

HIV/AIDS super highways

So far, although the link between movements of people and the spread of the AIDS virus has been acknowledged, no satisfactory solutions to the problems have been put forward. Simply labelling migrants as an 'at risk' group is not a solution. We need to tackle the roots of what makes them vulnerable.

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Brussels, late September 2002. Just a few hundred metres from the European Parliament where a conference is being held on preventing and combating human trafficking, Myriam, Mylena, Carina, Tamara and Konstadinka trudge back and forth across the streets of the city's red-light district. They work for *Espace P*, a Belgian non-governmental organization (NGO) that aims to prevent the spread of HIV and other sexually transmitted diseases (STDs) amongst prostitutes. They serve as linguistic intermediaries for sex workers who, like themselves, come from Eastern Europe, Africa and Latin America. They hand out information brochures and condoms but most of all they make the people they work with feel accepted, forge contacts and try to encourage migrant sex-workers to seek medical advice from the organization, which provides tests for STDs and vaccinations against hepatitis B free of charge.

For their training, they received the help of Vicky, a former volunteer with *Espace P* and now an employee of the organization. With more than ten years' experience, she knows better than anyone how to build up a trusting relationship with prostitutes from French-speaking Africa and, in particular, her Congolese compatriots. But recently, 'Mum', as she has come to be respectfully and affectionately known, has taken up a new challenge: meeting

the needs of as many of Kinshasa's poor as possible, especially the most vulnerable – the street girls. In short, Vicky is a fighter, a social worker who likes to work "on the ground" and gets nothing out of international conferences such as the one held in Brussels in September, which she attended to swell the ranks of representatives from NGOs.

And why should she feel otherwise? Seldom do the recommendations that come out of such meetings ever develop into positive results and at the same time the statements made are nothing new: enticed by false promises, without any identity papers, imprisoned, beaten and raped, increasing numbers of women from poor countries are falling prey to criminal networks that specialize in prostitution. Fear, ignorance and cultural integration take care of the rest. It is these people who prostitute themselves underground and on the margins of society who are most at risk from HIV/AIDS. But over the last few years, despite the numerous conferences, recommendations and action plans the situation has only become worse. The European Union's "Sexual trafficking of persons program" (STOP) is of little concern to criminal networks. The statistics are frightening: for example it is estimated that in Ukraine, 400,000 young women fall victim to trafficking and only a few hundred of those manage to escape with their lives every year.

The trade in human beings for the sex industry is just the darkest aspect of the problem. Figures produced by the International Labour Organization (ILO), the World Bank and the International Organization for Migration (IOM) estimate the current number of migrants worldwide at 90, 125 and 150 million respectively. But all the researchers agree that increasing economic polarization between rich and poor countries is only going to intensify these migratory movements and that national policies designed to cut immigration are simply turning legal migrants into illegal ones and that there is a distinct correlation between movements of people and the spread of HIV/AIDS.

AIDS, and more widely the deterioration in health levels generally, may be linked to the conditions in which people live in their home countries (most often situations of war or poverty) and which ultimately persuade them to leave. The journey itself has quite likely been long and very harsh. Migrants may have been attacked en route or fallen prey to traffickers. Having arrived, the language barrier and cultural differences often mean that health and safety campaigns do not reach them. Even worse, they have little or no access to health care and health insurance systems in their "host" country.

Today, it is vital to take into account how vulnerable these migrants are and at the same time to highlight, as does a recent report by UNAIDS and the IOM, the fact that "being a migrant, in and of itself, is not a risk factor; it is the activities undertaken during the migration process that are the risk factors".¹ Because once the health authorities have assessed the danger (both to the migrants and to their families), they are faced with a dilemma: how can they take effective action without stigmatizing migrants? Translating information brochures on how HIV/AIDS is transmitted into minority languages is not enough: all citizens have to be educated. One step in the right direction is a recent initiative by Greece's Ministry of Health and Welfare which has launched an information campaign under the slogan "Taking care of migrants' health

at the same time as our own." But from the standpoint of the universal right to health and of human rights, the overall situation is a negative one. According to Patrick A. Taran, a specialist in migration issues with the ILO, the discrimination, hostility and even violence to which most migrants are subjected has damaging effects on their mental and physical health. Moreover, "[such effects] pose enormous political, social and ideological obstacles to the extension of adequate or even essential health care services to them".

Progress is too slow

On the surface, migrants' health is a source of concern to the international community: over the past few years, many conferences have been organized at which "high-ups" have expressed their concern over this issue of migrants' rights. The United Nations has appointed a special rapporteur for migrants' human rights, and countries are steadily ratifying the international treaties that acknowledge these rights. But in practice, progress has been far slower. Although what is needed is for receiving countries to take specific measures to ensure that migrants are afforded the same opportunities for access to health care as the native population, this is very rarely the case, even for legal migrants. Sometimes the complete opposite happens. In the United States, the 1996 Immigration Act was amended by Congress to make it more restrictive in an attempt to limit access to social security, even for legal migrants. In Europe, Belgium and France are the only countries to adopt laws safeguarding irregular migrants' right to treatment for AIDS.² Unfortunately though, with the 15 Member States of the European Union trying to harmonize their immigration legislation to make it more restrictive, the general trend is not encouraging.

On the other hand, when it comes to working together to try and find real solutions to the problems migrants face with HIV/AIDS, Europe is making no progress whatsoever. In a recent self-assessment,

European Project Aids & Mobility (A&M), funded largely by the European Commission, concluded that “heterogeneity that exists within the field of HIV/AIDS and mobility makes it difficult for A&M to develop uniform policies and activities. The diverse range of environments, both on a national and organizational level, is further complicated by ever-changing political and policy agendas”.³

The term “migrant” encompasses many different situations. Our primary focus here is on the main category, i.e. economic migrants, but all migrants are affected by HIV/AIDS: refugees, army personnel, businessmen, tourists and so forth. Each group of migrants is constantly changing and every situation developing. A specific socio-economic context, a war or a natural disaster all require a specific and swift response. In the many conflicts casting a bloody shadow over Africa, every movement of troops, every change in the front line has a direct impact on AIDS figures. For example, the report by UNAIDS and the IOM highlights a positive initiative in Côte d’Ivoire: on some plantations, employers have improved the social infrastructures designed for the migrant workforce. This is an excellent innovation in a country that has traditionally been a magnet for hundreds of thousands of seasonal migrants from Sahel countries and where one in ten individuals is HIV-positive. But this report was drawn up in 2001 and since then the country has sunk into chaos and xenophobia.

Colonial legacy

From a historical standpoint, the colonial period created certain distinctive trends which persist today. On the whole, migrants were men who came to work on plantations, in mines and on construction sites, building roads and railway lines. The long periods of separation caused family models to become dispersed. In Africa, there are many households with only one woman at their head, mainly in rural areas. For example in Lesotho, 51 per

cent of men work in South Africa. There are many vestiges of the system of migratory work developed by the British in the nineteenth century and which became law under apartheid, such as single-sex hostels in mining regions in particular. Workers live there up to 16 in a room. Underground in the mines the work is gruelling and the danger ever-present while above ground, alcoholism, drug-addiction and prostitution are rife. In this environment, STDs and HIV/AIDS spread easily: 25-30 per cent of miners are HIV-positive, two and a half times the national average. When the mining industry finally woke up to the disastrous economic impact of AIDS, it started by focusing its prevention activities on the miners. This was followed by more extensive programmes incorporating prevention and health care for miners and prostitutes. In response to pressure from the unions, mining companies are now planning to fund triple-therapy treatment for those suffering from AIDS. Recently, other companies have launched programmes to bring families back together by converting single-sex hostels into reasonably priced family accommodation. But so far only a few hundred such hostels have been converted and what’s more, the programme only involves a small proportion of migrants: many families will remain fragmented because of the need to maintain their income from farming, even though it may be very minimal, and because South African immigration legislation does not permit the many foreign miners working there to bring their families into the country.

Many events are likely to change the status quo where AIDS is concerned. Change can come from unexpected quarters. A conference is a “risk” situation as is the concentration of NGOs in the wake of a humanitarian disaster. It’s no coincidence that the United Nations has set up AIDS education modules for its expatriate personnel, families and local staff. Another example: in the Horn of Africa, the World Food Programme (WFP) has to deal with famine on a regular basis. In 2001, the WFP decided to provide HIV/AIDS education

to the 2,300 lorry drivers who transport international aid from the port of Djibouti to disaster areas in Ethiopia. The following year, the IOM set up mobile units along these routes where people passing through the area (lorry drivers, prostitutes, displaced people, travelling salesmen, gold prospectors, demobilized troops and so forth) can receive information and condoms, and can undergo free testing and treatment for STDs.

It is an established fact that many routes in Africa and Asia are "migration corridors" and HIV/AIDS, tuberculosis and STDs surge through them with frightening ease. Long-distance lorry drivers are one of the most vulnerable groups and are therefore one on which prevention programmes focus specifically. But once again, efforts are too limited and too exclusive to be very effective. In a study entitled *AIDS and sexuality in Africa*, anthropologist D. Vangroenweghe highlights the wide variety of behavioural models amongst African migrants.⁴ In particular, he demonstrates how economic needs are taking over from cultural customs. For example, he describes a system operating on Nigeria's major road-transport routes that is based on a sort of long-term sexual partnership between drivers who are somewhat better off than the average population, but who work in unpleasant conditions, and women who live along these routes, are sometimes married and who "would be considered mad to refuse to have sex with one or several drivers in exchange for financial support, when their survival depended on it". Alongside these modern forms of polygamy and polyandry that are shaping the transport sector, the report also mentions the professional prostitutes plying their trade at major transport and trade hubs, and the young travelling saleswomen working in car parks and truck stops who supplement their income by having sex with the lorry drivers. The researcher also rejects conventional wisdom by highlighting the significance of the trend amongst single women of going to African towns in search of a better socio-economic future. They do not rule out settling down

with a man but they do not want a forced marriage as is often the case in the villages. All these factors are significant in developing strategies to combat HIV/AIDS. It is also important to underline the fact that nowadays the exodus from rural areas and migrations generally involve women just as much as men. According to the ILO report entitled *Migrant workers* (1999), half a million women from Sri Lanka are working in the Middle East and there are 12 times more female than male migrants from the Philippines in other Asian countries.

Transportation corridors

In a report for *Time* magazine, two journalists chronicled the advance of AIDS in China and visited towns like that of Ruili, on the Myanmar border: "From all over Asia, men gravitate [to Ruili] in search of jade, rubies, heroin and sex." They wrote: "In 1989, AIDS made a new inroad into the mainland, penetrating China around the Burmese border. The virus has since hitchhiked along a transportation corridor through Sichuan and Gansu provinces and northwards to Urumqi, a city in the far western deserts of Xinjiang province. The disease's travelling companions are a familiar crew: drug-users and traffickers, prostitutes and truckers, itinerant workers and salesmen. And wherever AIDS visits, it finds familiar accomplices to help it jump to the next town: official denial, ignorance, discrimination and poverty. In Ruili's main plaza, you can almost see AIDS spreading from one human to another as clearly as you could under a microscope."⁵

Ruili should be pinpointed on a world map of AIDS, but so too should Kaliningrad, a Russian enclave on the Baltic Sea; Abidjan, Accra, Lomé, Cotonou and Lagos, five West African capital cities on the same coastal route; Tijuana and all the industrial towns clustered along the US-Mexico border where foreign-owned assembly-for-export plants (*maquiladoras*) provide work for domestic migrants; and the thousands of other cities which, for a whole variety of reasons (a major market or railway station,

a university, etc.) are often important migration centres. As well as borders, ethnic groups should also be marked out (in Africa there are 1,800 such groups and one in ten of them straddle two or more borders), as should refugee camps, front lines, trade and contraband routes, mining regions, major construction sites, tourist paradises and any factor that might help to better understand how the virus spreads.

We could throw in the towel in the face of this complex problem. It's an alarming suggestion, certainly, but many migrants are already involved in HIV/AIDS prevention and health care programmes. What we have to do is make such programmes more effective and ensure that they do reach the most disadvantaged, especially the undocumented, women and children who have been victimized by traffickers. All governments need to understand that they are dependent on one another in facing up to this epidemic, and that a solution cannot be found by one country alone. The most promising progress has been made by local NGOs often representing migrants who form regional networks in order to take action at all stages of the migration process: in the country of origin, during the journey, and then in the host country.

Indeed, this is what the Coordination of Action Research on Aids and Migration (CARAM) network in Asia is trying to do by providing both AIDS education before departure, to prepare migrant workers for the living conditions they will experience, and follow-up measures in receiving countries and reinsertion programmes for those returning to their home country. There is of course one other approach: reducing inequality and strengthening social cohesion in our global village in order to control migratory flows. But wouldn't that be a somewhat utopian aspiration?

Notes

¹ UNAIDS and IOM: "Migration, Health and Human Rights", in *Migration and Health*, IOM newsletter, February 2002.

² Some 47 per cent of AIDS cases in Belgium involve non-Belgians. In France, one victim in five is of non-French nationality. In France, the association "Act Up" has highlighted cases of discrimination where the law has not been upheld.

³ European Project AIDS & Mobility: *Looking to the future*, October 2001.

⁴ D. Vangroenweghe: *AIDS and sexuality in Africa*, EPO, 2000.

⁵ Jim McGirk and Susan Jakes: "Stalking a Killer", in *Time*, 30 September 2002.