Barriers to Migrants and Mobile Populations in Accessing Comprehensive HIV Services and Treatment
Kaiser Family Foundation
July 20, 2010

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AMARA QUESADA: - HIV services and treatment. As most of you have been working around issues of migration or mobility and HIV would know that migration and the conditions around migration contributes to the vulnerability faced by migrant workers everywhere and you've probably heard several sessions around the issue already.

So today we will look deeper into this issue and look at what happens when migrant workers become positive of HIV, and see the situation in terms of how they're able to access or not access services in the country of destination where they get tested or when they get home after they are deported.

For this afternoon, we are lucky to have been able to assemble a panel of experts who will talk about different issues around access of HIV positive migrants to healthcare services, as well as the restrictions that are imposed on migrants in different phases of migration.

So, let's start with the first speaker beside me here is Mr. Peter Weissner. He's from Germany. He has a diploma in social science, particularly in politics and sociology. He's a member of the European AIDS treatment group and is a freelancer connected with the Deutsch AIDS-Hilfe and one of his biggest contributions I would say is putting out nine editions of the quick reference booklet on HIV specific travel restrictions.

I'm sure a lot of you have seen that. I particularly have used that reference in a lot of my research. In 2008 he was a member of the International Task Team on HIV related travel restrictions and is one of the authors of the global database on HIV specific travels restrictions, which is found at www.hivrestrictions.org. Peter.

PETER WEISSNER: Thank you. I'm going give you an overview of restrictions related to HIV entry and residents and human rights violations. I do this presentation because of my colleague Karl Lemmen actually Karl should be here, but he couldn't make it, so I'm going to present.

You see here a map and all those countries in red, they have restrictions in place. The countries you see in orange that we have there, there is only contradictory information and we cannot say if they have restrictions yes or no. The countries in green, they don't have restrictions.

There is a guide, a booklet you can see that you can have outside at the table. Before I start the presentation, I would like to just read a story, a personal testimony. This was an e-mail I've got.

“Sorry Peter for bothering you. I'm a 25-year-old male and I'm HIV positive. I'm holder of both China and Hong Kong passport. I now have a job offer in Australia which will not

only enhance my personal career development but also fulfill a long-held dream.

But as Australian government requires a medical examination, I'm afraid of being denied of working visa. However, I believe that Australia is a democracy and such things should not happen. Another concern, will the government disclose my HIV conditions to my would-be employer? Still I believe as a democracy its national and state government will keep such sensitive information confidential, right?

I'm presently too busy with my new job and could hardly spare time to ask people including those in the Australian government. Feeling so sad, as I'm only 25-years-old and should be deprived of some right because of a virus when I got an opportunity knocks at my door and I really want it.

I myself strongly believe I can contribute a lot of my would-be employer. I would definitely feel guilty if I'm refused a visa. Peter thanks for your time and if you cannot answer, at least point out the right direction to whom I should turn to help."

So I ask you, do whom do you turn to help in such a position? Who could provide information about the Australian [inaudible]. Is it advisable to contact the Australian authorities directly? Would you discuss it with your future

employee? Would you lie? And if you fail, what would be the consequences?

So what advice would you give to circumvent the restrictions in Australia? Would authorities deport you if they find out about your HIV status and if your visa would get denied, would you be able to apply a second time, would they give you a second chance? What would be your answer?

Just two words about our experience on the topics of Deutsch Aids-Hilfe did start doing community driven research in 1999. So we did get in contact with all embassies, all the embassies around and asked them, confronted them with the questionnaire, so we gathered data on HIV specific and residents regulations about right. The question that we asked was about is specific regulations on alien residents. If there is an HIV test that needs to get carried out, what are the rules of controlling it, deporting people living with HIV and AIDS, and would it be possible to import HIV medication for private use?

We distributed information since 1999, we came up with a guide called Quick Reference. We have nine editions by now. We have 10 translations in the languages and we created this database. I personally was a member of the UNAIDS Task Team to remove these restrictions.

So this is the result of our work; we have currently 66 countries with restrictions worldwide and 25 countries where we have contradictory information, so we simply don't know if there are restrictions, yes or no. There are eight countries worldwide where we don't have any information at all. We have 31 countries that deport people living with HIV and AIDS. And we have 119 countries without any restrictions at all.

So what is the impact for mobile populations in light of this sort of regulations? You have of course, health related questions included in the visa regulation form. You have to come up with a health certificate if you ask for a work visa or for a study permit, and the HIV test is mandatory. You might have medical examination. There might be a mandatory test at border before or after entry and if you are in the country on a regular basis each year and recruitment agencies might require HIV tests.

So these are the evil countries I would say. So there are 15 countries worldwide that categorically refuse entry of people living as HIV and AIDS, and this entails short-term visits. There are 19 countries that deny visas for short-terms stays and there are 15 European countries with restrictions.

And we tried to lobby in the forefront of this conference to revise these restrictions, but we didn't succeed. There are

deportations in 31 countries. I don't go through this because there was a presentation this morning.

What are the limitations of rights? This applies for people living with HIV and AIDS and there are limits of course the right to privacy. So if the voluntary counseling and testing funds are completely neglected. There is forced disclosure and this does have devastating, emotional, and financial impact, especially if those people have to lose their jobs.

There is no information about tests taking treatment options. If the test is taken and this has of course, negative impact on doctor/patient relationships, so would you trust your physician if he takes a mandatory test if he doesn't explain anything? Of course not.

This violates the right to health. It has often been mentioned that mandatory HIV testing drives people underground so we are very likely not going to contact the health system if tests are coming out in order to exclude people.

There are double standards. Access to health care service is always linked, this is Europe the case and in many other countries to residents of state and this should not be the case. Migrants don't have benefit of insurance, so I just wonder why it's not possible to combine migrant work access to

health insurance as it is the case for any other people who work in my country, Germany.

It limits the right to life. Deportation might be and very well could be often a death sentence for the people who suffer on this. It limits, of course, the freedom of movement so people living with HIV and AIDS have limited choices to look at residential permits to work, to study, to make a living, unite with families, or to participate for particular conferences.

And we know that there's no public health rationale for doing this. There's no public health rationale for restricting liberty of movement of choice, for residents on the grounds on HIV status, so this is a [inaudible] Susan Timberlake [misspelled?].

All this demonstrates that there are very clear perceptions of people living with HIV and AIDS and so infection, and so they say that people living as HIV, they should go outside of our country because they behave irresponsibly, they are a danger to public health, they have a short life expectancy and can't sufficiently contribute to society and are a burden of the healthcare budget and related to HIV, it tells you that HIV is a foreign problem that can get controlled at borders and I simply ask you is this a reality,

does this reflect the reality of 2010? Of course not, everybody knows that.

So what should the community do? What should be our response to work on that? I think first of all, the HIV community came out of the key principle to greater involvement of people living with HIV and AIDS. And we have to say that these principles are violated by these sorts of restrictions.

So, we have to say the people living with HIV contribute o society. We have to say that conferences shouldn't take place in countries where the right of the people living with HIV and AIDS is not respected. And we have to integrate people in health service planning and delivery. And we should not use HIV testing as a [inaudible].

We have to respect voluntary country and testing. This applies for migrants much more than to anybody else. We should fight against HIV screening designed to exclude or stigmatize.

This is the last slide. I think the fight for universal access starts here. It doesn't start in Africa or in Asia, it starts in every single country and universal access to means that migrant workers should be integrated and should have access to any service that anybody else. So this is more or less the key message and the other message would be that restrictions would fuel a stigma and criminalize people living with HIV and AIDS.

So there should be more cooperation between sending and and receiving countries, but we'll hear more about this later and we should raise awareness. If you have examples from your country you should send it to us and we can distribute it.

Just an acknowledgement to those people who have been involved in the fight to remove these restrictions and to spread the information. Thank you. [Applause]

AMARA QUESADA: Thank you Peter. May I request if you have questions, we will entertain them after all the speakers have done their presentations? For the next speaker, Mr. Rommell Franco Legwes from the Philippines. He is a member of Pinoit [misspelled?] Class Organization, an organization of people living with HIV in the Philippines. He is also been involved in activities of this organization, including providing care and support to other people living with HIV, as well as conducting research for the organization. He is also a volunteer health advocate for Action for Health Initiatives, that's my organization, so Rommell.

ROMMELL LEGWES: Yes. Good afternoon everyone. My name is Rommell Legwes. I am a former Filipino migrant worker and work in [inaudible] in Saudi Arabia as a private waiter for King's Palace for the last 10 months.

All my dreams were crushed when I was diagnosed with HIV. Today I will share my personal experiences as well as

experiences of other migrant workers who were detained or deported due to HIV.

First I want to talk about some of the things that make migrant workers vulnerable to HIV infection. One of the reasons why migrant workers are vulnerable to HIV is lack of information and HIV awareness and AIDS. Filipino migrant workers are required to undergo three to five year departure orientation on seminar.

Unfortunately, migrant workers are too anxious and eager to work abroad to do this. Also the time to write it with sexual orientation, that is not enough for migrant workers to understand all the important details about HIV.

When I got diagnosed, there was no information about HIV. All I know about HIV and AIDS came from television program. Still, this was not enough to protect myself, as I learned that we're not given any reading materials or given any [inaudible] to learn about HIV and other diseases in receiving countries.

Being away from our family, friends, and intimate partners, migrant workers often look for a way to cope with loneliness and homesickness. Many migrant workers have a relationship with migrant worker in the receiving country. I had a relationship with a female Filipino and that helps ease my homesickness.

Others will engage in intimate relationship often does so as means to have additional money. This kind of relationship helps other migrant worker to send more money to their loved ones left at the sending countries. Because of lack of awareness, many migrant workers did not realize the risks involved when engaging in unprotected sex, but sometimes those who are aware about using condoms to prevent HIV find it difficult to have a condom because of the restrictive culture in the receiving country.

In Saudi, I have not seen any stores that sell condoms. I engaged in paid sex while I was in Saudi Arabia. Because sex was criminalized in the country, these activities are always done very discreetly and this also contributed to my difficulty in accessing information and commodities to protect myself from HIV.

There are migrant workers who engage in sex with their partners, but do not use condom because they believe that their relationship is exclusive, migrant workers fall in love and put their trust in their partners. But unfortunately, this love and trust are given a reason, why do you choose not to use condom? And sometimes it makes them vulnerable to HIV infection.

Also, I know some Filipino migrant workers migrant workers with greater employers and some acquaintances. In this

incidence, migrant workers have no chance of using condoms to protect themselves. When working abroad, one of the most difficult barriers to overcome is the [inaudible]. I cannot avail myself of services or information because I cannot speak their language. Furthermore because of the differences in culture, I was not sure it would be acceptable to talk about sex or sexuality or HIV.

To top this, many of us are not aware of where we can access this kind of services in the destination country. Everyone knows that HIV testing is among the [inaudible] for migrant workers. We had to undergo the tests every time we renew our work permits. When I underwent a medical test to renew my work permit, I wasn't aware that they also tested me for HIV.

There was no counseling before and after the test. My medical test result was directly given to my employer. I only found out my result after two weeks. The lead assistant of The King, told me that I needed to go back to the hospital. I was accompanies with two of the King's staff in the car and at the hospital.

At the hospital, the doctors told me that I wasn't quite HIV positive. I asked the doctors to give me the result of my test. But she didn’t give me my test result; she just told me that I was lucky because I was brought to the hospital

and not in prison. I was detained in a small room in the hospital for two weeks. I didn't feel lucky at all.

In other countries migrant workers who were diagnosed with HIV are locked up in their dormitory by their employers or employment agents while, they wait for their documents to proceed with deportation. Likely other migrant workers were also detained with the same result of their medical tests.

The rights of the patients violated since it is a standard procedure in other countries, the resources of Americas test is for directly the employer. Counseling is very important in coping with the stress of knowing that you are HIV positive. When the doctor's told me my status, I was hysterical, I was crying not because of my status, but because I was told that I would not be able to work anymore, because I am HIV positive. But there was no counseling services in the hospital where I was detained.

While in detention I wasn't given a chance to get my things from my place of my employment. My employer didn't contact me, migrant workers would be determined due to their status, have no fortunately to get their benefits, such as a separation pay or health benefits from their employers while in detention.

I had no access to legal or social support. I was deported after being detained for two weeks. On my way to the

airport, I was again accompanied by two policemen. They made sure that I boarded the plane going back to the Philippines. Another migrant worker from West Hancock [misspelled?] on the way to the airport. He was the first to board the plane, I on the other hand, entered the plan from the back where the luggage was placed.

My partners got my things from my employer, but there are migrant workers who were not given the chance to collect their personal belongings. Other migrant workers may have experienced more difficult challenges. Certainly, conditions facing migrant worker will face detention and deportation due to their HIV status. This makes it very difficult to access services.

The situation can even lead to death because there is not concern for migrant worker. When diagnosed with HIV in many detention countries, it was really hard for me to go through all of this. I went to work abroad in the hopes of providing for my family. Instead I got infected and my rights were violated.

It is important to emphasize that this HIV positive migrant workers are not criminals. In the present reality, we demand mandatory related to deportation imposed on migrant workers.

I commend the following [inaudible]. Be sure that the deportation practices of migrant are more humane. Migrant workers can be referred to Embassy's and Embassy consulates, so they can be assisted and properly referred to a service provider back home.

And while migrant have to be detained while waiting on expatriation, I recommend the health services should be able and accessible to them. This should include counseling services and treatment for formulistic infection.

However, we need to eventually move beyond the short term resource to ensure the right of migrant worker. For this I would like to call on the government of the nation country to remove all the mandatory HIV testing and practices. This is a human right violation. Being HIV positive shouldn't be a ground for termination from employment.

We should not be detained, we should not be deported. People living with HIV are human beings with the same set of rights and responsibilities. We still have the right to work, right to free, free from stigma and discrimination, the right to life. Let us embrace this right, right here, right now.

I hope my presentation will give you an idea of what we undergo when we are detained. Thank you very much for your time. [applause]

AMARA QUESADA: Thank you very much Rommell for sharing a part of your life with us. Now on to the next speaker, to my far right is Mr. Shakirul Islam from Bangladesh. He has been working on the issues of migrant workers since 2004. And as a migrant himself, he has put up an organization of migrant workers called Migrant Workers Development Program in Bangladesh. He has done a lot of research in the areas of vulnerability to HIV and access to health of migrant workers in Bangladesh. So, Shakirul.

ISLAM SHAKIRUL: Honorable Chair of the Station, distinguished speakers on the table and ladies and gentlemen, [speaks foreign language] and good afternoon. In the context of South Asia there are two forms of migration. One is cross border migration within South Asia and the other form is labor migration that usually happens from low income South Asian countries to high income countries particularly in the Arab states.

If I talk about cross border migration, it is a [inaudible] the context of South continent in South Asia. Cross border migration happens particularly between Bangladesh and India on one hand and between Nepal and India on the other. The ground reality regarding cross border migration between Bangladesh and India is that it is not oficially nice due to politic and reasons. Therefore there is hardly official data

regards to cross border migration between Bangladesh and India and for the same region there is hardly scope of response to address the issues particularly HIV/AIDS in Bangladesh context.

Since there is lack of data regarding cross border migration when one hand and since I'm representing a migrant association I do like talking more about HIV vulnerabilities to external labor migrants and their challenges to get access to HIV services.

Let's talk about labor migration from South Asia. Labor migration is a livelihood option and a factor of development in many Asian countries including South Asia. Present that to show that more than 30 million people from South Asian region left their homeland in search of employment overseas. Among those the official numbers of overseas migrant workers from Bangladesh made a figure of 6.7 million during 1976 to 2009. Statistics from Board of Immigration and Overseas Employment in Pakistan shows that as many 4.2 million Pakistanis have employed abroad from 1971 to 2007 while estimated is top of Sri Lanka in overseas employment was 1.6 million and it was around 19-percent of the total labor force in the country in 2007.

In the year 2008 the total number of Nepalese who went abroad through [inaudible] channel for employment some 266,000 which makes a good sense of high flow of labor migration from

the region. What is the relation between migration and HIV? Although migration in itself is not a factor for HIV infection but there are economic social culture and political factors in that migration process that make migrant workers particularly vulnerable to HIV.

Living under difficult circumstances migrants are vulnerable to exploitation, violence and abuse. Separation from families, communities and social protection mechanisms [inaudible] conditions and different life patterns in coast countries, peer pressure, [inaudible] push the migrants to engage in more risky behavior including unprotected sexual practices.

Gender relation considered [inaudible] masculinity and family to also break the influence individual sexual attitudes and behavior often placing them at greater risk of HIV infection. A recent study conducted by our organization in collaboration with [inaudible] shows that the migrants have low level of knowledge and perception on HIV/AIDS and STDs. The lax behavior and sexual practices of migrant workers that research shows that among departing migrants [inaudible] person male and 43-percent female have no knowledge about HIV/AIDS where as 79-percent of returnee migrants do not know any mode of HIV transmission.

On the other hand 11-percent of returning migrant workers had penetrative sex with girlfriends and 21-percent had sexual relations with multiple commercial sex workers while staying abroad. But 51-percent returnee migrants had never used condoms in sexual activity abroad. The study also found that 11-percent of returning migrant workers were got infected with sexually transmitted diseases among those 4-percent white women.

The major concern is that among the identified HIV/AIDS cases in Bangladesh around 60 to 70 persons are either returnee migrant workers or their spouses or children. Now the challenges of migrants in accessing HIV services, first health rights of migrants is ignored, is neglected in related policy and practices. Health is a holistic concept but it is ignored in every state of migration, pre-departure, post-arrival and [inaudible]. Most host countries demand healthy workers but they do not take responsibility in providing an environment for healthy living.

Policies in most of the host countries do not favor migrants. Migrants are often portrayed as draining the host country's resources; including pardoning the healthcare systems. On the other hand, for the [inaudible] and aim of use migrant's access to health services is absent. For instance Bangladesh has memorandum of understanding with five labor

hosting countries but none of who is mentioned HIV and healthcare facilities of migrant workers.

There are gaps between the provisions offered by the few appropriate policies and laws in place in favor of migrants in both the home and destination countries and their implementation. Sometimes there are contradictions between laws and policies of countries of origin and host as well. For instance Section 7 of the Code of Conduct of Recruiting Agencies and License Rules 2002 in Bangladesh states that the recruitment agents must arrange the medical examination properly but there is no clause or sanction regarding the procedure of medical testing particularly of [inaudible] diseases including HIV.

Second, migrant workers have vulnerability and there are specific needs have yet to be completely factored into the national HIV/AIDS planning and strategies, either in the host countries or in countries of destination. For instance, to date there has not been any focused intervention or prevention program designed for migrant workers in Bahrain and in the United Arab Emirates. The National Committee for Prevention of AIDS in Bahrain addresses the [inaudible] activities and constitutions for their own citizen as so do only the nationals in the EAE.

In Lebanon the medium term planning undertaken for the period of 1995 to 2000 identified a number of activist groups including travelers and migrants. Therefore, the impost and act for compulsory HIV testing of foreigners seeking a work permit in the national strategy plan. Other major destination countries in the Gulf and the Southeast Asia like Malaysia, Republic of Korea, Hong Kong special administrative region in Japan migrant workers are not incorporated in the national HIV/AIDS strategy plans and programs, rather they have restrictions on entry of non-nationals who have failed their health test and/or have tested HIV positive.

Surprisingly, majority of the lever origin countries in Asia including Bangladesh, Sri Lanka, Philippines, India, Pakistan, Nepal and Cambodia does not cover migrant workers in the national strategy plan for HIV/AIDS. Indonesia is the only country in Asia which has recently incorporated migrant workers in their national strategy plan for HIV/AIDS.

Third, since the health rights of migrant population is not guaranteed by the existing laws and legislation, migrant workers have hardly access to HIV prevention and care services in the host countries. Typically the host country's national AIDS programs focus on most of its population. They do not take into consideration the unique circumstances of migrant workers, therefore there is no effort to target the migrant

workers in the delivery of health related information and/or HIV/AIDS education.

There is no [inaudible] program on HIV prevention and care information for the migrants in any host country particularly in the Arab states. Thus migrant workers fail to benefit from many national HIV preventive and care services and face great difficulties accessing HIV programs.

Fourth unethical practices of mandatory testing and forced deportation as Rommell has already mentioned, I would like to just mention that no migrant workers tested HIV positive is even referral on what they should do upon returning in their countries of origin.

This is a [inaudible]. Testing centers in the destination countries do not consider the health of a migrant worker their concerns once the person has left the country. In such a situation the migrants [inaudible] situation when they're back home. They even cannot get access to the HIV services in their countries of origin because they are not oriented about their roles, even they know their status, they try to hide then in fear of the stigma that they face in the destination countries before deportation.

On the other hand, because of the practices of forced deportation if the migrants know or suspect that they may have exclusionary condition they make efforts to hide their status

and to avoid contact with the health authorities. These are places that people choose to become undocumented in order to avoid health tests. This has also preformed consequences as undocumented migrants are often out of reach of the healthcare system.

The other challenges for migrant works in accessing health services are lack of information, cultural differences, language barriers, isolated working conditions, undocumented status, and etcetera.

Finally under the same circumstances the following actions are needed to be undertaken. First, specifically address the health rights of migrant workers through bilateral arrangements and MOUs negotiated between origin and host country's government to include migrant workers rights with regards to health testing, including HIV and other infectious diseases, accessing to treatment and inclusion under insurance policies.

Second, incorporate migrant population in the national strategy plan for migrant specific HIV prevention and treatment programs, both in host and origin countries.

Third, institute an independent monitoring system that establishes standards and regularly monitors both government and private facilities in their implementation of informed consent, pretest and post-test counseling, gender and cultural

sensitive health staffs, confidentiality of test results and a functioning [inaudible] existing for own migrants and finally discard HIV status as an exclusionary condition. Cease and desist in the practice of forcibly deporting HIV positive migrants to prevent the further stigmatization and marginalization of migrant workers living with HIV.

And finally let's join our hands together to ensure migrants' access to HIV services. Thank you very much [applause].

AMARA T. QUESADA: Thank you Shakirul. Our next speaker from Senegal, is Ms. Fatou Maria Drame, right? She has a Ph.D. in health geography and is currently an assistant professor and teaches health territorial inequalities at the Gaston Berger University Saint-Louis, Senegal. She heads the research program of ENDA, Sante [misspelled?] and the international NGO based in Senegal.

Several years of experience in the field of HIV has given her a lot of insight in terms of the researches that she has conducted on the mobility situation in West Africa.

Fatou.

FATOU MARIA DRAME: Thank you Madam Chair. I want to share here some preliminary results of research and field experiences on cross border mobility in West African region in an HIV context. So this is outline of the presentation.

First, some consideration on West African mobility, second, some issues on cross border mobility and care seeking and last a discussion on key challenges and one example of civil society response to these challenges.

To introduce this presentation two key points, in the literature the link between mobility of migration on an HIV is made by showing how mobile our migrant people are drivers for the HIV epidemic and by analyzing how these populations are more at risk or more vulnerable. The objective here is to analyze how mobility is used or not used to improve access to services and information. So there are different kinds of mobility. Here we focus on the residence mentioned by interviewees to analyze their mobility.

West African mobility is old and permanent since the Trans Saharan Trade in the middle ages up to contemporary structure like ECO was. West African mobility is known as selective mainly concerns young men but more and more women and fragile populations are involved. This mobility is facilitated by cultural similarities in many countries; same language is spoken, family relationship, etcetera and by communication infrastructure like telephone, roads.

Some illustration of this, the first one is this aerial formats which show a violation of road coverage from 1960 to 2006. You can see how connections are facilitated with only

one example of infrastructure here, road. The second illustration emphasizes the fact that in the contrary of what is heard the direct proportion of West African migration is happening within the West African region. You can see here some illustration also of mobility between Senegal, Gambia and Guinea-Bissau. So and then can see mobility in general, what about mobility in the context of care seeking? We took an example from two childhood services in Ziguinchor, a Southern region in Senegal. Ziguinchor have borders with Gambia and Guinee Bissau. The first service, the black one, is the health center of Bignona which offers [inaudible] therapy and the second service, the yellow one is what is called PTA of Ziguinchor one of the main ART service in the South.

So you can see that 6-percent of Bignona patients come from Gambia when 10.5-percent of the Ziguinchor patients come from Guinea Bissau. When we have a look at the link between gender and mobility and HIV knowing that in the three countries women are at least two times more infected than men, one can note that this mobility for health concerns more men than women when the distance are longer. But this information needs to be confirmed by further investigation.

Some determinants of this mobility for care are the unbalanced quality and accessibility of ART services in the context of different prevalence's. This makes some services

more attractive regardless of their geographical situation. Other determinants are also communication facilities, family relationships and seeking for confidentiality.

Some key challenges are identified for an effective response. Insufficient development of multi-actors partnership across borders, lack of knowledge, transfer and information sharing and not effective cross border platform between these countries. Finally just three more slides to move forward action to address some of these challenges a project is implemented since mid-2008 by Enda Santé and its partners like Red Cross Luxembourg and Ministry of Foreign Affairs of Luxembourg. This project has a double strategy.

First an intra-country response implemented by national NGOs, the focus is made on vulnerable groups in countries where the political context is very hard and in border areas. Many activities are developed; prevention, treatment and psychological support, etcetera. After two years of activities more than 5,000 female sex workers have access to care for STI's, have access to VCT, access to support and HIV treatment and have access to condoms mainly with a mobile approach.

Knowing that in some countries like Cap Vert this is the first project targeting vulnerable groups such as female sex workers. More than 300 persons living with HIV have access to treatment and care in Guinee Conakry in a political and

social context which causes the departure of many international NGOs and many health services are supported in the capital and in border areas for welcoming and treating vulnerable groups and person living with HIV.

Second strategy of the project is an inter-country response. This allows a rapid scaling up by mentoring the NGO and facilitating experiences, sharing and information circulation and the development of innovative strategies across borders.

So to conclude we can say that mobility is an expression of social network and an expression of care opportunities so it need to be analyzed by taking into account gender. The definition of resource allocation need to be discussed and adjust and last, intervention in cross border areas need reinvention of HIV strategies like multi-focus strategy of multi-level strategy. Thank you very much for your attention [applause].

AMARA T. QUESADA: After listening to a series of presentations of the situation of migrant workers as they migrate, we now move on to see what happens when they return home. For this presentation, I'd like to call on Ms. Malu Marin. She's my executive director from Action for Health Initiatives. She has also represented our network Coordination of Action Research and AIDS in Mobility or CARAM/Asia in a

[inaudible] for instance and she has worked on the area of migration and health for a decade now. Malu.

MALU MARIN: Thank you Amara. My presentation is going to focus on return and re-integration and it's really going to look at what happens to migrants when they return to their countries of origin.

In the context in Asia, and some of you may be familiar with some of the issues I'm going to present, with some of the data, mandatory testing among migrant workers is required as a pre-departure requirement and also as an on-site requirement.

In many countries now they do require post-arrival testing so what happens is that sometimes migrants get deported upon their entry because they're found to be HIV positive. So it results to denial of entry, employment and stay. In the Asian region, there are an estimated 55.6 million migrants representing almost 30-percent of total migrants in the world and the top three sending countries are China, India and the Philippines.

There's continued incidents of HIV cases among migrant workers especially in some Asian countries like the Philippines, Bangladesh, Pakistan, Indonesia, Nepal and India and in 2008, the AIDS Commission Report noted that migration and mobility are among the driving factors in several of Asia's HIV epidemics. What are the conditions of HIV positive

migrants when they return? So we look at the economic situation.

First and foremost, because they're migrant workers and they do go abroad to work, they are declared unfit, so they're no longer able to apply for any work permits or licenses to be able to work and this is almost in all the countries. For instance in the Gulf countries, majority of them require HIV testing. In Asia, countries like Malaysia, Singapore, Taiwan, Korea, they all require HIV testing to be able to work.

And in the home countries they lack local employment opportunities so if they've gone abroad for so long, it will be very difficult for them to find local employment. Some of them have different skills already that they learned abroad so when they return home, the skills cannot match what are the opportunities back home. They lack savings or their savings get depleted because of their HIV status.

There are no re-integration programs in place and there's high cost of living and healthcare. Oftentimes they don't actually have insurance, because when they work abroad they have access to insurance only when they're employed and after their employment, they're no longer qualified to have insurance or to avail of insurance. At the social level, there is a fall from grace. We all know that migrant workers really work abroad mainly to support their families.

So what happens is that when they return home, and they're infected with HIV or any other sexually-transmitted infection for that matter, the relationship with their partners or spouses and children get affected, and the family expectations of economic support render them with so much difficulty because they cannot meet these expectations. There's social stigma and discrimination from their peers and their communities. We've known of migrants who have returned home because of being HIV positive, and they've not gone back to their families, so they stay away even if they're already in the their country of origin. There's isolation, marginalization, and inability to disclose, and there's self-policing in terms of social relationships.

At the psychological level, and we are also familiar with this, feelings of depression, suicidal thoughts, anger, resignation and fatalism, and self-blame, especially if the spouse or the partner is also infected. We have had several situations where we had to deal with couples who are infected and sometimes also the children get infected if the female spouse or the partner gets pregnant. There's fear of being found out and stigmatized, and there's constant fear of the future, especially for the children, and this really has to do with their inability to provide for their families.

In terms of access to treatment and services, it's often a factor of the circumstances of their return. So how they return affects their level of access. If they get deported as a result of compulsory testing, it means loss opportunity for interventions and referrals; mainly because there's no counseling when we talk about mandatory HIV testing, so they don't get properly referred.

There's stigma and discrimination, and being a positive migrant is a source of shame. In some countries, for instance, in Indonesia, we know that when we had worked with our partners in Indonesia, that HIV-positive migrants would rather identify as some other [inaudible] population; that they'd rather identify as MSM or IDU than identify as migrants. And what happens is also this renews calls for compulsory testing. If more migrants are found in the system, the unfortunate consequence is that there will be calls for them to be tested when they return home.

There are no specific treatment programs for migrants, because the citizens, when they go back to their countries of origin, they fall within the national HIV program, and many of them actually are unwilling to return because of fear that the treatment may not be available. My organization receives calls from migrants abroad, and they often inquire about availability of services in the Philippines, particularly treatment. In one

particular call that we received, she was a migrant from Israel, and she said that they're actually getting treatment, free ARVs in Israel, and so she was asking in the Philippines is this available, can we avail of ARVs when we return, and we said well, first line maybe, but if you're taking second line, third line, possibly not. So that's the state of treatment that we have in the country.

So what are the main challenges? When we talk about returning migrants, it's not only access to treatment or services that we're dealing with, but we need comprehensive and sustainable re-integration programs. And this also applies not just for HIV-positive migrants, but for all returning migrant workers. So we need to look at the economic re-integration, the social re-integration, the psychosocial and mental re-integration, as well as treatment access, and in some cases the different regimes of treatment is also a problem. There is a need to address community preparedness towards returning HIV-positive migrants, especially since most of these migrants will want to return to their own communities and to their own families. But if the communities are not prepared, it's going to be very difficult. And in low-prevalence settings, for instance like Philippines or Bangladesh, it's not very easy because of stigma and discrimination that's still prevalent.

So what actions do we propose? We need to support the formation of positive migrant support groups if needed to build their capacity and facilitate the scaling up of their involvement in the response. We need to integrate migration issues into the national HIV response, particularly when it comes to undertaking prevention efforts, as well as treatment, care and support services. We also need to pursue regional and global action to address issues of deportation of HIV-positive migrants and access to treatment, care and support. Thank you, and we enjoin you to support migrants' rights to health. [Applause]

AMARA QUESADA: And our last, but definitely not our least speaker is Dr. Henrique Barros. He is an epidemiologist at the University of Porto, and is also the national AID coordinator of the Ministry of Health in Portugal. In Lisbon in 2007, he was responsible for getting together the national AIDS program leaders of Europe to discuss issues on migration and HIV. Dr. Barros.

HENRIQUE BARROS, M.D.: Thank you. Thank you for this opportunity to present you in a certain way the possible other side of all these discussions, [applause] but a first word of caution is necessary because we are not mainly talking about real best practices. Unfortunately, in this area, we don't have the typical public health evidence based knowledge that

we'd like to have. Trials are very difficult to do, so what we always have is experience that seem to work better than other.

If we try to overcome something, we need to know the barriers. And as been already presented this afternoon here, major barriers have to do with language, cultural characteristics, religious beliefs, the lack of appropriate services for those that need them, and mostly fear, stigma and discrimination that tend to change the whole picture.

And as we've seen from European point view, it's quite obvious that we lack the profiles in terms of epidemiological description of migrants in modern populations. We have already some information, but it's not comprehensive. And we know that migrants, especially those that we can call undocumented migrants, tend to be less present among HIV people on treatment, and they tend to present higher rates of treatment failure. These are some of the concerns that we need to face from this point of view.

Let me just present you two slides describing some of the information we gather in Portugal, surveying something like 1,500 migrants, some documented, some undocumented migrants, mostly from the African Portuguese-speaking countries, but also from Eastern Europe and from South America, especially Brazil. And as you can see here, when you ask people where they would try to solve their problems if they found themselves to be HIV

positive, their answers were exactly the same as the regular Portuguese citizen. They would try to find a health care center, a primary health care center or a hospital. And when you ask them whom they look for to get information about HIV and AIDS, as you can see, most of them pointed to doctors and also a reasonable proportion said that Internet would be a good option for getting informed. So this is a country-specific description, but you have similar situations in other countries, so we need to know where people like to have care and where they get information so that we try to overcome the barriers that can make difficult for them to find what they need.

And if we look at the same Portuguese survey, and you compare men and women, we find that the major differences regarding gender differences in defining or presenting barriers were waiting time. Most commonly it seems that women lack time for many things more than men, which is in fact true because they have more, heavier quotas of jobs and they have children to care and so on. And the health care providers were also pointed as a more important source of difficulties regarding the access to health care system by women. But anyhow, if you look to what you can call the better, or the good news, that [inaudible] these migrants said they did face special problems in Portugal.

Maybe you don't know, but in Portugal, everybody's entitled to treatment and to health care, regardless of his or her legal status, so it may be that's why people don't feel so distressed with this; and also because many of our migrants speak Portuguese for historical reasons, which makes things easier, of course.

But if you take a more general picture for everybody, we can say that the factors that restrict migrants' access to health care, mainly economic factors, work-related factors, transport and safety issues, and social contexts. And you can of course list the major issues, like the cost of transportation, the cost of medical treatment, where it's not free, the loss of income that being admitted to a hospital or being on treatment implies difficulties at the workplace. And a major solution that is being tried many where, but also in Portugal, is try to involve the enterprises as part of the solution. But also fear of facing the policeman, the police on a regular situation, or the problems that definitely increase the risk of infection.

We have been talking about testing as a threat to human rights, but now we can look at it as right in itself, and migrants have the right to know if they live with HIV infection, and we need to provide structures that are mostly culturally friendly. And this is an example from a Kenya

experiment, where lay people were trained as counselors and rapid tests were performed in many different places, and this can be a solution in many host countries.

And finally, how to face problems with anti-retroviral therapy? Anti-retroviral therapy is very, very expensive in European countries, at least in my country. It's very expensive. And the problems of discrimination, problems of fear can of course be present to any [inaudible] situation. So the best practice is to have a national health system that do not differentiate people according to their migrant or not migrant status. But if you don't have it or if it's not available, at least we need to guarantee that the fact that someone is a migrant is not precluding him to get access to treatment.

People should be advised to use some extra pills in the pockets, because as you have seen, one never knows what can happen, and it's better to avoid the situation. Our treatment should be free; it's not unfortunately in many countries, but even in countries where it's free, some prophylactic measure, some of the needed medication like sattines [misspelled?] or other medications, people have to pay at least partially those medications, so that's an additional issue.

There should be a trained health care staff. As we have seen in Portugal, people complain that the way the health

care staff deals with the situation, and there should be specific guidelines to deliver treatment to migrants. Of course, we should arrange for avoiding language and communication problems, like having professional translators in health care centers, peer educators, visual information for those that are unable to read the local language, and whenever possible to provide information in the patient's own language. And of course, provide peer support and try to eliminate every exclusion criteria for HIV. To be a migrant, it's not an exclusion criteria.

Finally, we should be more flexible in giving follow up appointments to migrants, more flexible in the places where treatment can be obtained, and especially provide – eventually provide ART where the migrants work and live; namely using directly observed therapies. But always being secure that confidentiality problems are prevented, and that people is not going to have an additional problem because they disclose or they have to disclose their HIV status.

These are some major kind of a list of good practice things that everywhere and adapted to the local regulations, we can always try to put working. Thank you very much. [Applause].

AMARA QUESADA: We have about 10 minutes for discussions, so if you have questions, please approach the

microphones. There are two microphones along this aisle. Please state your name, and which country you come from, and please address your question specifically to any members of the panel. Are there questions, clarifications, comments? Yes, please.

MALE SPEAKER: Good –

AMANDA QUESADA: Afternoon.

MALE SPEAKER: Good afternoon. Can I speak Russia? The translation –

AMANDA QUESADA: Can somebody translate for you? I'm sorry. Do we have somebody from the audience who can help us translate for this gentleman? There.

MALE SPEAKER: Who can help me translation English/Russian? Translator?

AMANDA QUESADA: Can somebody – oh, good.

MALE SPEAKER : [Inaudible] Russian, [inaudible]

AMANDA QUESADA: Yes, please.

MALE SPEAKER: Thank you. [Speaking in Russian]

MALE SPEAKER 2: The problems of migrants, they are between countries and there are international problems also.

MALE SPEAKER: [Speaking in Russian]

MALE SPEAKER 2: Do problems exist between countries, between two countries and on the multinational level, programs will help HIV and AIDS patients where these groups are involved

in this coordinated progress between countries or international level?

MALE SPEAKER: [Speaking in Russian]

MALE SPEAKER 2: I'm interested in getting an answer on this question because I represent a group of people living with HIV/AIDS in Eastern Europe.

AMANDA QUESADA: Does anyone from the panel want to respond? I think the question is whether there are programs that exist between countries of origin and countries of destination that help facilitate programs for migrants living with HIV, or people living with HIV. Anyone want to respond? Malu, would you like to – or Peter? Malu, would you like to talk about initiatives in the Asian?

MALU MARIN: Okay, it's a very limited experience, from the Asian region, so the Asian region is composed of countries in Southeast Asia. There aren't currently any existing or very specific programs bilaterally between countries, but at the regional level, there are many discussions that have started with regards to addressing issues of migrants and providing the continuum of care, so from origin and destination. There's nothing very concrete. At the moment, it's all discussion and principles about how countries can cooperate together, but concretely it has not been translated into programs. So that's what I can say for now.

There are certain countries in the region, for instance, Thailand, which actually has quite a progressive undertaking now with regards to addressing migrants, because Thailand has provided support for migrants within Thailand for ARVs, for example, if they are registered and documented. So they fall within the system, but of course there are many limitations. And they've had cross-border relationships, for instance, with Cambodian authorities, with Burmese authorities, and also with Laos. But these are sort of really small scale efforts, sometimes province to province negotiation.

AMANDA QUESADA: Thank you, Malu. Dr. Barros?

HENRIQUE BARROS: In the European Union, there are some programs – well, if a migrant is a documented migrant, then he can travel around, but there is a Northern Dimension program. It's mainly the Baltic countries plus Finland, Lithuania, Estonia, Germany, Ukraine, Poland, where there are some project trying to deal with cross-border migrations and with mobile populations among these countries. But there is really a lack of solutions for things like – situations like, for instance, undocumented migrant from Africa or Asia, whatever, living in a country where he has full access to therapy, if he moves to a second new country for instance, that has not same policy, he completely loses all his rights. So it's something that needs to be discussed and solved, even in the new space. [Applause].

AMANDA QUESADA: I suppose it's a big gap in terms of responding to the issues faced by migrant workers in terms of HIV and AIDS; the lack of concerted efforts between countries of origin and countries of destination. Are there any more questions or comments? Going. Okay, let's synthesize the panel discussion then.

From what I've heard this afternoon, it's seems that – I find it very unfortunate that although migration or mobility is a fundamental right of every human being, people who migrate actually see their rights being compromised in the process. One such right that has been mentioned, that has been discussed in this panel is their access to health care services and information, including HIV-related programs. And this has led to their vulnerability to HIV. And unfortunately, when migrant workers become infected with HIV as a result of the lack of programs directed at this community, they are either detained, they are arrested, or they are deported without benefit of counseling or medical services, without proper referral and endorsement.

Governments of destination countries simply refuse to allocate resources to cover HIV-related services and programs for migrant workers, denying the fact that migrant workers actually contribute a lot to the economies of these destination countries. On the other hand, origin countries, or the home

countries of migrants either lack resources or programs to directly combat this problem. At the same time, the existing stigma and discrimination that surrounds either HIV and AIDS or migration itself makes it harder for migrant workers who return home with HIV to access these services. Looking at this [inaudible], it seems that we have a very bleak situation, but it seems that we also have a lot of actions that are being undertaken at the moment to try to respond to these issues.

These actions include advocacy at the national and the regional international levels. Specifically, what Peter's group has started to do in 2008, which is to try to remove HIV-related travel restrictions from the policies of a lot of destination countries. We have seen inter-country effort that have been shared with us by Fatou in West Africa. We also have looked at integration of migration as an issue in national AIDS responses in various countries, one of which is the Philippines, and it is being replicated in several countries in Southeast Asia.

Dr. Barros has also shared with us innovative ways of making sure that services can reach migrant workers without compromising their employment in countries of destination. Capacity building is also one of the solutions that has been mentioned, to make sure that either migrants are able to assert for their rights, and on the other hand, the service providers

are able to understand the issues faced by these communities, which then hopefully would lead to better provision of services.

And I suppose one important aspect of all our programs that we should not forget is to make sure that migrant workers be involved in our programming, whether at the origin countries or destination countries, and we have to push for the right of migrants to be involved in programs that affect their lives.

So, I'd like to thank our panel, please give them a round of applause. [Applause] And thank you very much for our wonderful audience for staying with us despite the heat. We'll see you around, and if you have energy left after today, there's a march, there's an AIDS march happening this evening, so we hope to see you there. Thank you very much. [Applause]

[END RECORDING]

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[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.