectively means the loss of a livelihood. This loss to those forced from their lands and country by poverty and entering into considerable debt is enormous. In the event of testing positive, but not being informed correctly, the human and financial suffering on themselves and their families when they return home has severe repercussions.

The infringement of the human rights of migrant workers and the associated aspects of mandatory testing and deportation include:

- Mandatory HIV testing of migrant workers is discriminatory, as an HIV status does not preclude the capability to function at various levels. Such tests restrict the right to travel and when used in conjunction with deportation it denies the right to work.
- Selection of migrant workers as a category for mandatory testing appears to arise from their marginalized status as other expatriate workers are excluded from testing. Inconsistency of selecting migrant workers for mandatory HIV testing is based on the perception that they are transmitters of the HIV virus, when all persons are at risk. With the exception of Singapore, most host countries require only migrant workers to undergo mandatory HIV testing.
- Conduct of mandatory HIV testing of migrant workers without their knowledge and not providing pre- and post-test counselling violates the right to information, privacy and confidentiality.
- When a migrant is deported following an HIV test in the host country based on a false positive result then discrimination becomes more severe.
- The significance of HIV testing as an epidemiological tool or as a necessary medical intervention for treatment is not challenged. However, a focus on migrant workers for the conduct of mandatory HIV testing that subsequently restricts employment is an unfair practice and is not an effective way of managing the HIV epidemic.
- Testing is also unfair to host populations as it places the responsibility for handling the HIV epidemic on the migrant worker. Research and actions undertaken with migrant workers indicate that migration places them at risk of acquiring HIV. A false sense of security also occurs in the local population of the host country who consider that they are free of HIV when mandatory testing and deportation of migrant workers is undertaken.


CARAM News, no. 5

Tenaganita report, relating to a national of Bangladesh.
Protecting Human Rights

- The social responsibility of governments, companies, and other such institutions that test migrant workers for HIV and deport them is also questioned. Many migrant workers enter the host country with a clean bill of health but subsequently became HIV positive. It is noted that the window period and forged medical certificates may be misleading at the time of entry. It is noted that detection in post arrival medical tests is possible. Also, a possibility exists that a person was not infected after entering the host country.

- Currently, host countries that impose pre-employment medical tests to only employ healthy workers contribute to the imbalance of regional health. When health standards are controlled by a right to employ healthy persons for continued productivity, the responsibility to ensure continued health during employment and to provide for medical care and treatment is apparent. The responsibility is therefore to develop supportive and protective mechanisms to ensure that the migrant worker departs as healthy as on arrival.

(b) Consent

In Malaysia, migrant workers are required to sign a consent form before undergoing medical tests for the renewal of work permits. The form requires that the worker sign away the right to privacy, confidentiality, and possibly the right to employment and freedom from discrimination when testing HIV positive. Several aspects of this procedure are questionable. Was a choice offered? Were the consequences of providing consent for the mandatory tests and potential deportation fully understood and realised, and was a choice possible? When faced with the requirements of testing and the ensuing consequences the migrant worker faces considerable losses.

Mandatory HIV testing and deportation violate the rights of migrant workers. These include the rights to equality and non-discrimination, health, social security, work and freedom of movement. Such tests isolate the workers and limit their participation in combating the AIDS epidemic. The isolation and non-participation of those who are at a greater risk of becoming HIV infected due to reasons beyond their control will silently increase the infection rates and also threaten public health.

In the broad perspective such matters also relate to the health rights of poorer and less developed countries when measured with the affluent partners in the international labour market.

2. Access to medical care and services

Control of the HIV pandemic is expected to be achieved through preventive efforts. Support to these efforts will occur when the health of migrant workers is promoted. This includes their increased control over health outcomes, prevention of disease and access to treatment. Access to health care significantly contributes to reducing their vulnerability to HIV infection.

In 1999, CARAM, Bangladesh, conducted a quantitative and behavioural research survey of returning migrant workers. This survey indicated that in parallel with situations of high-risk arising from anonymity in a host country, the absence of effective health information and services increased HIV and STI vulnerability. It is noted that the right to health care is not often considered as a right for migrant workers in host countries. Often migrant workers are portrayed as depleting the resources of a host country by accessing the health care system. As a consequence policies and procedures are adopted to restrict their access to medical care and treatment. For undocumented migrant workers the fear of arrest effectively restricts their use of hospitals. When migrant workers are unable to access effective health care, their HIV vulnerability is directly or indirectly affected.

Arif, M. T. Dr., Why Foreign Workers are Later Found to be Sick, in New Straits Times, September 12, 1999.
(a) Costs and health financing

In Malaysia all foreigners are required to pay first-class fees although they are only entitled to third-class levels of treatment. This has a significant impact on migrant workers and a limited impact on expatriate professionals who enjoy other medical benefits. In addition the restricting of migrant workers in the use of public health care services resulting from immediate cost considerations have other implications.

- Payment of first-class medical fees for third-class medical facilities is inequitable.
- If migrant workers are a burden on a health care system and not entitled to subsidised medical care, then an unfair health financing policy for migrant workers exists. It is noted that often the migrant worker falls within the highest tax bracket of a country. On average, migrant workers in all sectors except for those working in the domestic sector pay an annual levy of a minimum of M$ 1,000. On this basis, subsidised health care should be a right of the migrant worker who is contributing to national growth and productivity and paying higher taxes than most nationals.

A Foreign Workers Compensation Scheme exists that migrant workers are required to contribute towards. This scheme only covers treatment for accidents and work-related injuries but excludes invalidity pensions for work-related disabilities.

There are a number of systems that include health care for migrant workers. In some instances the employer fully covers the worker, in other cases the cover is partial. Some companies have panel clinics and doctors to treat workers including migrant workers. In most cases migrant workers are required to bear the cost of diagnostic and surgical procedures that constitute the major components of health expenditure in major illnesses or accidents.

Case handling by Tenaganita of migrant workers revealed that although employers advance medical fees to migrant workers at the start of treatment, in most cases this is deducted from subsequent wages. This practice deters access to medical attention and may lead to self-medication, as reported by workers from Bangladesh and Indonesia.

(b) Access to health information

Most host countries do not include migrant workers in national health and HIV information campaigns. Such information is not considered as a right of migrant workers. Consequently, health information in the language of the migrant worker is not made available. Although migrant workers were included in the national AIDS action plan of Malaysia in 1996, migrant workers have yet to receive information relating to HIV and STIs in their respective languages during post-arrival orientation programmes or education programmes at the place of work.

(c) Health care workers

Research by CARAM, Malaysia, with migrant workers from Indonesia indicated that a deterrent to use of public hospitals is the presence of discrimination. In general, they preferred to use private medical facilities where they received equal consideration.

Language abilities also inhibit the accessing of health care. This also impacts on the quality of medical attention received that may have significant repercussions when the problem is serious. In one instance, Tenaganita reported that a migrant worker from Bangladesh lost sight in one eye as the doctors advising surgery misunderstood the worker’s request to proceed with the surgery.

(d) Restrictive policies related to health care

Although a provision for medical care may exist, access by migrant workers is limited due to
restrictive policies and practices. Tenaganita reports indicate that although a company may provide doctors or panel clinics other deterrents to access exist. For example, notification to the state of infectious diseases and deportation of those suffering from an infectious disease as listed in the Prevention and Control of Infectious Diseases Act, deters migrant workers from using panel and company doctors for STIs many of which are easily treatable. During outreach sessions, Tenaganita received requests for alternate STI care facilities, as migrant workers do not wish to access official facilities and lose their jobs.

In several instances employers have directly restricted access to medical care by migrant workers.

Within the context of health care rights of the migrant worker other aspects require examination.

- Health rights of migrant workers in the host country by the home country government.
- Deportation of migrant workers for easily treatable STIs.
- Denial of the right to medical treatment and the right to employment.
- Provision of health information and services to migrant workers by employers and governments, particularly when the right to hire a healthy worker free of infection exists
- Equal and dignified medical treatment and health care of migrant workers.

3. Labour rights violations and HIV vulnerability

Working and living conditions of migrant workers impact on HIV vulnerability by compromising their health and pre-disposing them to contracting infections. This occurs when long hours are worked with little or no rest, exposure to unsafe working conditions, poor sanitation and nutrition, and the withholding, underpayment or illegal wage deductions that impact on disposable incomes and consumption patterns.

4. Single entry policy

Most host countries require that migrant workers enter the country without spouses and partners. This policy reflects the perception that migrant workers are economic tools without social identities, and psychological and sexual needs. Human needs include warmth, belonging, and physical intimacy. Without the presence of partners or spouses migrant workers find other ways of meeting these needs. Research by CARAM, Malaysia with migrant workers from Bangladesh indicated that relationships were formed with local and other migrant females from Indonesia and the Philippines. Also they are exposed to sex workers. Due to personal, political and the legal aspects of host countries considerable risk in contracting HIV infections occurs. A single entry policy that denies the migrant worker the right to be accompanied by a spouse or partner also increases the prevalence of HIV.

5. Right to marry

In close relationship to the single entry policy is the right to marry. In 1996, subsequent to media comments relating to male migrant workers who married nationals, migrant workers were prohibited from marrying nationals and face deportation when it occurs. Although local Malaysians considered this to be a form of discrimination as it denied them the right to choose their life partner, for the migrant worker it has suppressed his human right to marry, raise a family and meet normal human psychosocial and physical needs.

Both the single entry restriction and the right to marry violate the rights of migrant workers. This also increases HIV vulnerability when migrant workers select unsafe means of pursuing relationships.

6. Detention camps and health

In Taiwan detention camps, the physical needs of detainees are adequately addressed and access to people and external support is freely available. However, in most of the other regional
detention camps migrant detainees face poor nutrition and sanitation, and minimal medical attention. Rape, sexual and physical abuse of female migrant workers is common. Such violations may cause direct infection with HIV and severely compromise the health of detainees and increase vulnerability to infection.

A memorandum prepared by Tenaganita relating to detention camps in Malaysia indicated that considerable suffering by migrant workers and violation of rights was avoidable if a coherent and comprehensive policy on migration had been in place. Also, suitable bilateral agreements between sending and host countries and the strict enforcement of laws and policies on errant employers and fraudulent recruitment agents would have alleviated many problems.¹³

Violations of the rights of the migrant worker happen simultaneously. The violation of the right to life, health, adequate standards of living, and medical treatment have the potential to impact on HIV vulnerability. Of particular concern are the moral and legal obligations of a state to protect and promote the rights of all people inclusive of guest workers. Action programmes to reduce this vulnerability need to recognize such factors. Most human rights violations of migrant workers occur in host countries and are violated in more than one situation. Violators of these rights include both states and employers. Action programmes developed in host countries are required to recognize these aspects.

G. Human rights violations on return to the home country

1. HIV positive workers

A migrant worker who is HIV positive on return home often means further erosion of human rights. One example is cited of an occurrence in the early 1990s when two HIV positive migrant workers returned home to Bangladesh from the Middle East. Initially, they were isolated in a hospital and then hounded by the media. Their photographs were printed in the newspapers as patient confidentiality had been breached by the hospital. An extract of a document that referred to migrant workers returning home to Bangladesh states: “Due to phobia and negative attitude towards HIV/AIDS in Bangladesh these returned migrant workers hardly identify themselves as positive because until now people with HIV are kept in the Infectious Diseases Hospital in Mohakhali, Dhaka, Bangladesh, which is like a jail.”¹⁴

Experiences gained in coping with HIV/AIDS have shown that the fight against AIDS is to include all members of society. Forcing people to go underground or go into hiding because of policies and practices that are not supportive or sympathetic does not assist in resolving the HIV crisis. Until returning migrant workers are protected and are able to enjoy their right to privacy, information, and access to appropriate health care it is not possible to protect the societies they belong to from the AIDS pandemic.

H. Human rights and HIV vulnerability of female migrant workers

The violation of the rights of female migrant workers is of serious concern. Although some aspects have been noted earlier, the unique vulnerabilities of females are now examined.

An increasing number of female migrant workers are directly related to their increased poverty and marginalization.¹⁵ Being dispossessed of land and other means of production at home, and left with minimal formal skills to participate in economic activities, they are only able to offer their energies that are increasingly being used in the domestic-work sector. As domestic work is

¹³ Memorandum on Abuse, Torture and Dehumanized Treatment of Migrant Workers in Detention Camps in Malaysia, Tenaganita, 1995.
in the informal sector with limited or non-existent protective mechanisms, their vulnerability to abuse, ill health, and infections including HIV is increased.

Rape and other physical violations also increase their vulnerability to HIV infection. In Malaysia, female migrant workers from Indonesia reported that they entered into sexual relationships with an Indonesian man to protect against rape by fellow Indonesians in the kongis (communities) where they live. NGO groups such as Solidaritas Perempuan have reported an increase in the occurrences of rape of female migrant workers from Indonesia, particularly in the Middle East. Female migrant workers from Bangladesh working in Malaysia report that they do not go out during free time or weekends, as they fear harassment by local men. Rape by employers is another violation of the human rights of female migrant workers. Not only are freedoms and mobility restricted but STIs and HIV infection risks are significantly increased.

Female migrant workers lack the capacity to make decisions in sexual relationships or negotiate for safe sex in the relationships they enter into in host countries. This also occurs in the home country on their return to their spouses and partners who may have indulged in unsafe sexual practices during the absence of the spouse. The lack of decision-making power violates the rights to be free from disease and infection and enjoy a healthy life. These factors also directly impact on their predisposition to HIV.

Control of the female body and reproductive rights is affected further when social and legal sanctions are subject to other influences. Examples of such influences are seen in government policies and business practices in host countries that prohibit female migrant workers from becoming pregnant during employment. The intention of these practices could be to prevent social integration of migrant workers in the host country, or avoid reduction in economic productivity. In addition, when female migrant workers become pregnant overseas, they undergo numerous legal constraints to obtain an identity for the child either from the home or host country. Laws in the Philippines tend to be more progressive in this regard. Case handling of female migrant workers by Tenaganita in Malaysia and Solidaritas Perempuan in Indonesia indicate that this is a major problem for female migrant workers from Bangladesh and Indonesia.

Additionally, the practice in some countries, Bangladesh and Pakistan in particular, of female migrant workers needing to obtain written permission of a male guardian, father or husband prior to migration offer another example of the socially and legally sanctioned control by males over females during the process of migration.

Human rights violations of female migrant workers that increases their HIV vulnerability is extremely serious as, biologically the female is more vulnerable to HIV infection than males. Therefore, the loss of control on their bodies and violation of biological and social rights places them at a direct risk of contracting HIV. Subsequent political and economic isolation arising from violations to work and economic rights or lack of access to redress significantly increases their vulnerability.

To reduce the special vulnerability of females to HIV several aspects require simultaneous attention. Violations to health rights are to be examined within the context of violations to the rights of freedom from discrimination and equality, control on the body, bodily integrity, information, mobility, employment, labour and to bear children. It is vitally important to recognise the impacts on the role and position of the female in society that infringe on her capacities to make decisions involving her life. Until this is achieved females will not be free from HIV and STIs. To reduce HIV vulnerability in females, the provision, and improvement of access to education and other services is to be accompanied, and is directly intertwined, with actions to increase their empowerment.

Violations to the human rights of migrant workers that increase their vulnerability to HIV have been examined. Further examination of these situations show that the close contacts of migrant workers inclusive of immediate family members, sexual partners, and others also risk of HIV infection. Therefore, the violations to human rights of migrant workers affect others that in turn multiply the opportunity for increased rates of HIV transmission.
It is necessary to protect the human rights of migrant workers to reduce their personal vulnerability to HIV and of the societies in which they live. Significant inter-related factors also arise and include:

- **Human rights of migrant workers are indivisible, inter-related, and inter-dependent for the development of effective action programmes to reduce HIV vulnerability.**

- **Most violations to the human rights of migrant workers occur in the host countries.** Action programmes need to recognise this. Actions to increase the empowerment of the migrant worker against HIV need to consider the lack of capacity of the migrant worker to control life in the host country. Increased effort is required to increase their human rights protection and promotion in host countries. Host countries in the region therefore have a considerable responsibility to control the HIV pandemic by protecting the rights of their guest workers.

- **In general, there is an absence of the recognition of health as a right. This is apparent in the current health policies, especially those relating to HIV/AIDS.** It is a contributing factor to why the prevention of HIV/AIDS has not received the priority and urgency that it requires. This aspect is not solely confined to governments and business entities but includes those working on behalf of migrant workers who still remain to be convinced that health rights are indivisible from all other economic rights of the migrant worker. A change of perspective is required to develop an effective and all embracing strategy to combat AIDS.

### I. Protecting and promoting human rights to reduce HIV vulnerability in migrant workers

Comments made earlier illustrate the need for changes to be made to perspectives and the tools and mechanisms used to manage and control the numerous constraints and restrictions that currently prevail.

1. **Recognition of the migrant worker as a human being and entitled to all human rights**

Action programmes are expected to fully recognise that migrant workers are human beings and are entitled to all human rights at all times. Currently, sending and host countries only acknowledge the economic identity of the migrant worker. For the development of effective action programmes these rights are to be fully recognised despite the unequal distribution of economic power of the sending and host countries.

Resource constrained sending countries are usually only concerned with programmes that increase the economic skills of outgoing workers to satisfy a labour demand from an affluent host country. Little attention is paid to increasing the other capacities of the migrant worker to include AIDS protection to enhance dignity and human rights.

At times the non-recognition of certain fundamental rights and liberties of people is justified by the application of Asian values and human rights as being contrary to Western values. Values influence concepts and definitions of rights, and may be relative, especially in a multi-cultural context. Pluralism also increases respect and understanding of the universality of human rights. It is noted that minimal emphasis is usually placed on the responsibility of states to fulfil individual human rights.

The promotion of human rights within vulnerable and weaker groups in society relates to

receiving the basic socio-economic foundations available to every society. A significant need exists to re-focus development goals from just increases in gross national product to increases in equitable distributions of income and wealth. Wide differentials in the socio-economic prosperity of a society increase the threat of an uncontrolled spread of the HIV pandemic.

2. Role of host countries

Host countries have a considerable responsibility to protect and promote human rights of migrant workers and protecting them from HIV infection. A regional responsibility also exists to control the spread of HIV.

Host countries are obligated to undertake measures to reduce HIV/AIDS occurrences in the region. Currently, the contribution of the migrant labour force to the economic development of a country is not acknowledged. Invariably it has been low-cost labour that has contributed significantly to host country development. Although host countries rapidly acknowledge the role of foreign investment in economic development little mention is made to the positive contributions of migrant workers. Often, migrant workers are portrayed as a necessary evil of the development process. This aspect should claim the attention of many as this perspective diminishes the contributions of the migrant worker. Therefore, the immense responsibility and accountability of host countries is to protect and fulfil the human rights of migrant workers. Host countries are also expected to act responsibly to reduce the regional spread of the HIV pandemic. Responsibilities also include maintaining and promoting the general health of the region by undertaking socially responsible development policies that concurrently increase economic gains and reduce social costs.

Sending countries are also responsible for undertaking measures to reduce the national and regional dimensions of the AIDS epidemic.

J. HIV and development

Considering the national and regional health threats posed by AIDS and activated by the current development strategies it is necessary to seriously consider the strategies being followed. Recent economic downturns have demonstrated that some development strategy options are not sustainable. The current AIDS pandemic requires an examination of the achievements of current development options and the outcomes when development strategies remain unchanged. Pursuit of people-centred development policies are expected to achieve economic gains that filter down to all levels of society, and social costs for effective management at national and regional levels.

K. HIV/AIDS: A regional responsibility

Prevention of HIV/AIDS is a regional responsibility. This responsibility is both individual and collective and is to be adopted collectively to create an effective response to the spread of HIV infections arising from the regional nature of the AIDS pandemic. Regional developmental strategies are also to encompass transnational labour migration.

L. Multilateral policies and mechanisms

Policies and mechanisms developed in the future need to be multilateral in scope. Collective actions to cope with the AIDS pandemic, removal of existing development constraints and inequalities, and economic differentials are required by both sending and host countries.

An examination of current inter-country agreements and Memoranda of Understanding that relate to migrant workers shows that the focus of the agreements is the regulation of migrant worker flows rather than protective conditions. This has arisen as a result of the differences in the negotiating strengths between the sending and the host countries. Sending countries tend to
limit their responsibility to negotiating increased quotas for labour exports rather than labour standards or guarantees.  

Bilateral agreements between host and sending countries require replacement by multilateral agreements based on principles rather than negotiating strengths. Development of multilateral policies will strengthen enforcement capabilities and accountability of participating governments.

As the status of the labour rights of migrant workers is a determining factor in HIV vulnerability, multilateral policies are required to incorporate protective labour mechanisms, and health safeguards to reduce the expansion of the AIDS pandemic.

Regional and multilateral policies are required to focus on:

(a) Labour protection

Labour protective mechanisms should provide for one standardized contract that includes provision for overtime pay, medical benefits for sickness and accidents, and housing. Provisions for the speedy legal redress and settlement of labour disputes should also be included. A need also exists to develop inter-country and regional mechanisms to bypass constraints of territorial jurisdiction for the prosecution of offences covering more than one country. This would apply to transnational recruitment violations. Migrant workers should also be free to exercise their labour rights. Sub-contracting, temporary, casual employment and trainee systems of employment to be prohibited as they increase job insecurity and vulnerability to various risks including health.

Rational legal frameworks of sending and host countries are required to avoid contradictions and protect the rights of the migrant worker. For example, in Malaysia, the Employment Act 1955 provides safeguards for the labour rights of foreign workers, however, statutes under the jurisdiction of the Immigration Department form barriers to foreign workers who seek legal redress.

Domestic workers are to be officially recognized as labour and included within employment statutes. This is expected to reduce the HIV vulnerability of female migrant workers by increasing their human rights protection.

(b) Mandatory HIV testing and deportation

Mandatory HIV testing and deportation of HIV positive migrants to cease as these procedures do not eliminate the problem and continuation has the potential to exacerbate the spread of HIV. Testing of migrant workers should only be undertaken to advance the health and interests of the worker. As a socially responsible public health measure testing is to be voluntary with informed consent when the testing is linked. Concurrent with the testing, pre- and post-test counselling is to be undertaken in accordance with an internationally recognized code of ethics. Support should also be provided to those who test HIV positive.

Multilateral policies relating to migration and HIV testing are required to strengthen the right to good health of migrant workers.

(c) Pre-departure programmes

Information is a right of migrant workers. Pre-departure programmes should provide information on migration, health, HIV, and STIs to workers before their departure. Details of laws, regulations, policies and culture of the host country

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should also be included. As this information often reaches the worker immediately before departure, dissemination through community based education actions is preferred to allow for increased understanding and informed decision-making.

(d) Access to health care

Health is a fundamental right of all human beings. Governments and employers of receiving countries are obligated to ensure that this right is protected and fulfilled. Regressive laws that restrict access to health care services either directly or indirectly are to be replaced by supportive laws and policies that increase health access and protection for the benefit of the workers and the societies in which they live.

(e) Single entry

The right of migrant workers to enter into relationships, to marry, and to raise a family is to be guaranteed. Policies that recognize human identities, and respect human needs and rights are required. Maintaining the rights of migrant workers will reflect the social responsibility of governments and businesses in host countries that do not attempt to maximize their economic gain at considerable human cost.

(f) Detention

Multilateral agreements are required to respond effectively to ensure the humane treatment of migrant workers who are legally detained. Agreements should encompass freedom from torture, rights to nutrition and medical attention and access to legal support. Recently, the increased migration of irregular and undocumented workers resulting from the economic downturn in the region has also increased the number of those detained. This situation requires a prompt and immediate response to the need for effective multilateral agreements governing legal detentions.

(g) Human rights education

Human rights education when integrated into community based action programmes is an effective means of increasing knowledge and understanding of such rights. Levels of sensitivity to human rights are also to be increased within those that govern and administer, the general population, and the less fortunate.

All governments are responsible for maintaining and fulfilling the rights of their populations. This becomes especially important as globalisation is rapidly eroding the control that people have over the decisions that impact on their life. Laws and policies that are currently threatening the lives and health of regional populations require revision and replacement to ensure the preservation of all human rights.

M. Empowerment

HIV vulnerability of migrant workers is expected to reduce as a result of undertaking the initiatives described earlier. However, a convergence of policies and practices is also required. In general, the initiatives suggested focus on the migrant worker at the individual level. Mention was also made of the need for adjustment of particular societal factors that affect HIV vulnerability to create an enabling environment. National and regional effort is required to reduce the pre-disposition of migrant workers to HIV by attending to factors of a structural nature. These include:

(a) Economic empowerment
Approaches to development that improve the distribution of national and regional economic growth will enhance individual prosperity and opportunities.

(b) Socio-political empowerment

A victory against AIDS may only be achieved through community effort. Action programmes within communities requires additional strengthening. This relies heavily on the levels of democratic participation in AIDS prevention and reduction. Economic, social and political rights are of equal importance and when they remain to be respected and fulfilled, the gains achieved in development will be undermined by the AIDS epidemic.

Strengthening of community actions necessitates a participatory approach that respects the experiences and wisdom of those affected or living with HIV. The perspective of the migrant worker also needs to be incorporated into the development of solutions that reduce cross-border migration and HIV vulnerability.

(c) Legal empowerment

A re-structuring and re-orientation of legal frameworks that will respect, protect, and fulfil human rights is required. These frameworks should protect and prevent migrant workers and those close to them from HIV/AIDS, and increase their access to treatment and care. Development of supportive legal environments is required at national, regional and international levels.

Special attention is also required to the potential misuse and abuse of official privileges of persons in authority and others to ensure that the fundamental dignities and human rights of all are preserved and upheld.

N. Conclusions

Protection and promotion of the rights of migrant workers effectively reduces the HIV vulnerability of the individual and the societies in which they live. Crucial elements are:

- An enabling national and regional environment to develop a protective mechanism that includes migrant workers. This requires regional cooperation and action, with the main responsibility being with host countries, as cross-border migration invariably requires their initiation. Generally, their economic capacities are also greater for the building of a supportive environment. Support from sending countries is also required to reduce and respond effectively to the HIV pandemic.

- The co-operative and collective nature of the action programmes requires implementation at the local level to increase community participation and the involvement of migrant workers to protect against health and HIV infection risks.

- The empowerment of migrant workers is a pre-requisite and also an end result of strategies that reduce their HIV vulnerability by protecting and promoting their human rights.
A wide variety of action programmes targeted towards mobile populations have been undertaken. However, only a limited range of knowledge has been disseminated on effective and appropriate approaches. The Co-ordination of Action Research on AIDS and Mobility, Asia (CARAM) has developed a specific strategy to work with mobile populations. Through research CARAM has attempted to incorporate the perspective of the migrant worker into advocacy and action programmes.

To create an improved understanding of the impacts of the activities of CARAM, a model for the evaluation of HIV/AIDS programmes was developed. Various outputs of education, basic social services, and advocacy work were recognised. The basic concepts of vulnerability, risk, human rights, and gender were respected. In conclusion, the dimensions of time and place for programmes were recognised as being critical entry points and included pre-departure, migration, adaptation, and return home.

The dimensions and concepts were linked to the time and place dimensions by a framework linking pre-departure programmes, education, host country services for migrants and programmes for those returning home. The evaluation model presented is expected to achieve improved multi-level co-ordination for effective action programmes related to the needs of mobile populations as they relate to STIs/HIV/AIDS.

A. Introduction

A relationship exists between population mobility and the spread of disease including HIV/AIDS in various parts of the world. Population mobility associated with increased risk of infection by HIV and other sexually transmitted infections (STIs) involves movement between areas of low and high economic potential. Additionally, the spread of HIV and STIs through population mobility is the result of high-risk patterns of sexual contact by this population and their partners at various points during travel such as in home communities, at transit points and at the destination.

Some research on population mobility and the associated risks of HIV/AIDS has been undertaken but the impact of action programmes for prevention and care has not been evaluated. It is considered premature to reach conclusions and recommendations until

* CARAM, Asia

comparative analyses are completed and the strengths and weaknesses of the various programmes identified. It is noted, however, that several unevaluated approaches to action programmes are advocated by various governmental and non-governmental organizations.

Presentations at two recent World AIDS Conferences held in Vancouver in 1996, and in Geneva in 1998, highlighted an absence of a comprehensive understanding of mobility, the various groups involved and the relationships between them. Commercial sex workers are often studied with respect to mobility. Also, long-distance truck drivers have been studied, and, rarely, military personnel. Migrants are also studied, but are usually confined to one-country studies and projects from a receiving country perspective such as in Europe and the United States of America. Other studies have been completed at the in-country level such as China and South Africa. Multiple-country and multiple-level mobility studies have been rarely undertaken.

### B. Methodology of CARAM

The Coordination of Action Research on AIDS and Migration (CARAM) is a partnership of seven non-governmental organizations (NGOs) from seven countries Bangladesh, Cambodia, Indonesia, Malaysia, the Philippines, Thailand, and Viet Nam. CARAM is undertaking a regional action research programme on mobility and AIDS.

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<th>The objectives of CARAM are:</th>
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<tr>
<td>➢ To advocate the improvement of the living conditions for migrants and demonstrate how this will reduce HIV vulnerability at national and regional levels.</td>
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<td>➢ To develop grass roots health and education action programmes relating to HIV/AIDS/STIs and improve access to medical facilities for migrant populations.</td>
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<td>➢ To protect the human rights of migrants at the various levels.</td>
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<tr>
<td>➢ To develop action research models and collect data to support and develop the intended objectives of CARAM.</td>
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The CARAM network exchanges information on research, action programmes, and advocacy through its regular newsletter, CARAM News. In addition, the Coordination Centre in Malaysia organizes an annual workshop for CARAM partners. Reports of related congress and research results of projects are published. Satellite symposia, booths, and publicity at international conferences, such as at the World AIDS Conference and the International Congress on AIDS in Asia and the Pacific are also on-going activities. An Internet Web site is also in place.

During a series of workshops research methodologies were developed with a focus on the perspective of migrants, to recognise their realities and comprehend the inter-relationships in the HIV epidemics of Asia. This research is participatory and integrated at various levels including priority setting, research aims, and analysis for the eventual implementation of action programmes. Participation is by migrants, grass-root organizations, local health-care workers, and local leaders. Research is action-oriented and is designed to result in action

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programmes that are subsequently tested within the framework of the research. This approach is cyclical in nature: problem identification, thence to data collection and analysis, potential solutions, data collection of action programme impacts and to further analysis ad continuum. Quantitative and qualitative high-quality scientific research methodology is used. This implies a high-capacity research programme for delivery of effective results, information, material, and knowledge to enhance the objectives of CARAM.

Combined efforts of the countries involved have resulted in the following action programmes:

- Pre-departure programmes for potential migrants to assist in their understanding of the prevailing conditions of the host country, and to educate on sexuality and sexual health, with particular reference to HIV/AIDS.

- Follow-up in host countries:
  - Appropriate health education in the language of the migrants to suit daily realities.
  - Access to health-care facilities particularly STI services in an affordable, and culturally and socially significant manner.

- Re-entry programmes for returning and repatriated migrants.

Teneganita has conducted action programmes in South East Asia for nationals of Bangladesh, Indonesia, and the Philippines in Malaysia. Other programmes in cooperation with the CARAM branch in Cambodia have been conducted for rural populations transiting to Phnom Penh, Cambodia, for work in Malaysia. Experiences and knowledge gained from these programmes are expected to be applicable to other mobile populations, however, other situations are expected to have characteristics of a unique nature that require specific features and focus.

Participation by migrants in identifying problems and the collection of the required information for analysis significantly contributes to effectiveness of subsequent action programmes.

Effective field research relating to HIV/AIDS inclusive of sexual behaviour patterns and preferences and unseen discrimination requires the maximum possible cooperation from those involved. Those who feel stigmatised and discriminated against are unlikely to willingly share information with outsiders. Improved research is achieved when those concerned are fully involved and understand the importance to them. An example of this participatory research activity is the programme conducted by CARAM and Teneganita in Malaysia.

In this programme the following steps were undertaken:

1. **Site visits by outreach workers**

   Sites where migrants live and work are visited. The migrants introduce contacts. Effective outreach activities require these contact points. For migrant groups resident for long periods organizations such as temples and churches are often useful starting points for dialogue. Important differences may exist between settled and new migrants, and temples and churches may only attract certain groups.

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7. Khus et al., 1998; Tep et al., 1998.
When organizations are not in place the work becomes more difficult. Language is also an important consideration. Obtaining the confidence of the worker often takes time, as many are suspicious of persons from outside of their group. This is particularly apparent with undocumented persons.

2. **Focus group discussions**

Outreach workers organize focus group discussions on HIV/AIDS and sexuality.

3. **Discussion sessions and follow-up**

Discussion sessions are taped and analysed using Focus Group Discussion methodology. Participation of migrants yields improved results. However, their participation is often difficult, due to requirements of work and relaxation needs. Results are presented to the migrant community to establish identity values.

4. **Research participation**

During the discussion sessions enthusiastic participants are identified and invited to participate in the research. This is a key element of the approach, although, sometimes it is difficult to identify participants unless they consider it to be in their interest. When outreach workers concentrate only on HIV/AIDS related matters attention is minimal as the problems of correct documents are often of a greater priority to the migrant.

5. **Participant training**

Selected participants are informed of the expectations of the programme and receive training. Training is simple and is focussed on attitudes and behaviour patterns. Social groups and regional differences not recognised by outsiders may be important influences. Cultural aspects are made explicit and attention given to HIV/AIDS as an interpretation of modernization.⁹ It is important to train on understanding their own prejudices with regard to females, sexuality, and HIV/AIDS.

6. **Questionnaires**

Short questionnaires of twenty direct questions were developed to collect additional quantitative baseline information.

7. **Feedback**

Feedback was collected to provide additional information for subsequent HIV/AIDS/STIs education programmes.

A complex aspect of this approach is the maintenance of good relationships with each migrant. This approach differs from conventional research approaches where data collectors drop into the community, acquire information, inform policy makers and donors, and disappear, never to return. Therefore, community participation and organization is crucial. Often this is difficult to do, as authorities and employers do not usually stimulate and encourage this activity. Undocumented migrants are invariably in a vulnerable and difficult position to organize themselves.

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After three years, the need to evaluate the various efforts became apparent. As guidelines for action programme evaluation were few CARAM developed its own.10 During development of the evaluation model various outputs of action programmes were recognized. These included education, basic social services, and advocacy. All relate to varying levels of empowerment: individual, community, and social. As mobility is dynamic there is a time and place dimension to programmes and some important concepts are involved when working with mobile populations.

C. Evaluation model concepts

In the symposium, Mobile Populations and HIV, at the 12th World AIDS Conference held in Geneva, 1998, three main concepts became apparent for the understanding of HIV/AIDS prevention and care programmes for mobile populations.

The three concepts of vulnerability, risk, and human rights are interlinked.11 Influences on action programmes by these concepts are detailed in section D.

1. Vulnerability

This is applicable to the migration conditions and concentrates on what the migrants share. Concern for vulnerability leads to community-based actions that impact on community empowerment.

2. Risk

This applies to individual behaviour and responsibility and actions will impact on individual empowerment. Concern for risk implies actions focused on health education and changes in behaviour patterns.

3. Human rights

Responsible action - acting correctly to prevent HIV/STD infection - requires that people have the rights to act responsibly. Therefore concern with human rights is essential. This concern implies advocacy and a focus on improving relevant policies, rules, and regulations that will impact on social empowerment.

D. Dimensions of HIV programmes and mobility

1. Vulnerability

Mobile populations are often marginalised that results in low self-esteem and short-term survival strategies. Most migrants travel without their sexual partners, and are at an age of high sexual needs and seek to satisfy the needs for companionship and sexual contact. In the home communities, cultural values and mechanisms of social control assist in maintaining patterns of sexual networking and behaviour that suit the boundaries of behaviour that are shaped by prevailing social norms. In a new environment, the effectiveness of these value systems and social norms may be attenuated. Structures of opportunity and constraint that affect their livelihood choices and possibilities may also differ considerably from those at home. Migrants in their new country are often unable to access information relating to STIs, HIV and sexuality in their own languages, and face difficulties in locating appropriate health-care facilities which places them at an increased risk of becoming infected. Many governments ignore these problems and often do not

respect the needs, sexuality, and identities of the migrant workers. In some instances, relationships between migrants and members of the local population are not permitted. Invariably migrant workers are seen only as a labour force to be returned home on completion of the work. These factors contribute towards an increased vulnerability to HIV infection.\textsuperscript{12}

A focus on the vulnerability of migrant workers leads to action programmes at the community level, such as the development of appropriate STI facilities, peer, and other group work to create awareness.

2. Risks of STIs and HIV

The situations of risk that migrant workers face are invariably related to economic forces and labour policies. Emergence and high incidence of STIs is closely linked to migration.\textsuperscript{13} In South Africa it was demonstrated that migration was an independent risk factor to acquiring HIV/AIDS.\textsuperscript{14} A community-based study showed that migration was associated to an age-adjusted 7.3-fold higher risk of HIV infection.\textsuperscript{15} Data collected during 1992 in the Philippines showed that 12 per cent of those infected with HIV became infected in other countries.\textsuperscript{16}

As increased opportunities of high-risk sexual contacts exist in mobile populations, individual choice becomes important. Education programmes specifically developed in suitable languages with cultural sensitivity assist in individual empowerment and choice of appropriate behaviour patterns. Such programmes, which include health education, create an awareness of unsafe sexual practices and their risks and encourage change in behaviour patterns.

3. Human rights

Closely related to vulnerability and risk are human rights. Considerable evidence suggests that human rights of migrants are not often respected. This is particularly evident with undocumented workers. Remedial action occurs within advocacy directed towards immigration and medical testing policies.

In many countries, HIV testing is mandatory for migrant workers. For some considerable time numerous authorities have viewed migrants as the carriers of HIV and this has resulted in epidemiological research of those crossing borders.\textsuperscript{17} These actions suit stereotypical ideas related to the appearance of HIV/AIDS in many countries. Placing the blame upon migrant workers for spreading HIV is an expression of these ideas. The idea that mobility in itself contributes to the dissemination of HIV infection is not considered as being productive, as it is unfriendly and does not address the real factors involved between HIV/AIDS and migration. Considerable documentation has been prepared that portrays people with HIV/AIDS as hostile outsiders.\textsuperscript{18} Mandatory testing of migrants interferes with human rights and many immigration policies are characterised by controls that serve narrowly defined national goals.\textsuperscript{19} Such systems provoke questions of ethics.\textsuperscript{20} Since the onset of the economic crisis in Asia during 1997, HIV testing has been a tool to repatriate

\textsuperscript{12} Haour-Knipe and Dubois-Arber, 1993.
\textsuperscript{13} Lewis et al., 1997, O’Keefe, 1997.
\textsuperscript{14} Jochelson et al., 1991, Colvin et al., 1995.
\textsuperscript{15} Jochelson et al., 1991.
\textsuperscript{16} CARAM, 1997.
\textsuperscript{17} Garrett, 1995.
\textsuperscript{18} Sontag, 1989; Baker, 1986; Sabatier, 1988; de Bruyn, 1994; Kitzinger and Miller, 1992; Mondragon et al., 1991.
\textsuperscript{19} Goodwin-Gill, 1996.
\textsuperscript{20} Sherr and Farsides, 1996.
migrants to relieve the pressure from national labour markets.\textsuperscript{21} Public health experts have understood these problems rapidly and have warned strongly against potential discrimination.\textsuperscript{22}

Prevention and care programmes for migrants are often closely linked to human rights. Limiting the focus to HIV/AIDS and STIs also limits the impact of such programmes. Vulnerability of migrants in the long-term may only be decreased when conditions for migrants are improved to reduce risk as an eventual outcome of the respect for human rights.

4. Gender

In addition to the three concepts mentioned earlier, other aspects are to be considered. Increasingly females are seeking work opportunities in the service production sectors, where wages are lower than those for males. In 1997, 60 per cent of the migrants from the Philippines were female. This trend is seen elsewhere leading some to suggest a feminisation of migration. In Bangladesh, where females have traditionally restricted freedoms and rights, female migration has become a survival strategy, with consequences for the dependency of females.\textsuperscript{23}

The services sector of domestic labour and the entertainment industry attracts many female migrants. Migration of entertainers has become a global phenomenon with a substantial section associated with commercial sex. Females from Cambodia, China, the Lao People's Democratic Republic, and Myanmar are provided to brothels in Thailand. In January of 1997, the Ministry of Public Health in Thailand estimated that approximately 16 per cent of the commercial sex workers in the country were non-Thai and that 90 per cent were from Myanmar. An estimate suggests that over 30,000 commercial sex workers are from Myanmar, of which 50 per cent are infected with HIV. In Cambodia it is estimated that 30 per cent of the commercial sex workers are from Viet Nam. Females are also taken as commercial sex workers to Europe and Japan from Thailand.\textsuperscript{24} In the Netherlands in excess of 50 per cent of the commercial sex workers arrive from outside of the European Union.

Many enter guest countries without correct documentation. The total number of female migrants working in the commercial sex industry is extremely difficult to assess. As most are without documents their vulnerability to the HIV infection is considerable. Specific programmes are needed to reduce risk levels and vulnerability and improve their human rights.

Increasingly, use of epidemiological categories such as commercial sex workers, is being challenged.\textsuperscript{25} Such categories may serve the public health sector; however, it is difficult to distinguish between females and behaviour patterns in various contexts. Females are often trapped in situations that do not enable to refuse sexual services, as migration payments to third parties, agents, travel expenses and bribes are high and takes considerable time to repay these debts. In addition, the recruiting agent has often paid a large advance to parents of young females. Often it is difficult to define the boundaries between voluntary migration and trafficking. Action programmes are required at various levels and locations. Observation, followed by early and effective action is required to respond to the trafficking of females.

\begin{itemize}
\item \textsuperscript{21} CARAM News, 1998.
\item \textsuperscript{22} Haour-Knipe, 1993: Acheson, 1990; Gostin et al., 1990.
\item \textsuperscript{23} Wolffers and Fernandez, 1999.
\item \textsuperscript{24} Lim, 1998.
\item \textsuperscript{25} Wolffers et al., 1999.
\end{itemize}
5. Targeting of prevention programmes to specific audiences

General statements regarding mobile populations inhibit the development of appropriate and effective programmes. The numerous characteristics of mobile populations impact on the vulnerability to STIs and HIV/AIDS. These populations are not isolated groups as they are related to those at home, to where they frequently return, and the inhabitants of the host country. Therefore, action programmes are to recognise spouses and partners in the home country and the potential partners in the new communities. It is necessary to consider the environment in which the migrants live and work as isolation from the host country context and their working environment, where they interact with the local population will influence the effectiveness of programmes. This is particularly relevant to relationships with other sexual partners and possible impacts on the community in general.

Most workers, whether rural-urban migrants within one country, or international migrants, arrive alone and live in economically disadvantaged areas or apartments close to industrial areas. These living areas are an important focus for attention. Often migrant workers from many countries, backgrounds, and reproductive age groups live in these communities, increasing their vulnerability to STIs and HIV. Developing action programmes requires full consideration of the variables, needs and requirements of the various groups within a mobile population.

E. Evaluation: A correct place and time

Significant differences occur in the levels of mobility within mobile populations. The mobility level influences possible community development and action programme planning. The greater the mobility the more complex it becomes to implement action programmes. It would seem that good opportunities exist for action programmes prior to the departure of potential migrants, locations of their work and living and on their return home.

1. Pre-departure

The pre-departure stage is characterised by push and pull factors. In some communities, migration is viewed as a potential survival strategy and a tradition. Within the social network, some people are seen as potential migrants or they feel responsible for their family. Some describe social pressure as the reason for migrating. Pressures also exist on daughters to migrate and support their families. In the Philippines migration has been accepted as a survival strategy since the last century. Action programmes at this stage need to be directed towards the whole community and involve the creation of awareness of the migration process and risks involved including STIs and HIV.

Pre-departure programmes are required to include reproductive health and HIV/AIDS information. Many currently operating pre-departure programmes lack the dissemination of this information. In the Philippines information relating to HIV/AIDS is not standard during the mandatory one-day pre-departure orientation programme. For those with signed contract the one-day programme provides information on airport procedures, government and non-governmental organizations (NGO) programmes and services and the realities of the receiving country. A short orientation on HIV/AIDS is required by law, however, implementing rules and regulations remain to be put in place.

2. Migration

This transient stage involves a period of travel, border crossing for international migration

and arrival. For cross-border migration the travel period may be long particularly for undocumented or illegal migration when travel offers many potential risks including sexual exploitation. On occasion migrants may remain for a considerable period at the border before moving to the next stage. The border crossing stay may be compared to a labour market where undocumented migrants become easy targets for unscrupulous recruiting agents. At the border between Myanmar and Thailand brothel-recruiting agents offer various opportunities to females who have been caught working illegally and have just been repatriated. For other migrant workers similar situations have been seen.

Many opportunities for action programme implementation exist. The important programmes are those that relate to the protection of human rights. For education programmes limited opportunities are available. Multi-language teams may develop educational programmes with logos and message reminders for the various groups. Pharmacists require training in STI management, as they may be requested to provide treatment.

3. Adaptation

This relates to the period when migrants begin to find their way in the new environment, developing new social networks, fulfilling their basic needs and identifying support mechanisms. During this period the migrants are highly vulnerable and when action programmes are most essential. These programmes become more effective when undertaken in combination with those focussed on spouses, girlfriends, and potential new partners. Programmes need to be directed towards several levels. This adaptation period may extend from a few months to several years and depends on education levels and variation in cultures between the home and host country. The adaptation process has impacts on HIV/AIDS care and prevention programmes.

In the work and living areas outreach activities, peer-steered programmes and drop-in health centres offer suitable entry points for action programmes. Community building and the protection and empowerment of females, including those in the commercial sex sector, is essential. Appropriate education relating to reproductive health is to be included and supported by family planning and counselling services, STI prevention and care, condom promotion and confidential HIV testing on request.

4. Successful adaptation

This period varies considerably from the initial adaptation process that occupies an indeterminate time frame, as this is dependent on the culture, education, and character of each individual and the variations between the home and host countries. This also depends on the generation and language skills and prevailing policies of the host country particularly when migrants are isolated. Often second generation migrants have greater needs in their adaptation to the new surroundings and may be confused by the needs of their parents’ culture and the dominant society with which they identify. This has consequences for their behaviour patterns and requires specific action programmes.

Although second and third generation young migrants in a host country may easily comprehend prevention messages, some existing cultural constraints may inhibit a free exchange of information and prevention material aimed at the general public may be rejected.

5. Return home

When migrants return home, they will need to re-integrate themselves into the community that they left. Often a place does not exist for the migrant worker or refugee. Also, they have undergone personal and cultural change. Their changed behaviour may lead to
certain risks that need to be addressed by specific actions.\textsuperscript{28}

Few programmes are targeted towards returning migrants. With the assistance of Shisuk and CARAM Bangladesh, the Welfare Association of Repatriated Bangladeshi Employees (WARBE) was formed to protect the rights of returned migrant workers. A planned activity is the possibility to discuss sexuality, STIs, and HIV/AIDS with returning migrants and their sexual partners. This is particularly important as the general population view the HIV epidemic as being brought by returning migrants. The lifestyles of migrants have also developed in directions that are dissimilar to those who remained at home that potentially creates misunderstanding. Specific needs of returning female workers have been researched and these needs are also to be addressed by appropriate action programmes.\textsuperscript{29}

\textbf{F. Framework}

From experiences with action programmes for mobile populations it is viewed as necessary to identify the exact entry points for HIV prevention and action programmes. A framework has been devised to assist in this task. The three concepts described earlier form the focus for activity. These focal points are related to the time and place when the action may be implemented. A framework assists in placing the relationships within mobility and the three main concepts. It suggests further the form of the appropriate action programmes at particular times and locations.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
\textbf{Location} & \textbf{Vulnerability} & \textbf{Personal Risk} & \textbf{Human Rights} \\
\hline
Pre-departure & Community-based interventions & Individually directed & Advocacy and action programmes \\
 & Awareness project for young people in areas with high migration & Education on health, STIs/HIV for departing migrants & Lobbying of policy makers for protection from exploitation by agents and third-parties \\
Transit & - & Education and condom promotion at temporary stops & - \\
First period & 1. Awareness projects & Health and STI/HIV education in own language and culturally sensitive & Lobbying for human rights recognition in host country Networking with local labour unions \\
 & 2. Development of appropriate health and STI services & & \\
Later period & Awareness of identity and sexuality & Culturally-sensitive educational material & Requesting special attention to problems of second generation migrants \\
Return home & Community work to support re-entry & Education of friends and families on HIV/AIDS and mobility & Influencing media with appropriate reporting of returning migrants and HIV/AIDS \\
\hline
\end{tabular}
\caption{Framework}
\end{table}

\textbf{G. Conclusions}

Experiences gained during the development of the evaluation model provide specific recommendations for future HIV/STIs prevention in mobile populations.

- Patterns in population mobility that are often associated with an increased risk of HIV infection are often activated by a perceived notion of improved economic opportunity. War and social disruption are other activators to population

\textsuperscript{28} Wolffers and Fernandez, 1999.
\textsuperscript{29} Wolffers and Fernandez, 1999.
movement. One action programme is not expected to address all the identified needs. However, policy makers, donors, and programme developers require to be constantly aware of the social changes occurring and the national and community implications. It is also essential that increased attention be given to creating improved balances between complementary programmes that address individuals, communities, and broader areas in addition to advocacy.

- The relationships between specific types of mobility and the associated social settings and situations of HIV risk require additional study and understanding. New studies that build on previous work with a focus on identified gaps and constraints in relationships between population mobility and the HIV risk are required. Studies with an applied orientation of research or action are particularly required. Focused learning, using quantitative and qualitative data is to be linked to programme implementation to ensure that information flows easily and rapidly between action and research.

- Numerous action programmes have been implemented for mobile populations. However, minimal knowledge has been disseminated as to the approaches used, their strengths and weaknesses, and results achieved in promoting protective actions against HIV/STD infections. Systematic reviews of such actions are required to identify the major lessons learned and how to develop a strong base for future work. Such reviews based on currently published and unpublished documents; direct feedback from programme staff, and members of target populations could assist in future programming activities. Geographic focus is expected to be both national and regional, with comparative analysis when possible, and results widely disseminated in regional workshops and satellite meetings of regional and world conferences.

- Considerable population mobility involves travel across international borders and often involves repeated return trips, cyclical migration, to destinations that are very different, ethnically, economically, and politically, from the home countries. The majority of HIV prevention programmes are concerned with limited areas within single countries or movement within national boundaries. National governments, NGOs, donors, and international technical assistance agencies are required to provide increased attention and additional resources to cross-border and multiple-country prevention programmes. In view of the particular demands of cross-border programmes, the options are to be considered according to an analysis of:
  - The added value that such approaches can provide beyond existing country-based programmes.
  - The political and organizational constraints to be addressed and mechanisms needed to ensure appropriate and effective actions.

- Whether the intervention is single-country or cross-border and multiple-country in scope, the organizational complexities of actions with mobile populations constrain the opportunity for follow-up, support, and quality control to take place. This is further constrained when an action programme covers more than one country. A plan for action programmes with multiple sites need to consider the management and organizational resources that are available to provide high quality actions at all sites. Efficient and effective follow-up actions and quality control are particularly important at sites in distant destination areas when mobile population groups encounter the greatest HIV risks with sexual partners in respect to frequency of unprotected sexual contacts and higher HIV-prevalence levels among groups of typical sexual partners. In the absence of a
cross-border support mechanisms, actions initiated in destination countries by AIDS prevention programmes based in the home countries are required to have strong links with partner organizations in host countries or acquire formal representation. A partnership or representation is essential for follow-up actions and support of programmes at high-risk locations.

Governments often do not provide a high priority to cross-border HIV prevention programmes, particularly when large mobile populations originate from another country. Governments and major national and international agencies are expected to focus on the regional and trans-national factors that link national economies with population mobility and the link to national health outcomes of mobility and HIV risks. International donors and technical assistance agencies may consider a wider range of programme needs and opportunities, and to collaborate in the development of acceptable and effective mechanisms and processes for co-ordination and co-operation with neighbouring countries.

Experiences with HIV prevention among mobile populations have constantly revealed that HIV/STI prevention is not the first concern of mobile populations. Those moving are concerned with livelihood and survival. Of lesser importance to them are health needs that may or may not include HIV/AIDS. Programmes are required to combine, directly, or through partnerships with other organizations, a range of actions that are complementary to the livelihood needs. Such actions would include attention to HIV prevention, reproductive, and non-reproductive health and socio-economic needs and advocacy.

The effectiveness of action programmes is determined by the response of the target groups, but is also conditioned by the response and support of participants. At the outset, prevention programmes will need to include the key stakeholders in the identification and planning processes and the implementation and final assessment and evaluation processes. A lack of attention to structural constraints beyond the direct control of a programme but may affect its success. Also, minimal attention to the needs of the stakeholders will impact negatively on programme effectiveness.

Mobile populations often move many times and face particular and new difficulties yet they remain organized. These populations, even in distant destination areas, have community-based organizations (CBOs) for social support and the well being of persons in the group. HIV/STD prevention programmes are required to identify and assess the role of the CBOs and, if appropriate, develop links to them, as this may be useful in addressing two recurrent challenges to HIV prevention programmes and is particularly relevant in resource-constrained situations. The main challenges being faced are:

- Acceptability by target groups of prevention objectives and messages
- Incorporation of and sustainability of protective actions against HIV infection as promoted by relatively short-lived prevention initiatives.

Mobile populations may be marginalised and disenfranchised in areas and countries far from home. Often they are perceived and treated as foreigners and outsiders. Their status as outsiders, often without any of the legal protection accorded to nationals of the host country creates multiple opportunities for the abuse of human rights. Prevention programmes are required to focus resources on protecting the human rights of mobile populations through specific actions and a focus on advocating policy changes in host countries.
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Model for Evaluating


Wolffers, I., and Fernandez, J., 1999. Female Migrants from Bangladesh. Two Studies, one from Bangladesh and one from Malaysia, Kuala Lumpur, CARAM.

Development is the process of enlarging peoples' choices to live long and healthy lives, to have access to knowledge, and to have access to income and assets: to enjoy a decent standard of living.