Mexico and Central America

Mario Bronfman*

ABSTRACT

This article covers migrants from Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua and Panama. While their main destination is the US, Mexico is also a destination for Central Americans and a transit place on their way to the US.

Central America's migrant population comprises mainly illiterate and unqualified men, rural in origin and of economically active age. Many are heads of families and significant numbers are from marginal groups, including indigenous peoples. Mexican migrants are similar in age, but most come from urban zones. Whether Central American or Mexican, the majority are undocumented. Many return home after having lived in the US for a time.

The little data that are available on HIV/AIDS in the region relate more to Mexico than to Central America. Honduras is the most affected country in Central America, with more than a half all reported cases. Currently, rural cases make a small but rapidly growing percentage of the total in both Mexico and Central America, an indicator of the growing impact of migration on epidemiological trends.

Available data on HIV/AIDS in the migrant populations of Central America mostly concern migrants in their places of destination (i.e., Mexico and the US). In contrast, a number of research projects on migratory conditions in Mexico shed some light on HIV diffusion, particularly research on Mexican migration towards the US. Among current AIDS cases in Mexico, 10 per cent have a history of residence in the US. This group is clearly differentiated from the rest of People Living With HIV/AIDS's (PLWHA) recorded in the country, with a demographic profile similar to that of temporary migrants.

Studies assessing risk behaviours and levels of knowledge of HIV/AIDS among migrants to the US show a descending gradient: almost everyone has

* Center for Research in Health Services, National Institute of Public Health, Mexico.

Published by Blackwell Publishers Ltd.,
108 Cowley Road, Oxford OX4 1JF, UK, and
350 Main Street, Malden, MA 02148, USA.

© 1998 IOM
International Migration Vol. 36 (4) 1998
ISSN 0020-7985

heard of condoms, few know about its preventive possibilities, fewer still have appropriate information about its correct use, only a minority use it, and even fewer do so correctly. Widespread risk and vulnerability factors among migrants include highly stressful living environments, high rates of alcohol use and sexual intercourse, and sex with sex workers and/or multiple sexual partners.

Migration in Mexico and Central America is profoundly related to economic and political conditions. Police and restrictive measures in the US have resulted in high levels of undocumented migration which has had significant and broadly documented consequences for the spread of HIV, while restricting migrants' use of services.

Two priorities are suggested. First, more research on Central American migrant flows to Mexico and the US. Second, reducing illegal migration will require intense political and technical work to convince decision makers of the risks that restrictive measures generate for the public health.

INTRODUCTION

This study covers Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua and Panama. The main destination of migrants from all of these countries is the US, although migration dynamics require that a clear distinction be made between Central American nations and Mexico. The latter is not only a source of migrants to the US, but also a place of destination for Central American migrants as well as a transit for Central Americans on their way to the US. There is also migration toward interior regions that, in some cases, is the result of economic change coinciding with the appearance and spread of HIV.

Although Mexico and Central America are part of the same political and cultural region known as Latin America, Mexico is part of the North American continent. The effects of this geographical reality have been accentuated with the signing of North American Free Trade Agreement (NAFTA) which includes Mexico, the US and Canada. For historical, cultural and economic reasons, Mexico has become the hinge between these two regions. This fact is more than just a literary expression; it modifies migratory processes in ways that increase the risk of HIV transmission.

Methodology

The collection of "grey literature" and official documentation in this region is a near-impossible task. There is no tradition in the public sector of maintaining files that would serve as a basis for this kind of research. There is also a frequent rotation of officials. Nor is there a concept of "career civil service" in the high

levels of public administration. In the case of Mexico, and several countries of Central America, even in the lower levels of public administration, so-called "posts of responsibility" and their occupants may be freely removed by their superiors.

For these reasons, the analysis includes academic literature. In Mexico and in parts of Central America, most of the work published in academic circles had been proposed, financed and used by government agencies. This applies especially to research on AIDS; academics temporarily perform the officials' roles and later return to the research (Bronfman et al., 1995; Magis, in press).

The search for material began during the third quarter of 1997 and included official decisions, constitutions and laws, reports and minutes of national, regional and international meetings, academic works such as articles, books or unpublished reports, newspaper articles, administrative documents from government offices or others interested in this issue. However, it soon became clear that the issue of relationship between migration and AIDS was on the "discourse agenda" of most countries (i.e., to be talked about), not on the political agenda (i.e., for anything to be done about it).

Central America

In recent years, the profile of Central America's migrant population has been mostly one of an illiterate, little-qualified and little-educated male population, largely rural in origin. The majority are in economically active age groups and many are heads of families. Significant numbers are from marginal groups, including indigenous peoples.[1]

While most of the region's migrants go "to the North" (US, Canada and Mexico), there are distinct differences between these countries migration policies. In contrast to Mexico and the US, Canada has a more flexible policy insofar as it has special programmes to promote the integration of different immigrant groups. In the US, Central American immigrants represent only a small share of the country's large migratory flows, and are assimilated with the Hispanic population which is dominated by Mexicans. This group faces many difficulties in gaining access to official programmes for housing, health and education, a situation aggravated recently by Proposition 187 in the State of California. The majority of undocumented persons live in conditions of poverty and inequality compared with the rest of population.

As noted above, Mexico is a place of transit for Central American migrants. Although there are no reliable data on the magnitude or characteristics of this migration, it is known to include persons from all countries in the region with the exception of Belize and Costa Rica. Refugee settlements on the southern border, and the growth of some nearby urban centres, indicate

significant undocumented immigration which is not covered by census data.

Migration has an important human rights dimension. Most migration in the region is associated with violation of different human rights in places of origin, often followed by violation of migrants' human rights in transit and places of destination. It is ironic that, while Mexico has expressed many complaints (and with good reasons) about violations to which its nationals in the US have been subjected, there are countless examples of similar violations committed in Mexico against Central American immigrants.

While the migration policies of transit and destination countries are sometimes a response to migratory processes, first and foremost they are a *determinant* of those processes. For example, in the 1980s the US limited the number of Guatemalans and Salvadorans that it accepted, but opened its borders for Nicaraguans who were "escaping" from the Sandinista regime. This led many Guatemalans and Salvadorans to enter the US and work there clandestinely.

Mexico

There have been considerable flows of Mexican migrant labour to the US since the border between the two countries was established in 1848. Until the 1960s, most Mexican migration to the US was circular, comprising mainly adults and youngsters of rural origin who entered the US and returned to their places of origin after six or eight months. The 1980s saw a massive increase in authorized Mexican migration, due mainly to the 1986 Immigration Reform and Control Act (IRCA). During the 1990s, authorized migration from Mexico remains considerable as the relatives of legalized Mexicans attain permanent resident status. In 1996 alone, when more than 160,000 Mexicans became authorized immigrants, all except 5,300 were admitted under categories based on family bonds. Future demographic consequences of IRCA could be considerable, with estimates showing at least 1 million relatives of legalized persons being eligible to apply for admission to the US (Gómez de León and Tuirán, 1996).

The number of temporary authorized border crossings between these two countries are enormous, e.g., an estimated 280 million in 1996 alone. In contrast, the number of non-authorized Mexican entries to the US is unknown, although in 1995 there were more than 1.3 million detentions of persons who attempted to enter without being checked.[2] Efforts to calculate the actual number of Mexican migrants (including permanent residents as well as authorized and non-authorized temporary migrants) face a variety of methodological difficulties.

Even so, the number of US residents born in Mexico was at least 2.5 million in 1980 and 4.5 million in 1990. In 1996, the Mexican-born population residing in the US was estimated at between 7.0 and 7.3 million, of which authorized

residents were 4.7 to 4.9 million and non-authorized residents 2.3 to 2.4 million. The Mexican-born population represents approximately 3 per cent of the total US population, and is equal to 8 per cent of total Mexican population. Approximately 22 per cent arrived during the last 5 years, including about 500,000 who have become naturalized US citizens. These figures are additional to 11 million American citizens of Mexican ethnic background who were born in the US (Mexican-Americans).

Although the circular flow pattern continues, in recent years there has been a regional flow diversification; an increase of urban zone migrants, and occupational diversification of migrant populations. Mexican migration to the US has the following characteristics:

- Migrants are predominantly males in the economically active age groups.

- The proportion of migrants who did not have job in Mexico is increasing, though the majority were employed there.

- Most come from urban zones, although lately the proportion of rural-origin migrants has increased.

- The main destination is California which, together with Texas, Illinois and Arizona, concentrates 90 per cent of Mexican emigration to the US.

- The majority do not have documents to enter or work in the US.

- Many return home after having lived in the US for a time.

Mexico's position on this migration can be summarized as follows:

- Mexican migration depends on labour supply and demand in both countries, and the factors associated with demand in the US are as important as those corresponding to the offer in Mexico.

- The migration issue must therefore be dealt with in relation to other economic, especially commercial, factors.

- Mexican workers in the US perform legitimate activities and do not compete with the local labor force.

- Mexican migration gives rise to costs for both parties which can be attended jointly.

- Unilateral measures, especially those of police and repressive ones, will not regulate the migratory flow.

- Mexico cannot stop the flow with repressive measures without breaking its own Constitution that guarantees free transit.

In recent times, the main US policies affecting this migration have emerged from 1965 Immigration Act and 1986 Immigration Reform and Control Act (IRCA). The latter legalized about two million Mexicans in the US under the Programme for Residents Before 1982 and Special Agricultural Workers Programme (SAW). These programmes also applied sanctions to employers who knowingly hired illegal workers. More recently, the US Congress adopted the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 to reinforce application of laws on the border and in working places, facilitate the expulsion of non-authorized foreigners, and impede their use of public programmes.

Political debate about migration in the US is frequently marked by an alarmist tone, generally presenting undocumented workers as migratory lawbreakers who occupy jobs that belong to American citizens. As a consequence, important sectors of American government and society support reducing the flow through unilateral measures such as reinforced border vigilance and the construction of walls, curtains and fences. These measures have failed in the past and, in general, produce perverse effects. The recurrence of this approach is paradoxical given it is occurring during a period when economic relations between Mexico and the US are being fostered by the North American Free Trade Agreement. The US Congress, presumably motivated by the belief that authorized and non-authorized migrants participate “excessively” in public assistance programmes, approved migrant-related provisions as a part of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996. This law restricts access to social assistance programmes even to the authorized migrants.

Socially, Mexican migrants occupy an intermediate social position between native whites and native blacks. For example, polls show a general preference for whites as the most desirable neighbours, blacks as the least desirable and “Hispanics” somewhere in between. According to a survey of State prisons in 1991, Mexicans comprised almost half the State prisoners born abroad. This may reflect differences of treatment in the criminal justice system. Migrants along the border are two to four times more likely than native citizens to be arrested, detained before trial, and found guilty and imprisoned. Non-authorized migrants are also less likely to be released from jail before trial.

Border communities are two-nation entities in which many residents on both sides of the border have strong family, commercial and social bonds with the other side. The volume of movement in both directions at this long border between Mexico and the US is considerable. The great majority of persons who cross do so for short visits in order to buy products. Relationships between such

adjacent communities are not free of tensions. Transborder crime and vice are constant causes of concern in many border communities. Border cities complain about the fiscal effect when residents from the other country have access to public services such as health assistance and education. The growth of poor and unincorporated zones in this area also presents both public health and environmental problems.

Violence on the way to the border and at the border itself is considered one of the most negative features of migration between the two countries. It is largely, though not exclusively, related to the non-authorized migration. Migrants may be victims of a variety of different crimes, from attacks or abandonment by the "coyotes" (persons who facilitate the crossing of "illegals", charging large amounts for the service), to robberies, rapes and even murders. Registered and unregistered deaths related to attempts to cross the border are an increasing worry. Incidents of human rights abuses by federal, state and local officers of both countries have also been recorded. Undocumented migrants are extremely vulnerable to abuses by employers.

HIV/AIDS IN THE REGION

There is little precise epidemiological data on the region, although there is more about Mexico than Central America. Most data on Central America are included with the larger region of Latin America. An estimated 1.3 million persons live with HIV/AIDS in Latin America, a figure which covers a number of different epidemics, each with its own dynamics. At least three can be characterized by their main paths of transmission (Bronfman and Magis, 1996):

- Homosexual transmission in the Andean area and Mexico.
- Homosexual transmission in Argentina, Chile and Uruguay, but with a rapid increase among intravenous drug users.
- Heterosexual transmission in the Caribbean area and Honduras.

Undoubtedly, Honduras is the most affected country in Central America. Even taking into account data deficiencies, this country reports more than half of all cases reported in Central America. According to information provided by NGOs, four persons die from AIDS every day, and the situation is acquiring proportions normally associated with the most affected parts of Africa (personal communication). The probable causes of this situation are several. One is cultural, in which masculinity means to have several partners. A recent study shows that 76 per cent of polled men maintain several relationships concurrently that include sex. Other likely factors are economic and political, such as the installment of US military bases in the 1980s (associated with the

war in Nicaragua), a large amount of commercial sex work in Puerto Córtez, and the proliferation of *maquilas* – textile factories in which the female-to-male employee ratio is 12 to one (Gómez Nadal, *El País*, October 19, 1997).

Data from the rest of Central America are much less reliable, but several trends are identifiable. Most cases are localized in capitals or big cities and the epidemic appears to be moving both towards younger generations and to specific groups. As in other regions, there is an increase in heterosexual transmission and therefore an increase of infected women and children. In considering the relationship between migration and HIV, it is significant that AIDS cases are now being reported in rural areas.

In Mexico, several patterns have appeared. Homosexual transmission prevails in big cities. In the North-west, near the border with the US, use of intravenous drugs has become significant. Near the southern border, some factors responsible for the Central American heterosexualization phenomenon are to be found (Bronfman and Magis, 1996). As of September 1997, an accumulated 32,802 cases had been reported in the country, although this may be serious under-reporting; estimates for the year 2000 run as high as 75,000 cases (CONASIDA, 1997). In the beginning of the epidemic there were no cases of rural AIDS. At present, however, rural cases make up 5 per cent of the total. This phenomenon is inevitably associated with migration, being an indicator of the growing impact of migration on epidemiological trends (Bronfman and Minello, 1995). This percentage is unequally distributed in the country, with States such as Hidalgo and Zacatecas reporting that rural cases exceed 20 per cent of total cases (Magis et al., 1997).

HIV/AIDS in migrant populations of Central America

Very little specific data are available on HIV/AIDS in the migrant populations of Central America. That which does exist relate mainly to migrants in their places of destination (see the following sections on migrants in Mexico and the US). However, research currently underway should provide useful information in the next two years. One example is the study of truck drivers currently being carried out in almost all countries of the region with support from the Dutch government (Madrigal et al., 1996). Epidemiological research is also being carried out along the border between Honduras and Guatemala (personal communication).

HIV/AIDS in Mexico's migrant population

In contrast with the scarcity of information for Central America, a number of research projects provide a general panorama of migratory conditions in Mexico which have a bearing on HIV diffusion. Some studies provide relevant information on specific groups of emigrants.

The southern border of Mexico, bounded by Guatemala and Belize, is the entry place for Central American migrants to the US and refugees entering Mexico (the latter were especially numerous in the late 1980s). As many persons in both groups lack papers that would legalize their situation, illegal status is accompanied by conditions of marginalization, exploitation and lack of access to social and health services. At the same time, conditions in the migrants' places of origin are often characterized by deterioration of social and cultural structures, violence and systematic violation of human rights (Farías, 1994).

Specific research on AIDS in the southern border of Mexico is only at the early stages. At the beginning of the 1990s, studies of commercial female sex workers in different cities in the State of Chiapas found that most came from Central America. Although none were found to be HIV-positive, 37 per cent presented STDs among which the most frequent were condylomatosis, candidiasis, trichomoniasis, gonorrhea and syphilis (Pérez López et al., 1991). Other studies corroborated the presence of different STD varieties, and indicated that rates had increased by 1993 (Uribe and Bronfman, 1997). At time of writing, a set of projects being developed in this region seek (among other objectives) to quantify HIV and STD prevalence, analyse the social and cultural determinants of these diseases, and design and apply educational interventions. Information from these studies will be available in 1999.

A great deal more research has been undertaken on Mexican migration towards the US, some of which sheds light on the spread of HIV/AIDS. The first significant research, which provided a reference point on the issue, concerned the difference in AIDS incidence rates in both countries. In 1988, approximately 30 per cent of AIDS cases in the US were located in the southern border States, i.e., in the migrant-attracting zones or those in transit (Bronfman, 1989).

While in Mexico the rate of AIDS cases per million persons was 136 (11,034 cases); as of January 1993 the rate in the US was 990 per million (224,146 cases) (WHO, 1993). The most affected States were California, Texas, New York and New Jersey which, together with Florida and Illinois, concentrate 72 per cent of Mexican immigration (Warren, 1994).

Other early research focused on migrants' demographic characteristics. In 1991, average age was 26.2 years and 84.3 per cent were between 15 and 34 years. Men represented 89.1 per cent of the total. This profile closely resembled that of AIDS cases recorded for these variables in Mexico (CONASIDA, 1997). While this coincidence alone did not confirm causal relationship between both phenomena, together with other data it suggested a high probability of increased risk practices once at their destination:

- Most are in the age group of highest sexual activity.

- Fifty-eight per cent of migrants were single, and the remainder left their wives or partners at home.

- Their destination was a society with more “open” sexual habits than those in their places of origin.

- Receptivity to existing educational and preventive campaigns against HIV/AIDS was low due to their living conditions, low education levels and lack of English.

Among current AIDS cases in Mexico, 10 per cent have a history of residence in the US. This group is clearly differentiated from the rest of People Living With HIV/AIDS’s (PLWHA) recorded in the country. Their demographic profile is similar to that of temporary migrants, with a higher proportion of men aged 25 to 44. The proportion of intravenous drug users is also high, approaching the US epidemiological pattern. But most remarkable is the change in occupational composition of these groups. Since 1987, the proportion of non-manual wage earners, workers, craftsmen, peasants and farmworkers has increased remarkably so that in April 1989, 44 per cent of the cases had antecedents of residence in the US (Bronfman, 1990).

New evidence has been presented recently concerning the relationship between migration and AIDS. Results published in 1995 show that 25 per cent of rural cases were found to have a history of temporary migration to the US, compared with 6.1 per cent of urban cases. Distribution by sex showed a significant difference: 21.3 per cent of female cases in rural areas had a history of migration compared with 14.4 per cent in urban areas. The ratio of women with AIDS to men with AIDS was one to four in rural areas compared with one to six in urban zones. Although these patterns do not represent a significant problem because of the low numbers involved, it is nonetheless important to point out that the pattern has changed in the last 10 years. Its significance for the future is worrying, since its salient feature (migration to the US) is not expected to diminish. Although the AIDS epidemic in rural areas is more recent than in the cities, it presents exponential growth that (unlike in urban areas) has not yet reduced. The epidemic also occurs in a social group with extremely precarious life conditions (Magis et al., 1996).

Transmission among rural men comes from sex with women in 28 per cent of cases and with other men in 26 per cent of cases. If the epidemic’s ruralization trend in Mexico becomes stronger, women will suffer even higher impact for two reasons. First, their disadvantaged status in the vast majority of rural areas in Mexico is more accentuated than in urban areas. This means that the possibility of talking with their partners about any aspect of their sexuality (including sexual practices outside of their relationship), is lower and thus they have little capacity to negotiate the adoption of preventive measures. Second, the small size of the

originating communities may permit relatively high prevalences to develop in a short time, with potentially devastating economic, demographic and social impacts (Del Río-Zolezzi et al., 1995).

Another problem associated with migration is the increase in injecting drug use. Ruiz Badillo, et al. (1997) emphasize this problem and state that "the significant presence of this phenomenon in border cities in the north of our Republic, combined with high levels of migration towards the US, suggests that it is one source of AIDS epidemic's expansion both locally and towards other regions of the country."

Local studies of the relationship between migration and AIDS have been carried out mainly in originating areas of high levels of migration. Pineda, et al. (1992) found that the areas of Michoacan State with the largest migration to the US were also those most affected by HIV/AIDS: some 39 per cent of AIDS cases had a history of residence in the US. Statements by health sector officials indicate a similar phenomenon in Zacatecas (Correa Pacheco, *El Nacional,* 2 December, 1997).

HIV/AIDS among migrants in the US

The other side of the problem may be seen in studies of the migrant population in the US. Again, there is no specific information about Central Americans, and studies referring to "Latin Americans" or "Hispanics" may in fact describe Mexicans since they represent the majority of persons in these categories. Two qualitative studies carried out in Watsonville (Bronfman and Minello, 1995) and Los Angeles (Bronfman and Rubin-Kurtzman, in press), indicate that migration has an impact on individuals which can be seen in the modification of sexual habits and the adoption of practices with HIV-related risk.

Organista and Balls Organista (1997) reviewed existing literature on this issue. While acknowledging difficulties in quantifying exact numbers of migrants in different categories due to divergence between sources, they conclude that migrants have become another "high-risk" group. The following socio-economic characteristics were common: low incomes, low education, and predominantly male (though one-third were women or children). One in four was undocumented. While it is difficult to estimate HIV prevalence, data found in the studies reviewed extend from a disproportionately high 13 per cent in southern California (Jones et al., 1991) to zero per cent in northern California (López and Ruiz, 1995). Knowledge of AIDS seems to be high but not homogeneous, and important myths persist. Use of condoms is also inconsistent, and strategies used to promote their use do not appear to have been very successful.

Mainstream newspaper reports and articles from other responsible sources provide further information on the issue. For example, an article from a

publication of the Panos Institute (Osorno, 1997) provides a wide range of quantitative and qualitative information from the State of New York. The New York Health Department found that, among migrant groups, Mexicans occupied the eighth place in absolute terms of cases of AIDS (N=161) reported by March 1996. However, they were in the second place, after Haitians, in terms of accumulated cases per 100,000 inhabitants. The article points out that a migrant's risk of exposure to HIV is highly dependent on location. For example, many migrants work on US farms and have contact with prostitutes who surround camping sites. But in New York (the State with the greatest number of AIDS cases in the US), possibilities are multiplied, ranging from organized brothels to sex on the street with crack addicts. The article also describes the risks involved when migrants, having been infected with HIV, return to their villages on holiday or for patron saint feasts and may infect their sexual partners or transmit the virus to local prostitutes.

CURRENT LEGISLATION AND REGULATIONS

Very few available documents refer explicitly to the relationship between AIDS and migration, an issue which is generally absent from official documents. Most existing documentation consists of presentations from conferences or journalistic articles about practices which infringe existing provisions.

Some years ago a regional legislative review conducted by the Latin American and Caribbean Network of Human Rights and AIDS (LACCASO) confirmed the absence of legislation in the region that regulates movement of foreigners with specific reference to STDs and HIV/AIDS (Carrasco, undated). However, some countries' migration laws permit deportation or exclusion of foreigners who suffer from diseases qualified as severe, chronic and infectious, such as tuberculosis, leprosy, trachoma. Obviously, this legislation could be applied to STD and HIV/ AIDS. The review indicates that:

> … in international transit the existence of discrimination and stigmatization toward certain nationalities and ethnic groups is a fact, which has been aggravated by HIV/AIDS epidemic. In the Caribbean area, for instance, Haitians are generally considered 'disease carriers.' Recently, when the US proposed quotas for Haitian refugees to the countries in this area, government reactions and public opinion were very negative criticizing such proposal. Nevertheless, serological tests of Haitian refugees have been practiced without any justified reason and with the possibility of exclusion.

Besides the basic international agreements signed by most countries, Latin America and the Caribbean have certain regional agreements such as American Convention on Human Rights and Conventions on Territorial, Political and Diplomatic Asylum which regulate admission and transit of foreigners in the

member countries. Article 22 recognizes that rights of circulation and residence apply to every person legally present on a State's territory. However, section 3 restricts these rights for several causes, one of which is for reasons of public health protection. The right of circulation is therefore not absolute but relative, and depends on what each of the Convention's signatory countries considers a risk to public health.

In July 1993, the Declaration of the Third Ibero-American Conference of Heads of States and Governments urged Latin American States to remove HIV tests as prerequisites for any type of visa (temporary job or resident, transit passenger, tourist, student, etc.). It also urged that research be undertaken into "human displacement" issues, and that bilateral and multilateral health assistance agreements be established among Latin American countries. To date, these recommendations have not been formalized and no Latin American and Caribbean country has made any formal pronouncement on migration and AIDS.

Although some States have laws which could permit HIV testing of migrants, Carrasco comments that "these laws are little applied in practice [and the tests] are not required as part of medical examinations, but they are a requirement for long-stay visas." However, even though programmes of selective immigration (i.e., for refugees, return of national citizens, students, etc.) do not demand HIV tests, journalistic accusations indicate that such tests are sometimes imposed.

Several examples of migratory laws that permit prohibitionist policies in Central American countries, and contradict international agreements signed by them, can be mentioned. In Guatemala, the Migration and Aliens Act says that "the General Administration for Migration may suspend or ban the admission and stay of foreigners due to reasons of public order, national interest or State's security, as well as *health*, moral and good habits" (Chapter V, Article 67, author's emphasis). Elsewhere, the Act requests a medical certificate for immigrants, though no specific mention is made of STDs or HIV/AIDS.

Similar provisions can be found in Costa Rica (General Migration and Aliens Act of April, 8, 1986, Heading I, Article 21), Honduras (Population and Migratory Policy Act September, 25, 1970, Chapter VIII), Panama (Rules of Foreign Residents Act, Article 12), El Salvador (Decree No. 299, February, 18, 1986, Chapter IV, Article 38) and Nicaragua (Political Constitution of Nicaragua of November, 19, 1986). Each makes reference to health and sanitary standards as criteria for immigration or naturalization as a citizen, but none refers specifically to HIV/AIDS.

In Mexico, the situation is different: 1993 saw the approval of the Official Mexican Standard for Prevention and Control of Infection by Human Immunodeficiency Virus, of which paragraph 6.3.4. indicates that detection of the virus

"must not be considered as a criterion for decision about an employment contract, expulsion from a school, evacuation from home, departure from the country or admission to it, for both nationals and foreigners. In the case of the latter, it will not be a cause for denying residence nor could it be used for the deportation."

Our review of "grey literature" found material on migration and HIV/AIDS in the region that provide a different view of the de facto, as opposed to the de jure, situation. For example, Carrasco refers to a 1991 report from Deutsche AIDS Hilfe/Berlin which indicates that countries such as Belize, Costa Rica, El Salvador, Paraguay, and Mexico (among other Latin American and Caribbean countries) demand HIV tests from all persons who request long stay visas (Carrasco, undated).

Among human rights relevant for the relationship between migration and HIV/AIDS are the right to free circulation, and of requesting asylum and obtaining it. Transgression of these rights increases vulnerability to become infected by HIV. For instance, many States, including the US, do not allow migrants to be accompanied by their family members, and the resulting isolation may increase vulnerability to HIV (Bronfman and Minello, 1995). In the case of refugees, compulsory tests as a requirement for asylum may result in some family members being granted asylum but not all, leading to the rupture of family structures.

KNOWLEDGE ABOUT STDS AND HIV/AIDS

There is little information available from Central America about overall knowledge of HIV/AIDS, and nothing on migrants' knowledge in particular. A report produced by an evaluation mission sent to Central America by the governments of Norway, Netherlands and Sweden, states that "many information campaigns have been conducted through the mass media. No evaluation of the impact of this strategy has been carried out, but there have been criticisms of the excessively symbolic content and of messages which are aimed at increasing knowledge rather than at change of behaviour" (Gondrie et al., 1995).

In Mexico, a study of Guatemalan women living as refugees in Chiapas included related topics such as sexuality, pregnancy, some STDs and family planning. A 20 per cent sample of female population in refugee camps in that region found that 62 per cent of women had their first pregnancy before the age of 17 and 11 per cent before the age of 15. The polled women perceived this as a risk for their health and explained its occurrence by lack of information, saying they had had no knowledge of the link between sexual relations and pregnancy. Fifty-five per cent reported not being acquainted with family planning methods and less than one per cent mentioned familiarity with condoms (UNHCR, 1992).

Another study carried out in Chiapas among sex workers and their clients (of which the latter include migrants and truck drivers) reported "misinformation of the population studied in relation to condom use and many aspects of human sexuality". In the case of prostitutes, this misinformation was such that the periodic tests they submitted to had the unexpected effect of contributing to a false appearance of security, thus promoting the non-use of preventive measures (Uribe and Bronfman, 1997).

Various studies have assessed levels of knowledge of STDs and HIV/AIDS among the populations that migrate to the US. Some of these studies have been made on Mexican territory, others in the US, and some on both sides of the border for purposes of comparison. A study sponsored by CONASIDA (the Mexican national agency for AIDS control and prevention) aimed to assess the impact of an educational programme in Morelos and Guanajuato, two States from which temporary migrants go north to the US (Loya Sepulveda et al., 1997). The researchers concluded that knowledge was low, unequal and mixed with myths and prejudice. The most identified transmission path was sexual contact, with some transmission by blood and a minimal level of perinatal transmission. There were differences in information and risk perception according to sex and age, and tackling issues of sexuality was difficult and fraught with conflict. Women believe that the persons with higher risks are men with promiscuous practices. Men have social "authorization" for sex, but women do not. Youngsters possess deficient, fragmented and little-socialized knowledge from school; married women are the least informed group and have fewer possibilities to control modification of risk practices since they suffer drastic isolation and do not have their own socialization spaces or social identity. Nevertheless, they are well disposed to receiving information on HIV/AIDS. The most requently mentioned information sources were TV and school.

In most cases, knowledge was increased by the programme being evaluated. The report deduced that "AIDS is very far from being conceptualized as a public problem in a rural environment; [therefore] offering basic information about HIV/AIDS must be top priority. Talking about sexuality virtually represents a transgression, and it is therefore important to carry out specific educational strategies appropriate for this population."

A study carried out in Los Angeles among Mexican migrants came to the same pessimistic conclusions (Bronfman and Rubin-Kurtzman, in press). It found that "low levels of formal education, high rates of illiteracy (around 10 per cent) and deficient command of language influence migrants' sexual behaviour, since they reduce the efficacy of conventional educational campaigns; they limit the migrants' capacity to read educational material or assimilate verbal information and deprive them of timely information that would facilitate prevention." However, in spite of these limitations, all the persons polled "know that AIDS is an illness. Strong educational campaigns accomplished an

impact and all migrants reported having received some public information about AIDS. Main information sources were the media, especially television, schools, and educational programmes for adults and churches." However, when the content of the information they possess is analysed, it proves to be insufficient: "Although the migrant population lives in a context of extensive informative coverage, it has fragmented knowledge of specific situations in which AIDS can be caught."

Another study carried out among Mexican temporary migrants in the US deduced that "women know what AIDS is and how it is transmitted…Their information level proves to be, apparently, adequate and sufficient" (Bronfman and Minello, 1995). The most mentioned information sources were television (channels in Spanish in which programmes about AIDS are very frequent), persons who give talks about AIDS and the school system. Exposure to information is also present in their places of origin in Gómez Farías (State of Michoacan) because many houses receive programmes which they used to watch in the US.[3]

Information about AIDS among male migrants might be expected, a priori, to be very good. AIDS is much discussed in the US. Migrants are exposed to information about the disease and how to avoid infection not only on TV, but also in places where they work and live and in the schools that many migrants attend. However, this information has gaps: migrants retain some doubts or myths about the transmission (some talk about risks of kissing or shared kitchenware); prejudice about "risk groups" persists; transmission from mother to child is not mentioned.

Organista and Balls Organista mention the above studies and includes some others. The majority conform to the described pattern: migrants have information about main transmission routes, but between one-third and one-half still believe that mosquito bites, kisses, public baths and other casual contacts may be equally risky. Other studies confirm the hypothesis that migrants have less knowledge than American whites and that women have less than men. However, it is worth noting that López and Ruiz (1995) found from a sample in the North of California that 21 per cent of migrants polled had never heard of AIDS.

RISK BEHAVIOURS AND CONDOM USE

Detailed knowledge about AIDS characteristics and transmission mechanisms alone does not guarantee that risk behaviours will be avoided. The following section discusses available information on actual behaviours relevant to the spread of HIV/AIDS.

Once again, there is little information about the Central American migrant population except for the few studies of sex workers in the south of Mexico who come mainly from the countries of that region. Information on these issues is not much better in Mexico. This is confirmed by an undated document from the country's National Programme for Farm Laborers, which states that studies about AIDS and migration "have rarely focused on farmworkers employed within the borders of our country." The only relevant work concerns construction workers in Mexico City (González Block and Liguori, 1992). Although the main focus of the study was the sexual culture of this labor sector, the authors point out that many of these workers are temporary migrants who arrive alone and live together in the same space where they work. This, the authors suggest, puts them at risk of unprotected sex with other men.

An indirect idea about risk practices among Mexican migrants was provided by Magis, et al. (1996) when they compared cases of rural AIDS with urban ones. They found that bisexual behaviour had increased among rural migrants. When the researchers selected those with a history of residency in the US, they found that risk behaviours (including having used injectable drugs or had sex with prostitutes) also increased.

The greatest amount of information available on migrants from the region concerns Latin American migrants in the US, most of whom are Mexican. The much-quoted work of Organista and Balls Organista (1997) cites studies which show the following risk behaviours among Latin-American migrants: high frequency of purchased sex from prostitutes; frequent use of shared syringes for medical purposes; a growing, although still small practice of sex between men.

In Tijuana, the border city with the world's largest number of international crossings, a study of injecting drug users found that 92 per cent shared syringes and 35 per cent had sex with both men and women. Moreover, men reported low use of condoms in vaginal or anal relations (17 per cent). HIV prevalence in this population was found to be 1.5 per cent although it is probable that the figure underestimates the real prevalence since testing was voluntary. Although this group cannot be categorized directly as migrant, conditions in that border city where migrants are concentrated waiting for the chance to cross to the US, is strongly determined by the migration process (Ruiz-Badillo et al., 1997).

A study by Salgado de Snyder et al., (1996) focussed on risk behaviours among women married to or living with workers who migrate to the US. In a sample of 100 women living in rural Mexican communities, most had some information about AIDS and one in three considered herself to be at risk of infection because of the suspected extramarital sexual activity of their partners. But the great majority did not do anything to prevent the risk of infection. The

researcher concluded that they were highly vulnerable to infection and identified four main risk factors:

- Unprotected sexual contact with their migrant husbands including anal sex.

- Insufficient appropriate information, especially relative to preventive measures.

- Traditional gender roles which include submissiveness and obedience to the husband.

- Reliance on injections as the preferred solution to health problems, with most, injections being given by an *injectionista* who did not use disposable syringes.

The latter factor may have additional significance given evidence that many undocumented workers who fall ill in the US return to their communities without being diagnosed and look for the *injectionista*'s services to cure their ailments (Hayes-Bautista and Matsui, 1990).

Several works (Organista and Balls Organista, Salgado de Snyder, Magis, etc.) cite a study carried out in the mid-1990s in the migrant-originating city Gómez Farías, in the State of Michoacan, and the destination city of Watsonville, California. The study aimed to evaluate the impact which migration had on the sexual habits of undocumented Mexican migrants (Bronfman and Minello, 1995). This qualitative strategy combined ethnographic observation, interviews with key informants and in-depth interviews. Both men and women were surveyed in Gómez Farías and in Watsonville. The data showed that important changes result during the migratory process, which have potential impact on HIV dissemination.

These changes occur differently among men with distinct sexual preferences and among women. In general, heterosexuals learn new positions for vaginal coitus, but also new practices such as anal and oral sex. Something similar happens with women, especially those who migrate alone. Migrant men find that female partners in the US are more experienced and willing to participate in non-traditional contacts. In some cases, homosexuals start these practices, derived from their sexual preference, in the US or perform them more freely than in their places of origin. Two concurrent factors may contribute to such development: having arrived in a society which "tolerates" this preference more easily; and the feeling of being "freer" from social and family control. In general, the surveyed homosexuals reported having had many partners, including workmates, strangers and friends. Some prefer *gabachos* (the name given to Americans by Mexicans); others prefer Mexicans because, among

other reasons, the fear of AIDS which they perceive to be a disease of Americans, not Mexicans. The preferences vary: some penetrate, others are penetrated, but the majority had multiple experiences. All concur that this diversity was discovered and learned in the US where roles among homosexuals are less stereotyped than in Mexico (Carrier, 1989).

A group that must be taken into particular account are men who do not identify themselves as homosexuals and are not perceived by "others" as such, but who have sex with other men. The evidence implies that this behaviour is derived from loneliness and isolation, and the consequent affective deprivation. The surveys in Gómez Farías indicate that these migrants do not continue having sex with men on their return home. However, other practices (especially oral sex and, to a lesser extent, anal sex) are demanded by the migrants from their partners during their stay in Mexico.

Perhaps the riskiest behaviour has been identified from indirect information and confirmed by ethnographic observation, and involves a triangle of migrant workers, *cantinas* (local bars), and drug dependent sex workers. The migrants receive their weekly payment in cheques. Given their undocumented status, unfamiliarity with the American banking system, and their isolation in the rural areas where they work, they cannot open bank accounts and cash their cheques there. The only place where they are cashed easily are the *cantinas*. The triangle is completed by drug-dependent prostitutes who work in the bar's neighbourhood. These women offer their services for the equivalent of the cost of one drug dose, making them cheaper than all other prostitutes. The potential for HIV transmission is obvious, if not yet clearly quantified or documented.

Alcohol plays an additional role beyond the one that is usually ascribed to it as a relaxer of inhibitions. In the case of migrants who have sex with men and do not define themselves as homosexuals, the usual argument that justifies such contact is that it occurred while the man was drunk. This provides the excuse and perpetuates the assumption that a man in such a condition is not responsible for his actions.

Another study about the role of migration in modification of sexual habits was recently carried out in Los Angeles where the majority of Mexicans in the US is concentrated (Bronfman and Rubin-Kurtzman, in press). This study concludes that although material life conditions among Mexican migrants are, to a certain extent, better in the US than in Mexico, emotional and affective conditions are markedly worse. Migrant experience in Los Angeles is solitary, alienating and unhappy. Changes in sexual behaviour of migrants to Los Angeles which increase the risk of catching HIV/AIDS, include multiplicity of partners, sex with other men, oral sex and major recurrence to female commercial sex workers. Even though most migrant women have only one sexual partner, they do not believe that they are his only partner. Alcohol consumption

and use of drugs among migrant men is frequent. In spite of this, very few use intravenous drugs. As well, the precarious economic situation of some migrants compels them to exchange sexual relations for food, shelter and money (so-called "survival sex").

A recent book about Latin American migrants in the US brings together a variety of research and secondary data analysis that throw light on risk practices and vulnerability (Mishra et al., 1996). Most of the risk factors mentioned above are reflected in the book, including highly stressful living environments, high rates of alcohol use and sexual intercourse, and sex with sex workers and/or multiple sexual partners. An important finding in a study on female sex workers in two border cities (Ciudad Juárez in Mexico and El Paso in the US) was the high rate of drug consumption: 100 per cent of those from El Paso and 60 per cent from Ciudad Juárez were drug consumers (Ferreira-Pinto et al., 1996). Neither group reported using condoms regularly, which the authors ascribe to a lack of information about HIV/AIDS in general and the use of condoms in particular. Some of the women reported having had no money to pay for a condom and if they had money, they would prefer to spend it on drugs.

Almost all studies discuss condom use, and suggest the issue can be described as a descending gradient: almost everyone has heard of condoms, fewer know about its preventive possibilities, fewer still have appropriate information about its correct use, only a minority use it, and even fewer do so correctly. Although there are many quantitative studies on this, their findings must be considered with reservation. Organista and Balls Organista review publications in which the figures vary remarkably.

Among migrants of both sexes, knowledge about means of prevention is not expressed in a consistent behaviour. Use of condoms is highly variable. Still, it is among migrant men where its use as a preventive measure is increased, which makes us suppose that migration has certain positive, although slow, effects on the use of condoms.

PREVENTION AND CARE

Our search for documentation about prevention and care was even less successful than for the other subject areas. While this might reflect a real absence of such activities, our personal experience indicates that there are some programmes, especially in care, that exist but are not reported in any written form. These programmes are found in some States of the US and are carried out by non-profit organizations with a high level of voluntarism and commitment. It is important to mention these projects, for they are a significant portion of the social response which is most sensitive in cultural terms, and therefore most efficient.

In Central America, we could identify only one such project; its target population was long-distance truck drivers and their assistants/companions. Executed by the Central American Confederation of NGOs for Struggle against AIDS (CONFESIDA) and the Latin-American Institute for Prevention and Education in Health (ILPES) from Costa Rica, the project has teams in Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica and Panama. This project has a research component from whose results it is planned to derive an intervention for STD and HIV/AIDS prevention (Madrigal et al., 1966). In Mexico, a similar project began recently, financed by USAID. We found no evidence of care services specifically for migrants in the Central American region. In Mexico, however, a major effort has been made to investigate the epidemic's characteristics and test specific actions among migrant populations.

As HIV infection is increasing in Central America (especially in Honduras), whence come most migrants in south-east Mexico, the Mexican National Council for AIDS Control and Prevention (CONASIDA) tried for several years to identify interventions that may be carried out in this region. Until now the main target group has been female sexual workers and their clients, because sex workers are in permanent contact with mobile populations and are largely migrants themselves. One research project, Migration, Sexual Commerce and STD/HIV/AIDS in the Southern Border of Mexico, financed by WHO's GPA programme (Uribe et al., 1996), found that 93 per cent of sex workers were undocumented migrants from Central America who stay in the country for about three months. Their clients included truck drivers, military men, customs and local security agents, all of whom are mobile populations. The study concluded that any prevention strategy must involve local and health authorities of the region, and must be *placed* in fixed points of the zone, such as customs checkpoints, brothels, bars and other sites where truck drivers and military men usually gather.

As a result of this study, pilot interventions were tested in two cities (Tuxtla Gutiérrez and Comitán), and an education programme that includes all groups in Ciudad Hidalgo (on the Mexican-Guatemalan border) was initiated which not only offers information but provides workshops for increasing self-esteem and organization. An assessment of the programme showed positive results: six months after its application, there had been a significant reduction in STD prevalence among sexual workers (Uribe and Bronfman, 1997; Uribe et al., 1996).

There is no written evidence of occasional or permanent care programmes in this area related to HIV/AIDS, except the regular checkups demanded from sex workers in order to allow them the exercise of their profession. It is well known that these checkups have limited efficacy. In any case, when a seropositive prostitute is detected, she becomes "clandestine" in order to be able to keep working, or moves to another place for the same purpose.

The northern border of Mexico has received major attention over time. CONASIDA has been involved in several activities. Its 1994 Annual Report notes the creation of an Assistance Center for Mexican Migrants, in accordance with an agreement signed between Health Ministry and Ministry of Foreign Affairs to give support and information to Mexican migrants in the US. The centre began work in the Mexican consulate in Los Angeles, but there is no recent information concerning its activities or evaluation of its work. The 1996 report mentions a training programme within the framework of the agreement but gives no details.

One of the most important educational activities aimed at the migrant population is a three chapter TV soap opera called “If We were Angels, or Everyday Life”, which came as a result of research described in Bronfman and Minello (1995). The script combined depictions of everyday situations with personal testimonies in a slightly humorous framework, and featured the participation of five famous actors who did their job without charge. It was broadcast in December 1992 in cities with high migrant expulsion as well as in those of frequent destination in the US. The estimated audience was 6 million, measured by the usual rating methods and through the change in the frequency of Spanish-AIDS hotlines calls in the US (Bronfman and Lopez, 1996). Specific assessment of its impact on behaviour was not carried out.

Another video generated by the same research was a one chapter TV programme titled “Life Continues…”, created by the film maker Maricarmen de Lara. Supported by the McArthur Foundation and PAHO, it targetted migrant women in Mexico and was distributed together with a manual for use in rural communities. Verbal reports indicate that this video has been used with good results in different parts of Mexico, but there is no written report.

Under the sponsorship of CONASIDA and National Institute of Public Health (Loya Sepulveda et al., 1997), a study among women from rural areas with high migration rates was carried out to assess and design interventions using illustrated material, including a flip-chart presented in a community gathering along with the video, “Life Continues...”, and a comic strip. Evaluation showed that materials managed in groups (flip-chart and video) were not successful because of the target population’s discomfort with discussing subjects related to sexuality in a group setting, and their reluctance to participate in collective events with such content. The study indicated that the comic strip was more successful in terms of information but commented that since “possible changes occur slowly, it is important to address the messages repeatedly.”

The Panos Institute (Osorno, 1997) reports an effort named “Goal Project” initiated by the Mexican consulate in New York in coordination with an NGO called the Hispanic Children and Family Committee. For two months a group of specialists visited a Manhattan playground where a Mexican soccer league

plays and thousands of Mexicans gather. The project distributed information and condoms. A similar effort was started in places from where the majority of migrants originate in Mexico. It's impact has not been assessed.

Besides these efforts carried out by Mexican institutions, or jointly with institutions from the US, there are many unaffiliated programmes in the US itself. Although there is no written information about the majority of them, a few have been documented. Mishra, et al., 1997 describe a preventive educational programme designed specifically for farm workers, titled "Three Men without Borders", which includes a story illustrated with photos and a radio play. Guided in its design by research, the entire programme is in Spanish and is based on four principles: a) a low literacy approach which uses pictures to tell a story; b) a story line that incorporates lifestyles and health behaviours; c) use of a medium that is culturally sensitive and that people may read on impulse; and d) wide dissemination since one photo-story may be shared and read by several people. Its impact was measured through a quasi-experimental design which showed a significant change in the experimental group compared with the control group.

Another effort to "mexicanize" interventions was carried out in Los Angeles by the L.A. County STD Programme, which used a specially trained *mariachi* group (a traditional musical group) to disseminate preventive messages in its songs. An increase in recollection of the prevention messages was apparently achieved as well as an increase in condom demand and higher acceptance of counseling on STD/AIDS *in situ* (Rulnick et al., 1995).

Finally, an undated article by the US government's National Commission to Prevent Infant Mortality describes several federal health programmes available for migrants. However, none is specially oriented to AIDS nor are they obliged to care for people living with HIV/AIDS. As the document recognizes, "unfortunately, even when taken together, the federal programmes serving migrant and seasonal farmworkers are unable to reach all farmworkers, and some serve only a small proportion of the population….Moreover, although the Migrant Health, Migrant Education and Migrant Head Start programmes are providing HIV prevention services in one form or another, these efforts cannot meet the need. Budgets are very limited and funding is not specifically targeted for HIV education, screening and treatment within any of these programmes" (National Commission to Prevent Infant Mortality, undated).

CONCLUSIONS AND RECOMMENDATIONS

This review has highlighted the scarcity of written material on the relationship between migration and AIDS. However, we do not want to leave the impression that we are describing a field in which nothing has been done. There are some important exceptions to the lack of information.

First, the migration of Mexicans to the US has been well studied and documented and been the object of policies both in the countries of origin and destination. These policies have been mostly unilateral, although there are examples of bilateral agreements. The most recent trends suggest that there is an advance towards bilateral policies that would take into account all aspects of this phenomenon, though it is not possible to predict how fast or indeed whether they will be put into practice. Meanwhile, police and restrictive measures in the US have resulted in high levels of undocumented migratory flow. This fact has significant and broadly documented consequences for the spread of HIV, while restricting migrants' use of services, even those to which they have the right.

In the case of Central American migration, there is an almost total lack of solid information about the magnitude, direction and characteristics of the flows. A few studies have given indirect information, but very little about specific conditions in the places of origin, transit and destination. Again, restrictive measures in transit and destination countries push the migrants towards illegality.

There is general agreement that present socio-economic conditions in the region, and the economic models that these countries have adopted in order to face these conditions, are unlikely to diminish the enormous and complex flow of migrants. Indeed, it is more likely that the flows will increase.

Two priorities are suggested by our review of the literature:

- Research on the magnitude and characteristics of Central American migrant flows to Mexico and the US must be promoted.

- An environment that would allow the reduction of illegal migration must be created. This implies intense political and technical work to convince decision makers of the risks that restrictive measures generate for the public health of all the involved in this issue.

For the first priority, reliance could be placed on the methodologies used successfully in studies already carried out in Mexico and the US. For the second, however, there are no exemplary experiences available in the region, and therefore a considerable degree of creativity will be required.

In contrast to Mexico, where existing aggregate data are relatively reliable, there is an absolute lack of epidemiological data about STDs and HIV/AIDS in Central America. Clearly, there is an urgent need for improving data collection systems in Central American countries in order to understand the dynamics of the epidemic in each country and on a regional level.

The greatest amount of available information is about Mexican migrants who return to Mexico from the US, about their communities, and about Mexican migrants in the US. There is evidence that migration is associated with the ruralization and, partly, feminization of the epidemic. Likewise, the increase in injecting drug use as a risk factor along the northern border of Mexico is associated with migration, notably the migrants' adoption of risk practices. This information, though scarce and relatively dispersed, justifies the need for implementing specific interventions. At the same time, more information must be collected about the presence and dynamics of the epidemic in different mobile populations.

The most appropriate methodology for data collection is sentinel surveillance. Valuable experience has already been accumulated in Mexico using this methodology, which has given consistent and scientifically rigorous results. In order to expand these studies to other migratory groups, courses could be implemented in academic institutions and the public sector for training researchers in this form of investigation, particularly concerning sexuality in mobile populations. Such courses would also help give this issue the legitimacy and prestige necessary for including it on research agendas.

In relation to legislation and regulations relevant to AIDS and migration, there are reasons for concern:

- In all countries, legislation provides for "hygiene", "public health" or "morality" to be used as grounds for prohibiting entry or denying a visa.

- There is a broad margin for the discretion of officials responsible for the application of the law.

- There is evidence that these officials, in general, are inclined to adopt restrictive measures.

- There is evidence that HIV tests are demanded in some countries and that actions are taken according to the resultant serological status.

For these reasons, it is crucial to create explicit standards banning the requirement of serological tests and protecting all travelers, especially migrants, from such requirements. The best way to do this might be through a regional mechanism with the presence and pressure of appropriate international organizations.

Regarding the knowledge of migrant populations about STDs and HIV/AIDS, there is insufficient documentation to make definitive statements. In Central America, we were unable to find specific information on such knowledge

among migrants. In Mexico, some studies have been done in areas of high migratory origin, and among mobile population groups or those related to them. After observing levels of correct information, incorrect information and lack of information, we conclude that current knowledge is not sufficient to prevent the risk of infection. Knowledge seems to improve among Mexican migrants in the US who are exposed to major information density, although the same pattern exists.

Recommendations on this issue can be made on two levels. The first is related to generalized information deficits. It is necessary to increase information campaigns on the general level in order to provide an information "umbrella" and maintain a sufficient information density. At the same time, more focussed information must be designed and disseminated which is appropriate to the socio-cultural characteristics of migrant populations and their families, as well as to their specific barriers to protection. Many messages with these characteristics have been made and spread, but their evaluation has been limited to a pilot experience, or has not been done at all. However, we suspect that there are several experiences noted in the text which could be a part of a "best practices" reservoir.

A second level is that of knowledge about STDs and HIV/AIDS among migrants and their families. Research instruments must be designed to permit a clear distinction being made between useful and non-useful information, and the degree to which the latter influences behaviour.

The migration we are analysing has always been a migration from places with lower levels of information and less sophistication in behaviour than in place of destination. And, with the sole exception of Honduran migrants, it has always originated in places where HIV/AIDS prevalence rates are lower than in destination places. This combination of factors has some positive aspects. For instance, while Mexican migrants to the US may adopt higher-risk practices, they may also increase their preventive behaviours and their level of information. On the other hand, some research suggests that those who started using condoms in the US do not continue doing so on their return, because it would be an admission of their infidelity to their stable partner.

In summary, all the studies carried out with Mexican or "Latino" migrants in the US show, with certain variation in numbers, the same patterns:

- More frequent use of prostitution than in their places of origin (among men).

- Adoption of new sexual practices such as oral and anal sex (among both sexes).

- Sexual practices among men which include penetration, but which do not entail self-identification as homosexual.

- Greater diversity of sexual partners (both sexes).

- Initiation in use of injectable drugs (both sexes, but low rates).

In those studies in which it could be compared, increase in use of condoms was observed, although at very low levels, as well as having received better information.

It is therefore essential to mount permanent campaigns offering clear information about risk practices and stressing the proper use of condoms. In both cases, the campaigns must be made specifically for the migrants, taking into account their difficult living conditions and their socio-cultural characteristics. There is a great deal of experience from which to learn about designing and implementing such campaigns, including what might probably be termed "best practices". However, it is currently impossible to state which these are, since there has been little rigorous evaluation, and some are just pilot experiences.

The least material was found relating to existing resources, both for prevention and for care, which is undoubtedly a very good indicator of the relative absence of interventions and services. However, a few projects or interventions are known to exist that have not been documented in writing, among which are some we would be inclined to call "best practices". Taking into account this reality, it would be an important step to identify existing projects and carry their evaluation in order to identify the most effective ones and facilitate their replication. It is also urgent that increased assistance services be made available to migrants in their different stages: at place of origin, transit and, especially, destination.

The recommendations suggested above need, as a precondition, the issue of the relationship between migration and AIDS to be present on both the political and research agendas. To achieve the first, it is essential to carry out constant lobbying with national programmes and health authorities. This must be done using arguments most effective with this audience, including practical considerations resulting from the social and economic impact of the epidemic and, above all, political and administrative costs and benefits. International organizations may have the most important role in this task, because national authorities are, in general, alert to international pressure.

Getting this issue on the research agenda, from which it has been strangely absent, will require financing and academic recognition. Once again, international organizations may be most effective at convincing financing agencies

to designate resources for this issue. Additionally, academic publications about AIDS and those about migration should be encouraged to reserve space for studies on the relationship between migration and AIDS. With this, two main concerns of academics would be solved: financing of their projects and diffusion of their results.

Another mechanism for creating a favourable "environment" for study of the issue would be the creation of a Task Force in each country of the region. Membership should include committed and concerned academics, activists and officials from the areas of health, population, foreign affairs and education.

NOTES

1. This section on migration in the Central American countries is based largely on Castillo and Palma's 1996 book*, La emigración internacional en Centroamérica. Una revisión de tendencias e impactos.*
2. This figure reflects a record of events, not individuals, thus ignoring the possibility that a person could have been detained and returned at other times, as in fact happens.
3. It should be noted that communication is strengthened when those who transmit the message include persons who are visibly sick or infected.

REFERENCES

Bronfman, M.
1989 "Migration and AIDS in Mexico", XVII Conference of the Latin American Studies Association, Miami, (in Spanish).
1990 "AIDS in Mexico", *Demos, Carta Demográfica sobre México, 1990,* (in Spanish).

Bronfman, M., et al.
1995 *AIDS in Mexico, Migration, Adolescence and Gender*, CONASIDA, Información Profesional Especializada S.A. de C.V., Mexico, (in Spanish).

Bronfman, M., and C. Magis
1996 "Third World-ization, poverty and ruralization: The evolution of AIDS", *Demos. Carta Demográfica sobre México,* Mexico, (in Spanish).

Bronfman, M., and J. Rubin-Kurtzman
Sexual Habits of Mexican Temporary Migrants in Los Angeles: Practices involving risk of HIV infection, (in press).

Bronfman, M., and N. Minello
1995 "Sexual habits of Mexican temporary migrants in the USA: practices involving risk of HIV infection", in *SIDA en México. Migración, Adolescencia y Género*, CONASIDA, Información Profesional Especializada. S.A. de C.V., México, (in Spanish).

Bronfman, M., and S. López Moreno
1996 "Perspectives on HIV/AIDS prevention among immigrants on the US – Mexico Border", in Mishra, et al., *AIDS crossing borders. The Spread of HIV among Migrant Latinos*, Westview Press.
Carrasco, E.
undated *Migration and HIV/AIDS, Latin-American and Caribbean Network of Human Rights and AIDS,* (LACCASO), Venezuela, (in Spanish).
Carrier, J.M.
1989 "Sexual behavior and spread of AIDS in Mexico", *Medical Anthropology,* Vol. 10.
Castillo, M.A., and S.I. Palma
1996 *International Emigration in Central America: A Review of Trends and Impacts,* FLACSO, Programa Guatemala, (in Spanish).
CONASIDA
1997 *Epidemiological Situation for AIDS and STDs,* 4(4), Mexico, (in Spanish).
Del Río-Zolezzi*,* et al.
1995 "The HIV/AIDS epidemic and women in Mexico", *Salud Pública de México,* 37(6), November-December, (in Spanish).
Farías, P.
1994 "Refugees and mental health in America", in *Experiencias del Refugio Centroamericano. Persperctivas de Salud Mental y Psicosocial*, El Colegio de la Frontera Sur, Mexico, (in Spanish).
Ferreira-Pinto, et al.
1996 "Mexican men, female sex workers and HIV/AIDS at the US-Mexico border", in Mishra, et al.,*AIDS crossing borders. The Spread of HIV Among Migrant Latinos*, Westview Press.
Gómez de León, J., and R. Tuirán
1996 *Mexican Migration towards the United States: Continuity and Change*, CONAPO, Mexico, (in Spanish).
Gondrie, P., et al.
1995 "Evaluation mission medium-term plans for AIDS prevention and control in Central America 1993-1995", presented to the governments of Norway, the Netherlands, Sweden, and Central America, 15 February to 18 March, 1995.
Gonzalez Block, M.A., and A.L. Liguori
1992 *AIDS and Mexican Socio-economic Strata: Public Health Perspectives,* Instituto Nacional de Salud Pública, Cuernavaca, Mexico, (in Spanish).
Hayes, Bautista D., and O. Matsui
1990 *Immigration and AIDS. Internal report of the Chicano Studies Center,* University of California, Los Angeles.
Jones, J.L., et.al.
1991 "HIV-related characteristics of migrant workers in rural South California", *Southern Medical Journal*, 84(9): 1088-1090
Lopez, R., and J. Ruiz
1995 "Seroprevalence of human inmunodeficiency virus type I and syphilis and assessment of risk behaviors among migrant and seasonal farmworkers in Northern California", unpublished manuscript, prepared for Office of AIDS, California Department of Health Services.

Loya, Sepulveda, et.al.
1997 "Effects of an educational intervention to prevent HIV/AIDS in a rural migrant population", paper presented at the XI Congreso Latinoamericano de ETS y V Conferencia Panamericana de SIDA, Lima, Peru, (in Spanish).

Madrigal, J., et al.
1996 *Campaign for Prevention of HIV/AIDS and STDS among Central American Truckdrivers in Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica and Panamá, Costa Rica,* Confederación Centroamericana de ONG de Lucha contra el SIDA (CONFESIDA), Instituto Latinoamericano de Prevención y Educación en Salud (ILPES), (in Spanish).

Magis, C.
Linking Policy with Research: The Case of AIDS, (in press).

Magis, C., et al.
1996 "The AIDS epidemic in Mexico: overall analysis 1981-1986", *Gaceta Médica de México*, 132(5), (in Spanish)

Mishra, S., et al. (Eds)
1996 *AIDS Crossing Borders. The Spread of HIV among Migrant Latinos*, Westview Press.

National Commission to Prevent Infant Mortality
undated *HIV/AIDS: A Growing Crisis among Migrant and Seasonal Farmworker Families*, United States.

Organista, K., Balls and P. Organista
1997 "Migrant laborer and AIDS in the United States: a review of the literature", *AIDS Education and Prevention*, 9(1).

Osorno, G.
1997 "HIV threatens aspirations of Mexican immigrants in the USA", *SIDA: Crónica Mensual,* Panos Institute, Washington, (in Spanish).

Pérez López, A., et al.
1991 "HIV infection prevalence and its relationship with other STDs in a group of prostitutes in Huixtla, Chiapas", *Investigación Clínica,* January-March, (in Spanish).

Pineda, T.E., et al.
1992 "Profile of the Michoacan emigrant to the USA and the impact of the disease in the region", III Congreso Nacional de Investigación sobre Salud, Mexico, (in Spanish).

Ruiz-Badillo, A., et al.
1997 "Study of HIV/AIDS infection risk among drug injectors in the city of Tijuana", VII Congreso Nacional de Investigación en Salud Pública, Mexico, (in Spanish).

Rulnick, S., et al.
1995 "Using mariachis to deliver HIV education and prevention messages to recent immigrants in Los Angeles Country", V Congreso Nacional sobre SIDA, Mexico.

Salgado de Snyder, V.N., et al.
1996 "AIDS: risk behavior among rural Mexican woman married to migrant workers in the United States", *AIDS Education and Prevention,* 8(2).

UNHCR
1992 "Provisional conclusions on surveys regarding women's health in refugee camps", Mexico, (mimeo).

Uribe, P., et al.
1996 "Migration, commercial sex and HIV infection, and possible interventions", International Congress on AIDS, Vancouver.
Uribe, P., and M. Bronfman
1997 "Southern frontier: commercial sex and HIV prevention", (letter), *La Jornada*, July 3.
Warren, R.
1994 "Estimates of the anauthorized immigrant population residing in the United States by country of origin and state of residence", paper presented at the Conference on California Immigration, Sacramento, California, California State University, (mimeo).
WHO
1993 *Weekly Epidemiological Record*, Geneva, (3), January.

MEXIQUE ET AMÉRIQUE CENTRALE

Le présent article s'intéresse aux migrants du Belize, du Costa Rica, du Salvador, du Guatemala, du Honduras, du Mexique, du Nicaragua et du Panama. Si les Etats-Unis sont leur destination de prédilection, le Mexique a également les faveurs des migrants d'Amérique centrale et constitue un pays de transit en route vers les Etats-Unis.

La population de migrants d'Amérique centrale est constituée pour l'essentiel d'hommes analphabètes et sans qualifications, d'origine rurale et en âge de travailler. Beaucoup sont chefs de famille et appartiennent pour une bonne part d'entre eux à des groupes marginaux, notamment aux peuples autochtones. Les migrants mexicains sont d'une tranche d'âge comparable, mais la plupart viennent des zones urbaines. Qu'ils soient originaires d'Amérique centrale ou du Mexique, la majorité des migrants voyagent sans papiers. Beaucoup d'entre eux rentrent dans leur pays après avoir vécu pendant quelque temps aux Etats-Unis.

Le peu de données sur le VIH/SIDA dont on dispose dans la région se vérifie davantage en ce qui concerne le Mexique que l'Amérique centrale. Le Honduras est le pays le plus touché en Amérique centrale, puisque c'est dans ce pays qu'ont été signalés plus de la moitié des cas recensés. Actuellement, les cas recensés dans les zones rurales ne constituent encore qu'un faible pourcentage – mais en augmentation rapide – du total des cas répertoriés au Mexique et en Amérique centrale, ce qui atteste de l'incidence croissante de la migration sur les tendances épidémiologiques.

Les données disponibles en matière de VIH/SIDA pour ce qui concerne les populations de migrants d'Amérique centrale ont essentiellement trait aux migrants dans les pays de destination (à savoir le Mexique et les Etats-Unis). Par comparaison, un certain nombre de projets de recherche relatifs aux conditions de migration au Mexique ont jeté un certain éclairage sur la propagation du VIH, et plus particulièrement les travaux de recherche effectués sur les migrants mexicains se rendant aux Etats-Unis. Sur les cas de SIDA actuellement recensés au Mexique, 10 pour cent concernent des personnes qui ont déjà résidé aux Etats-Unis. Ce groupe se différencie nettement du reste des personnes infectées recensées dans le pays, avec un profil démographique similaire à celui des migrants temporaires.

Les études qui s'intéressent aux comportements à risque et au niveau des connaissances sur le VIH/SIDA parmi les migrants qui se rendent aux Etats-Unis révèlent ce qui suit : pratiquement tous ont entendu parler des préservatifs, peu sont informés sur les possibilités de prévention que cela offre, moins encore savent comment il faut les utiliser, une minorité seulement s'en servent, et ils sont moins nombreux encore à le faire correctement. Parmi les

comportements à risque et les facteurs de vulnérabilité chez les migrants, il faut citer un cadre de vie très difficile, une forte consommation d'alcool et des rapports sexuels très fréquents, notamment avec des professionnels du sexe et/ ou des partenaires multiples.

La migration au Mexique et en Amérique centrale est profondément liée aux conditions économiques et politiques. Les mesures policières et la politique de restrictions aux Etats-Unis se sont traduites par une très forte immigration illégale qui a eu des conséquences considérables et largement attestées sur la propagation du VIH, tout en restreignant l'accès des migrants aux soins de santé.

L'ouvrage propose deux priorités : Premièrement, il conviendrait d'effectuer davantage de recherches sur les flux migratoires d'Amérique centrale vers le Mexique et les Etats-Unis. Deuxièmement, la diminution de l'immigration illégale passe nécessairement par un intense travail politique et technique pour convaincre les décideurs des risques que font courir les mesures de restriction sur la santé publique.

MÉXICO Y CENTROAMÉRICA

Este artículo trata de los migrantes de Belice, Costa Rica, El Salvador, Guatemala, Honduras, México, Nicaragua y Panamá. Si bien su destino principal es los Estados Unidos, México también es el destino escogido por los centroamericanos y constituye un lugar de tránsito rumbo a los Estados Unidos.

La población de migrantes de Centroamérica comprende principalmente hombres analfabetos sin calificaciones, de origen rural y en edad económicamente activa. Muchos son cabezas de familia y en su mayoría provienen de grupos marginales, incluidas poblaciones indígenas. Los migrantes mexicanos tienen la misma edad, pero provienen principalmente de zonas urbanas. Ya se trate de centroamericanos o de mexicanos, la mayoría no cuenta con documentos. Muchos retornan a sus hogares después de haber vivido durante algún tiempo en los Estados Unidos.

La poca información de que se dispone con relación al VIH/SIDA sobre esta región concierne principalmente a México y no tanto a Centroamérica. Honduras es el país más afectado de Centroamérica, puesto que contiene más de la mitad de los casos recensados. Actualmente, los casos rurales constituyen un pequeño porcentaje pero en raudo aumento del total tanto en México como en Centroamérica, y son un indicador del creciente impacto de la migración en las tendencias epidemiológicas.

Los datos disponibles sobre el VIH/SIDA en las poblaciones migrantes centroamericanas conciernen principalmente a los migrantes en sus lugares de destino (es decir, México y los Estados Unidos). Por otra parte, una serie de proyectos de investigación sobre las condiciones migratorias en México deja entrever cómo se lleva a cabo la propagación del VIH, particularmente la investigación realizada en la migración mexicana hacia los Estados Unidos. Entre los casos de SIDA actualmente en México, el 10 por ciento ha residido en los Estados Unidos. Este grupo puede diferenciarse claramente del resto de personas que viven con el VIH/SIDA registradas en el país, con un perfil demográfico similar al de los migrantes temporeros.

Los estudios que evalúan los comportamientos que entrañan riesgos y los niveles de conocimientos sobre el VIH/SIDA entre los migrantes que parten rumbo a los Estados Unidos, registran niveles descendentes: casi todos han oído hablar de preservativos, pocos saben sobre sus posibilidades preventivas, menos cuentan con información apropiada sobre su utilización correcta y sólo una minoría los utiliza, siendo incluso muchos menos los que los utilizan correctamente. Los factores de gran riesgo y vulnerabilidad entre los migrantes comprenden entornos de vida sumamente estresantes, elevadas tasas de consumo de alcohol y de relaciones sexuales con trabajadores del mercado del sexo y/o múltiples parejas sexuales.

La migración en México y Centroamérica está profundamente relacionada con las condiciones económicas y políticas. La policía y las medidas restrictivas en los Estados Unidos han dado lugar a elevados niveles de migración indocumentada que ha tenido considerables y ampliamente difundidas consecuencias en la propagación del VIH, al tiempo que restringen las posibilidades de que los migrantes recurran a sus servicios.

Se propone establecer dos prioridades. En primer lugar una investigación más exhaustiva sobre las corrientes migratorias centroamericanas hacia México y los Estados Unidos. En segundo lugar, si se desea reducir la migración ilegal será preciso intensificar la labor política y técnica para convencer a quienes toman decisiones sobre los riesgos a que dan lugar las medidas restrictivas en la salud pública.