

SWASTI, HEALTH RESOURCE CENTRE

Migration and HIV

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Migration and HIV

Introduction

Across Asia and the Pacific, there are large migrant populations moving both within countries and across international borders. These populations, who often have poor access to healthcare services, are challenging to study. Although countries' epidemiological profiles take different shapes, there are also clear similarities that help to understand the region's epidemic. While HIV prevalence among the general population is generally low, key populations such as sex workers and their clients, men who have sex with men and people who inject drugs continue to have extremely high prevalence rates in specific geographical locations. Along with these high-risk groups, each country in the region now classifies migrant populations, both international and internal, as vulnerable to HIV infection.

Being a migrant is not a risk factor in itself, but poorer health and higher HIV vulnerability among migrants are explained by: discrimination, gender inequality, sexual violence and exploitation, dangerous working environments, poor living conditions, poor access to education and social services and, most importantly, poor access to health care. Migrants often lack access to mainstream health care, education and social services. Many migrants do not have legal status within their destination countries and live in isolation, making it difficult to protect themselves against the people who might exploit them or sexually abuse them. Social isolation and other factors may lead migrants to participate in high-risk behavior, including use of drugs and alcohol. Male migrants away from home may also pay for sex, while the female migrants might look to sex work when they need extra money and have no social network to support them. All of these situations and activities increase migrants' vulnerability to HIV infection.

Scope: This regional review is curtailed due to the breadth of the topic. Migratory trends, economic push-pull factors, HIV epidemiological data, legal and policy environments, as well as national/regional HIV programming are all essential elements of any discussion on HIV and migration. This review will touch on all of these elements in a limited fashion while focusing on two high-volume migratory corridors that reflect the current trends in HIV epidemiology among migrant and mobile populations in Asia and the Pacific.

Migrants: Migrants can be defined in several ways, most simply as either international migrants (i.e. external migrants) or as internal migrants, who have left their home communities for a lengthy period of time but who remain in their nation of citizenship. Seasonal laborers, for instance, are often internal migrants. External migrants may have legal status in their host country or may be undocumented. Undocumented international migrants are often estimated to comprise the majority of the migrant population in a given country, complicating efforts to collect data, conduct outreach and provide health services [1].

Mobility: Mobility is a broadly-encompassing term for people who may be on the move in the short or long term. Mobile (in contrast to migrant) populations include people who work in long-distance freight, transport and seasonal activities, An important distinction between migrants and mobile populations is that mobile populations may be on the move either voluntarily or involuntarily. Frequently, mobile populations are characterized by long-distance movement but with regular returns to their home communities (e.g. truck drivers) [1].

For a variety of reasons, data collection on migrant and mobile populations has lagged behind that of other vulnerable groups. The very nature of migration makes accessing individuals and compiling population-level data challenging. However, data show that in Asia and the Pacific, the highly mobile migrant populations, such as truck drivers, fisherman and itinerant laborers, have the highest prevalence of HIV among migrants [2].

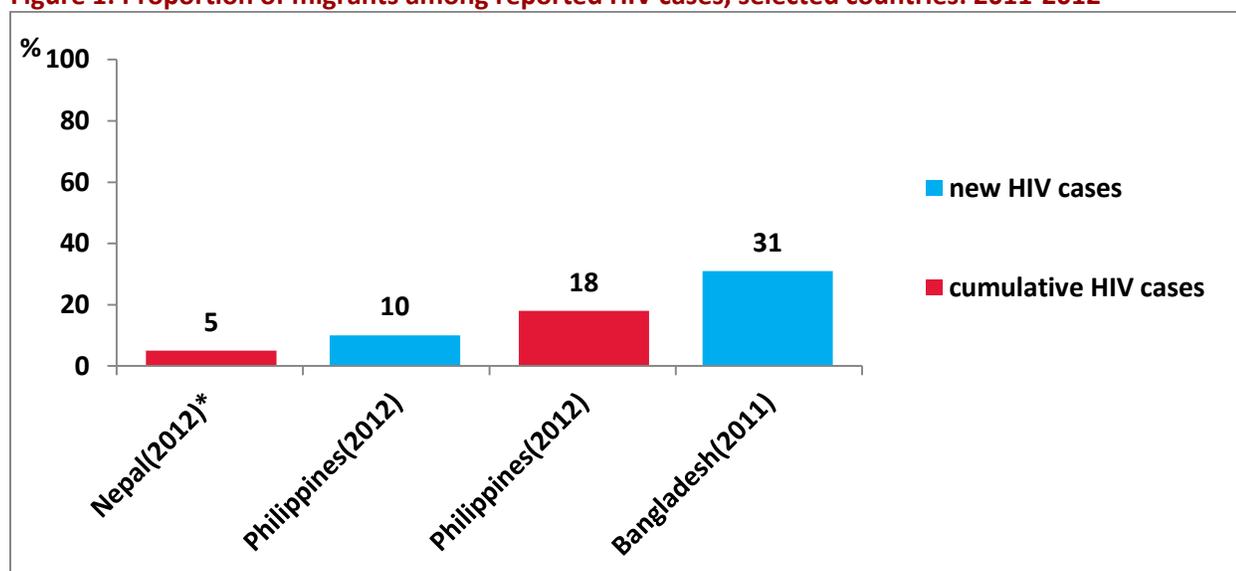
1. Overview

In 2010, there were an estimated 53 million international migrants in Asia and the Pacific, comprising 25% of the global migrant population. Migrants comprise an estimated 1.3% of the region's population, not including internal migrants, which in some countries (particularly India) add substantially to the total migrant population figure [3,4].

Of particular concern in the region are male mobile or migrant workers who are clients of sex workers and return home to their communities, where they pass the infection on to their spouse and/or intimate partners. In order to effectively prevent this route for HIV transmission, it is essential to gather data about migrant movements and behaviours to better target HIV outreach, prevention, care and treatment. Without these efforts, HIV epidemics among relatively small high-risk groups may spread to populations currently at lower risk.

Figure 1 displays the proportion of migrants among new and existing cases of HIV in selected countries in Asia and the Pacific. In 2011, for instance, 31% of new cases in Bangladesh were found among migrants. However, it is important to note that migrants are often subject to mandatory HIV testing, so the disparity in prevalence between migrants and the general population may be biased [2,5].

Figure 1: Proportion of migrants among reported HIV cases, selected countries: 2011-2012



Source [6]: Prepared by HIV and AIDS Data Hub for Asia and the Pacific, based on Bangladesh World AIDS Day Presentation 2012 http://www.bdnasp.net/index.php?option=com_content&view=article&id=104&Itemid=124; data retrieved on 14 Jan 2013; Nepal National Center for AIDS and STD Control at <http://www.ncasc.gov.np/index1.php?option=information&id=38>; National Epidemiology Center Philippines. (2012). Philippines HIV/AIDS Registry: December 2012

* Migrant workers and spouses of migrants

Migration and economic corridors

The greatest volume of migration in Asia and the Pacific occurs along established economic corridors. Although migrants are found throughout the region, focusing on behaviours in these known corridors provides the best opportunity to collect data and scale-up interventions. In South-East Asia, the Greater Mekong Subregion (GMS) includes several economic corridors along which the majority of migrant movement occurs. Within India, the major economic corridors include: Ganjam to Surat, Mumbai and Thane; Bihar to Delhi, Haryana and Punjab and

Eastern Uttar Pradesh to Mumbai and Thane. Other significant routes include: Nepal to India, Bangladesh to the Gulf States and Myanmar to Thailand.

Overseas Filipino Workers (OFW) provide a useful snapshot of current epidemiological trends among a large-volume migratory corridor and of related policy responses. HIV prevalence in the Philippines has remained low (<0.1% in 2012) [7], but estimates suggest the rate will double by 2015 [8]. The Government of the Philippines has responded by including OFWs in the designated most at-risk populations and by initiating targeted programming among OFWs returning to the country. The Government of the Philippines has long required HIV prevention education for OFWs and has more recently renewed its commitment with the 5th AIDS Medium-Term Plan, which seeks to provide more comprehensive HIV/AIDS-related services among migrant populations, including referral services in destination countries and reintegration programmes [8,9].

Economic impact of migration

Several of the top ten countries receiving remittances worldwide are in Asia and the Pacific. In 2010, India received US\$55 billion in remittances (highest in the world), while the Philippines and Bangladesh received US\$21.3 and US\$11.1 billion, respectively. Perhaps more significant is the substantial proportion of GDP accounted for by remittances in some countries in the region: Nepal (23% of GDP), the Philippines (12%), Bangladesh (12%) and Sri Lanka (8%) [10]. The growing magnitude and importance of remittances to national economies in the region over the last decade illustrates that the increasing scale of migration, as people seek economic opportunity further away from their home communities.

Age and gender of migrants

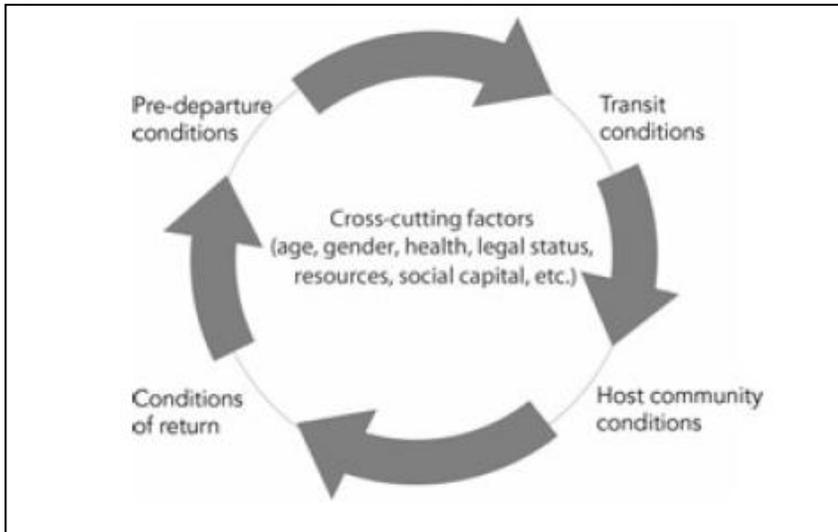
Migrants are overwhelmingly young and increasingly female—women comprise about 50% of international migrants in the region [11,12]. Between 2000 and 2010, the number of documented female migrants from Bangladesh seeking employment overseas increased from 454 to 24 838 [13]. However, due to the large number of long-distance truck drivers and other internal migrants, men still make up a majority of the total, broadly-defined, migrant population in the region.

2. Why migrants are vulnerable to HIV: commonly confronted issues

While many migrants and mobile populations are at higher risk of HIV infection, the status of migrant is not intrinsically a risk factor for HIV and migrant groups face different levels of vulnerabilities.

The International Organization for Migration (IOM) illustrates the vulnerabilities faced by migrants and mobile populations as a cyclical process (see Figure 2) in which individuals face different types of vulnerability depending on what type of migrant they are and in which part of the cycle they find themselves. The cycle identifies points where gains can be made in providing services and strengthening the policy environment.

Figure 2: Phases of mobility influencing HIV vulnerability



Source [14]: “HIV and ‘People on the Move’: Six Strategies to Reduce Risk and Vulnerability During the Migration Process. Hourar-Knipe, et al. International Migration. Oxford, 2013. ISSN: 0020-7985

Discrimination, harassment and isolation

Stigma and discrimination directed towards migrants is a common occurrence across the region and compounds the vulnerabilities caused by illegal status, lack of social support and isolation. Whether it takes the form of a restrictive legal environment or is experienced in day-to-day interactions with host country citizens and authorities, the existing vulnerabilities, such as the tendency to engage in high-risk behaviours, are magnified by discrimination over time [15]. A 2007 study in Thailand found that harassment by police was directly hampering migrants’ access to health care [16].

Qualitative data gathered from migrants often reflects a general feeling of fear—during transit, in destination communities and, surprisingly, in source communities. Migrants passing through borders are exploited for bribes and see their goods confiscated if they do not have receipts. Bangladeshi women have reported discrimination when returning home from working in India, where it was assumed they engaged in sex work. One migrant woman from Bangladesh stated: “After coming back to Bangladesh, I felt that people here don’t like me, they hate me. They said that I came from Mumbai; they whispered that I am a sex worker. I lived in Mumbai, I should feel ashamed”[17]. Living in constant fear of stigmatization, migrants are less likely to access health services (if they are available), where they might be turned away [18].

Sexual violence

Generally, migrant women are more vulnerable to violence than their host country peers because of a lack of community protection, lack of knowledge of their rights and relative isolation [2]. Sexual violence can take many forms—including rape, coercion into the sex work and being forced to have unprotected sex—and all these factors increase the risk of HIV infection [19]. Furthermore, migrants (men and women) experiencing violence and exploitation by employers typically have few legal options open to them.

Gender inequality and migration

The effects of gender inequality on vulnerability to HIV are complex but essential for HIV prevention and treatment programmes. Although gender norms vary among nations and regions, in general, women of low-income in Asia and the Pacific experience inequality in their relationships with spouses or intimate partners, a position usually compounded by a lack of education [20,21]. Such a position renders women more vulnerable to

HIV, as they are often economically dependent upon the work of their migrant male partners. This is especially true where there are few opportunities for women to earn income additional to that provided by their partner. The ramifications of gender power imbalances extend to women's freedom to negotiate condom use with their partner, who may have had unprotected sex with sex workers or other casual partners in the course of their time away from home [22]. A study in rural India found that men with a migrant history were four times more likely to be HIV-positive than men who never migrated. Most (62%) HIV-positive married men attributed their status to their out-migration history [23]. Multiple studies have documented the increased risk experienced by the wives of migrant men due to complex socio-cultural factors and isolation from ongoing HIV interventions [23-27]. With interventions focused mainly on high prevalence areas where migrants seek work, the wives of migrants left in the community of origin are not the target of HIV outreach activities like prevention, education, counselling and testing [17].

As international migrants become progressively feminized, the gender inequality experienced by female migrants is becoming an increasingly important area of focus. Most women, especially those who migrate to the Persian Gulf countries, become domestic workers—an occupation that often lacks legal protections afforded in other, male-dominated, occupations. In addition, domestic workers face the threat of sexual abuse and isolation through the control of their movements, making it difficult to access appropriate health care [28].

An important aspect of gender inequality in migration can be seen at the policy-making level in Bangladesh, where restrictions were imposed on the freedom of women to migrate internationally (although the restrictions were amended in 2005). Due to these restrictions, estimates of the actual number of Bangladeshi women who have migrated internationally are 10-50 times the official estimate [13]. Without proper documentation and data, it is difficult for authorities to properly plan and provide for the needs of female migrants.

Lack of access to health care

Many of the issues that migrants face culminate to limit access to health services. For international migrants, in addition to legal barriers imposed by host governments, there are language barriers, travel restrictions imposed by employers and authorities, lack of knowledge of health issues and available services and discrimination by service providers [19]. In a study of migrants' access to health care in Thailand, migrants were asked to list the primary reasons why they did not or could not access health care, particularly health care related to ART. Among the most frequently cited reasons were: fear of harassment and arrest, lack of proper documentation and having no time off from work [16]. This is of particular concern as migrants tend to see a decrease in health due to the vulnerabilities caused by the migrant lifestyle [11].

Refugees

Refugee populations are often overlooked in mobility and HIV-related issues. Asia and the Pacific has some of the largest refugee camps in the world and a refugee population estimated at 8.4 million in 2012 [29]. Many of the difficulties in providing services to refugees are well known, but the magnitude of the effect that refugee populations have on HIV incidence rates is poorly understood. Refugee populations are accepted as part of a broad understanding of the definition of migrants and mobile populations, yet national HIV plans for migrant populations frequently do not address the needs of refugees. Understanding that refugee populations can affect HIV incidence in a similar way as other migrant populations will lead the way towards more effective HIV prevention and treatment programming among refugees [22].

3. Regional migratory corridors: unique vulnerabilities by geography

The Greater Mekong Sub region (GMS)

The GMS, comprising Cambodia, China's Yunnan and Guangxi provinces, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam, is home to more than 3 million migrants. Primary migrant occupations are low-wage and include construction, agriculture, fishing and domestic/household work. Available data indicate that HIV prevalence among migrants is generally higher than adult HIV prevalence in host and source countries. For instance, adult HIV prevalence in Thailand is 1.1%, but among Cambodian and Burmese migrants working in Thailand it is 2.5% and 1.2% respectively [7, 15]. Figure 3 displays primary economic corridors for migrants in the GMS.

GMS: Thailand

As the epicenter of migration and the HIV epidemic in the GMS, Thailand faces a challenging environment for effective interventions. Thailand's economic strength, as well as its central geographical location in the GMS, have long made it a hub for regional economic migration and a host country for refugees. The number of migrants in Thailand is estimated at more than 2.5 million (documented and undocumented), with up to 150 000 more displaced asylum-seekers. Nearly 80% (1.5 million) of migrants in Thailand come from Myanmar. Many migrants from Myanmar are considered refugees and live clustered in (or near) camps, in close proximity to the Thailand-Myanmar border. Poor living conditions and scarce employment opportunities can increase the tendency to high-risk behaviours [30].

A wide-ranging study of migrant populations in Thailand found HIV prevalence among migrants in ports and industrial sites to be as high as 6 to 10%, highlighting key vulnerable migrant groups for interventions [31]. Fishermen who frequent Thailand's ports are more likely to visit sex workers in the course of long periods of time away from their home communities. In the Thai port of Ranong, 63.1% of the Myanmar migrant fishermen reported having paid for sex in the last 12 months. In addition, migrant fishermen in Thailand (and indeed across the region) are more likely to engage in drug and alcohol abuse than migrants in other occupational sectors. For example, a study found 27.7% of Myanmar migrant fishermen reported the use of addictive drugs in the last 12 months [30]. The difficulty of providing prevention and treatment services to such a highly itinerant population compounds their vulnerability to HIV infection.

GMS: China

In the northern region of the GMS, China's Yunnan and Guangxi provinces remain a focus of regional concern. A study of migrants in China that used the Estimation and Projection Package (EPP) model to process prefecture and county-level surveillance data to generate HIV prevalence and epidemic trends for migrant populations in China estimated that HIV prevalence was increasing among migrants from 0.032% in 2000 to 0.087% in 2011 [32]. The study concluded that, although prevalence was low, because of the large absolute number of migrants and their increased participation in high-risk behaviours, the migrant population would have a significant impact on the China's overall HIV epidemic [32].

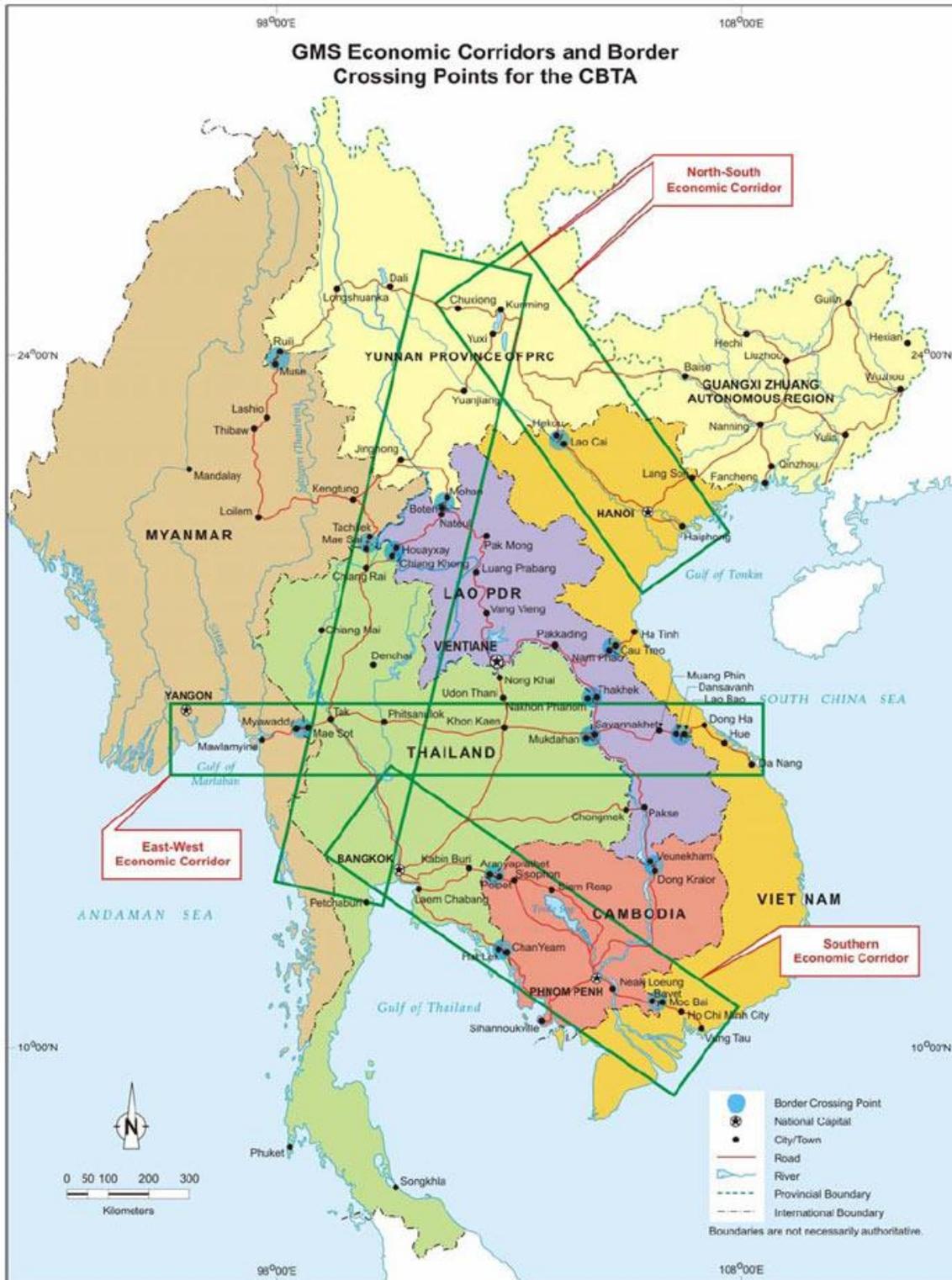
South Asia

Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, Sri Lanka

South Asia includes many important migratory corridors, including some that are primarily internal (such as those in India) and across international borders. Nepali workers migrate overwhelmingly to India, while Bangladeshi laborers travel to the Persian Gulf countries. The complexity of migratory movements, the huge

volume of migrants and the number of countries involved make holistic, comprehensive HIV-related migratory policy both essential and exceedingly difficult.

Figure 3 Regional map and primary migratory corridors (UNDP, JUNIMA, 2012)



India

NACO India claims that “migration is fueling India’s HIV epidemic” [4]. Due to the size of India’s migrant population and its current number of people living with HIV (the highest in the region), events in India will be at the centre of the regional AIDS response. India is both a destination and a source of huge numbers of migrant laborers. It is estimated that 258 million Indian men are migrant laborers within India, primarily in Maharashtra, Andhra Pradesh, Haryana and Karnataka—states that also have high HIV prevalence [33].

While the observed HIV prevalence among single male migrants in India is low, it is moderate among truck drivers. There is significant inter-site variation within the country: some sites for single male migrants as well as truck drivers have 0% HIV prevalence; conversely, the highest reported prevalence is 3.85% for single male migrants and 8.06% for truck drivers. Over half of the truck driver sites have a prevalence of >2.0% [34].

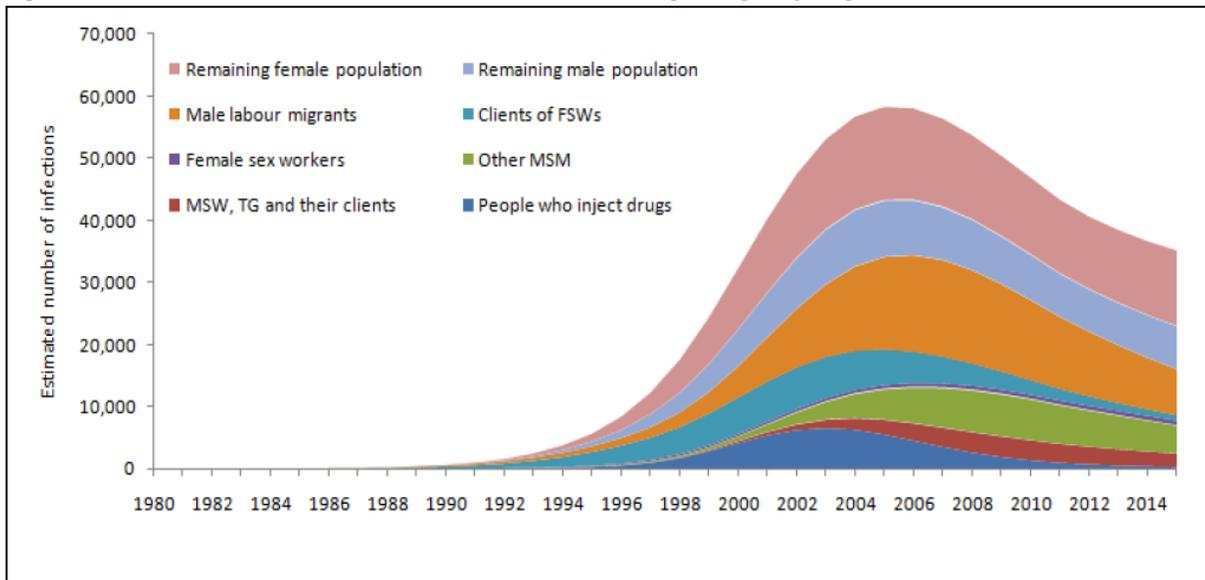
Data from 2009 showed that internal male migrants in five states in India were far more likely than sedentary males to purchase sex. Among migrants, 16 to 88% reported paying for sex, compared to 2.2 to 15% of the general male population [22]. Overall, the majority of new HIV infections are transmitted through heterosexual contact and 39% of all estimated people living HIV are women [35]. Typically, HIV spreads from key populations (such as sex workers) to their clients (such as truck drivers) to the general population [36].

Nepal

Nepal is primarily a migrant source country in the region, although in 2009 there were an estimated 818 700 migrants living in Nepal, representing 3% of the Nepalese population [5]. The value of remittances to the economy of Nepal cannot be overstated: in 2008, 23% of GDP was attributable to the remittances of migrant workers abroad. Although migration provides significant economic value to Nepal, as in Bangladesh and India, restrictive migration policies exist both officially and unofficially. Furthermore, Nepal is a major source of human trafficking in the region, with 5000-7000 women and girls aged 10-20 trafficked to cities in India every year. Overall, 77.3% of all Nepalese migrants live in India and 14.5% live in the Persian Gulf countries [5].

The HIV epidemic in Nepal is considered to be concentrated, with the estimated 2012 national HIV prevalence at 0.30% [7]. Prevalence among key populations is far higher. However, in 2011, the greatest burden of estimated PLHIV was found among women (27.3%) and male labour migrants (27%) [37]. According to the results of one study, 22 to 38% of the Nepalese women trafficked to India returned to Nepal HIV-positive. Girls who were trafficked under the age of 15 were at the highest risk of infection [38]. Of particular concern is the spread of HIV among the spouses of migrants who remain in Nepal. There is increasing evidence that not only the migrant workers, but also their spouses, are vulnerable to HIV infection [37]. Figure 4 illustrates the burden of infection across key populations and clearly demonstrates the burden among women.

Figure 4: Estimated distribution of HIV infections among risk groups aged 15 to 49 (1980–2015)



Source [37]: (Ministry of Health and Population, Nepal 2012)

Legal status and the rights of migrants

All countries in Asia and the Pacific have now listed migrants and mobile populations as vulnerable groups in their respective national HIV response plans. Although not all countries have signed onto various international agreements that protect the rights of migrants in transit or while in host countries, progress has been made as both the positive economic impact of migrant laborers and their effect on the spread of HIV have been acknowledged by governments and country coordinating mechanisms. Countries such as China, Fiji and Mongolia have made progress towards zero discrimination on entry, stay and residence of migrants [39]. However, official ratification of international conventions protecting migrants' rights should not be taken at face value. Monitoring of enforcement and implementation is essential in guaranteeing migrants' rights.

In 2011, the nations of the GMS signed the Memorandum of Understanding on Joint Action to Reduce HIV Vulnerability Associated with Population Movement [15]. The Joint Action Plan details the ways countries will work together to improve treatment, care and support of migrants within their borders. These steps include: creating cross-border bodies to harmonize HIV and AIDS policies and referral protocols regarding migrants; drafting legislation to protect migrants from Cambodia, Lao People's Democratic Republic and Viet Nam; and the creation of Migrant Worker Resource Centres (MRCs) to provide support and knowledge to migrants on a wide range of issues pertaining to HIV. Harmonizing treatment policies is especially important because adherence to ART regimens is essential for positive long-term health outcomes and the reduction of the emerging HIV drug resistance (HIVDR).

Mandatory HIV testing

Many source countries in the region (such as Bangladesh, India, Indonesia, Nepal or the Philippines) have enacted policies to protect their citizens from mandatory HIV testing, but enforcement is problematic and testing is often a condition for employment. Additionally, a number of organizations such as the Coordination of Action Research on AIDS and Mobility (CARAM Asia) have projects focused on easing migrants' access to care and for an end to mandatory HIV testing. Facilities that currently perform migrant testing, be they private clinics or Government-approved programmes, do not usually provide follow-up counselling and, frequently, do not

inform migrants of their test results [22]. Furthermore, for those migrants travelling internationally, the period of pre-departure testing and screening is a missed opportunity for counselling and education. Many studies show that migrants' knowledge of HIV is poor, yet the most opportune period to educate migrants on HIV and HIV prevention is underutilized [11].

Despite repeated calls by international migrant rights organizations for these human rights violations to stop, mandatory testing is ongoing. The Gulf Cooperation Council (GCC) countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates) are an increasingly important destination for migrants from Asia and the Pacific and all GCC countries require HIV testing to renew migrant visas. Those who test positive are summarily deported and their status is shared with testing clinics around the region, where they are designated as "permanently unfit" for employment. Among the issues surrounding mandatory testing is that migrants often contract HIV in the host country—but are treated as criminals through detention and deportation. Compounding the problem of mandatory testing and deportations is the fact that many migrants who test HIV-positive are not notified of their status [19].

Migrant access to antiretroviral therapy (ART)

With the identification of migrants as one of the key populations at higher risk of HIV infection in most countries in the region, strides have been made in providing ART to migrants and other mobile populations. Migrants who are living with HIV endure a double stigma: they are discriminated against for being migrants and for being HIV-positive. This hinders their access to HIV prevention, care and treatment services, including access to ART. Health care providers do seem discriminate against patients and there is usually a lack of reliable and affordable access to health care. ART treatment in particular requires patients to be registered in a local residential area, but migrants often cannot do this and thus are denied access to ART from ART centres. This has led to their relying on privately available ART, which is costly. There are economic concerns, including medical treatment costs, transport costs to get to care facilities and the fear of loss of income. These factors all further hamper migrants' access to health care. Other barriers to health care include the fear of being arrested or harassed by the police when travelling—which may force migrants to pay bribes. There are also work-related issues that are more specific to migrants: employers have a lot of power over their migrant workers, sick leave is rarely allowed and many migrants work long shifts, making it almost impossible to follow ART [15, 16]. For seafarers and plantation workers, the physical distance is also a barrier to follow ART.

Improving ART access requires a two-pronged approach that includes national treatment programmes and cross-border cooperation between destination and source countries. This approach allows treatment programmes to reach internal and international migrants and cross-border cooperation improves ART adherence after migrants cross the border to return home.

Knowledge of ART and how one can benefit from treatment tends to be low among migrant populations, further depicting the need to increase outreach activities. One study documented that only 10% of Nepalese migrants in India were aware of the availability of HIV treatment [17]. These low rates of ART knowledge were found across the region: just 14% of spouses in Nepal had heard of ART while just 20% of study respondents had heard of ART in Bangladesh [40].

As the primary migrant destination country in the GMS, Thailand plays a major role in confronting the spread of HIV among migrants in the region. Thailand's national HIV response strategy for 2012-2016 guarantees the provision of ART for any individual with HIV regardless of migratory status [41]. One migrant sub-population that has garnered the attention of Thai HIV treatment initiatives is migrant women who are pregnant. In response to the high HIV prevalence among pregnant migrant women, Thailand enacted programmes specifically for them [42]. However, due to their high mobility, migrant women's adherence to treatment regimens is difficult to

maintain [31]. GMS nations are continuously working on cross-border strategies against language barriers, treatment variation and continued stigmatization to provide better ART access.

Countries in South Asia face similar barriers in ensuring ART to migrants and have been making efforts to develop knowledge and strengthen cross-border cooperation. Cost of treatment continues to be a barrier even in places where ART is free, such as at Government-run clinics in India, because hidden costs (such as transport) remain [43]. Much like the countries of the GMS, Bangladesh, India and Nepal are moving toward improved regional cooperation on HIV in migrant populations, but more work is needed in South Asia. For instance, national policies do not address cross border HIV vulnerability and national programming in these countries does not yet contain migrant-inclusive HIV strategies in both source and destination regions [44].

Countries also face barriers for internal migrants needing consistent treatment. For example, India's ration card system, which allows individuals to access healthcare, among other social services in their state, are often not accepted in other states—making ART adherence problematic for internal migrants [43].

Recommendations

Vulnerability and risk reduction

Migration *per se* is not a risk factor for HIV infection. However, a wide variety of underlying factors and conditions associated to migration make migrants more vulnerable to HIV and more likely to engage in risky behaviours. Interventions that target these root causes are a necessary aspect of HIV prevention. Root causes include migrants' legal status, controls on freedom of movement in destination countries and poverty, compounded by lack of health care access. Addressing poverty and violence against women at the same time as addressing condom use, for instance, will help close the gap between vulnerability and risk reduction programming. Many countries can offer social protection schemes and set up bilateral agreements for cross-border assistance on social protection. For internal migrants specifically, it is critical to strengthen social protection schemes and enable migrants to access these schemes even when they are not on home soil. For single migrant women particularly, there is a need for shelters, as well as access to sexual and reproductive health care and other protection mechanisms that guarantee equal rights in both source and destination countries.

Health care access

Relaxing restrictions on migrant access to health services will help maintain good health, as well as promote HIV prevention and treatment. In addition, sexually transmitted infections (such as syphilis) that increase the risk of HIV transmission can be treated. Promoting access to basic health care for migrants in destination countries will require multisectoral cross-border cooperation. Better ART tracking for internal migrants will help reduce loss to follow-up within countries. This issue is far more complex for cross-border migrants— and it will remain so unless a strong and open partnership exists between countries.

End to gender inequality in migration

Female migrants suffer injustice disproportionately in comparison to males. Women often face mandatory pregnancy testing, punitive action in destination countries if they become pregnant and are frequently forbidden to access reproductive health services. If they do seek health care for pregnancy, they run the risk of redundancy and deportation. Though all the nations of South-East Asia are party to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), these and other discriminatory actions towards women continue [19].

Comprehensive cross-border strategies

Rights-based pre-departure HIV testing and screening is an excellent opportunity to provide HIV prevention, education and outreach services. Countries need to develop and effectively implement policies that take advantage of that opportunity with pre-departure training and targeted interventions at high-volume transit sites, such as ports and border crossings. These interventions, such as HIV testing, should be voluntary and not a requirement when crossing borders. Mandatory pre-departure training programmes in Cambodia, Indonesia and the Philippines are supposed to include a discussion of HIV risk and prevention, but the protocol is not always followed [19]. Countries need to agree on a standardized pre-departure training package for all migrants to facilitate delivery of appropriate HIV prevention information as well as knowledge of migrant rights [22,45]. Host countries should guarantee access to HIV services as well. Thailand has taken steps to give people living with HIV living in Thailand access to ART regardless their nationality and agreements with neighboring countries (such as Cambodia) allow migrants to bring a three-month supply of ART when returning home [41]. International bodies such as the South Asian Association for Regional Cooperation (SAARC) and the Association of South-East Asian Nations (ASEAN) must continue to address issues of HIV and migration both diplomatically and through the creation of regional programming and harmonized national policies [46]. The goal to have HIV services seamlessly crossing borders and to create a continuum of care for migrants starts with international agreements and taking migrants and people living with HIV out of illegality.

Strengthen data collection

While the great majority of national AIDS control organizations have placed migrants among key populations, little is known about migrants in comparison to other key populations. Governments and HIV/AIDS organizations must make a concerted effort to collect data on migrant demographics, patterns of movement, social and sexual behavior, HIV prevalence and barriers to health care access [46]. Such data are essential for developing an appropriately targeted response. Using quality data, programmes can use limited resources in the most efficient manner to have a positive impact on the rising number of HIV-positive migrants and their partners in source countries.

Interventions must be nuanced

Interventions should be nuanced for migrants' different backgrounds and needs. Seafarers, for instance, require a very different intervention approach from domestic workers. Without a multifaceted rights-based approach addressing migrant populations within their specific context, interventions run the risk of missing key groups of the mobile population. However, to use limited resources effectively, targeted interventions must be prioritized to those migrant populations that are most vulnerable. For example, men who pay for sex represent the largest infected population in Asia and the Pacific. Male migrants pay for sex at a higher frequency than the general population and, therefore, put their wives and partners at increased risk. Married women have traditionally been viewed as a low-risk population because they usually only have sex with their husbands, but it is essential that interventions be targeted specifically to prevent intimate partner HIV transmission to them [2,20]. Interventions at transit points are an effective way to reach mobile populations. Railway stations, bus stations, airports and heavy traffic corridors should be identified for HIV outreach and prevention before migrants are diffused among the broader population.

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