HIV & MIGRATION

Regional Profile: Asia 2009

HIV Situation Overview

In 2007, it was estimated that there were 4.9 million people living with HIV in Asia, of whom 440,000 became newly infected in the past year and approximately 300,000 died from AIDS-related illness (#UNAIDS, 2008a). While overall prevalence of HIV in Asia is lower than in certain other parts of the world, particularly Africa, there is a large variation in HIV prevalence within Asia – from almost 0%, up to 2.4% recorded in the Papua province of Indonesia (#UNAIDS & WHO, 2007).

Indeed, different countries are at different stages of the epidemic, and there is considerable regional variation within each country. In some Asian countries, HIV prevalence seems to be on the decline. Such decline has been experienced in Thailand, Cambodia and Myanmar (#UNRTF, 2008) and has been attributed to the effectiveness of preventive efforts. Other countries, however, present a more complex picture. For example, in Indonesia, while HIV prevalence has leveled off in some sentinel surveillance sub-populations in certain parts of the country, the absolute number of people living with HIV continues to increase. The overall epidemics in Indonesia, Pakistan and Vietnam are growing rapidly, especially among high-risk groups (#UNRTF, 2008). While overall prevalence in India is low (0.36%), with 2.47 million people living with HIV, it is third after South Africa and Nigeria in numbers of people with HIV (#UNDP, 2009).

Although HIV epidemics across different Asian countries vary considerably, they share important characteristics. Most are driven by unprotected paid sex, the sharing of contaminated needles and syringes by injecting drug users (IDUs), and unprotected sex between men (#UNAIDS, 2008b). As such, Asian epidemics are commonly addressed in relation to 'most at-risk populations' (MARPs) which include IDUs, female sex workers (FSWs) and their clients, and men who have sex with men (MSM). Migrants and mobile populations are also sometimes cited as at-risk populations. The purpose of this overview is to assess migrants' vulnerability to HIV in Asia.

HIV & Migration - Overview

Migration patterns in Asia

According to the International Labor Organization (ILO), 70 – 80 million of the 120 – 130 million people living outside of their countries of origin are migrant workers, of whom growing populations are women and migrants in irregular status (#ILO, 2002). ILO also estimated that over 25 million of the 40 million people worldwide infected with HIV are workers. While job creation at home is important, an increasing number of developing countries are looking to take advantage of foreign employment opportunities (#ILO, 2008). Many countries have adopted or are seeking to adopt policies and legislation to help take advantage of these opportunities, regulate them, and to safeguard the rights of their citizens (#ILO, 2008). While there are regular, state-facilitated channels for many highly skilled workers, this is not often the case for low or semi skilled workers who often must resort to irregular methods of obtaining foreign employment and entry (#ILO, 2008).

Low skilled migrant workers from Asian countries tend to migrate within Asia to more affluent neighbouring countries, including Hong Kong, Taiwan, Singapore, Malaysia and Thailand while many others go to Gulf countries (#ILO, 2008).

Some countries have traditionally been labor-sending countries like China, Indonesia, Nepal, Sri Lanka and Vietnam (#Wickramasekera P, 2002). Other countries both send and receive migrants, like India, Pakistan, and Thailand. In 2004, Thailand sent out 150,000 workers while it received 2 million foreign migrant workers (Juguet JW, 2008). For India, like China, the foreign labor force is only a small fraction of the total labor force (#Wickramasekera P, 2002). However, some parts of the country, like Kerala, depend on overseas labor migration. Pure labor-receiving countries in the region include the Middle East, Taiwan and Singapore (#Wickramasekera P, 2002).

For many of these countries, the remittances sent home by migrant workers play a substantial role in the economy of the country. Remittances to developing countries are estimated to be USD 290 billion in 2009, and will outstrip all private capital flows and official development aid (#The World Bank, 2009a). They will amount to 1.8% of the GDP for developing countries in 2009, and in some countries they represent the largest source of foreign exchange (#The World Bank, 2009a). For example, Sri Lanka received USD 2.53 billion in remittances in 2007, accounting for 8% of the GDP, with remittances being 3-4 times more than the amount of foreign assistance (#The World Bank, 2009b). Despite the fact that India's international labor force is only a fraction of its total labor force, India receives the most in remittances than any other country (#BBC World News, 2008). In 2007, Indian migrant workers sent back USD 27 billion. China is the second-highest recipient of remittances (#The World Bank, 2009).

The Greater Mekong Sub-Region

Figure 1: The Greater Mekong Sub-Region
Source: Mekong Press (www.mekongpress.com)

The Greater Mekong Sub-Region (GMS) is comprised of Cambodia, Lao People's Democratic Republic (Lao PDR), Myanmar, Vietnam, Thailand and the Yunnan Province of China – all of whom share the 4,200-kilometres long Mekong River (#UNESCO, 2004). The sharing of porous border crossing points among these countries translate into melting pots for various groups including transport workers, traders, border police and military personnel (#DFID & FHI, 2001).

Vulnerability to HIV and AIDS is increased in the GMS due to drug use, sex work and human trafficking. The drug trafficking routes from the 'Golden Triangle' of Myanmar, Lao PDR and Thailand dissect the GMS and provide easy access to a variety of illicit drugs (#UNESCO, 2004). The GMS borders are also sites of booming sex industries, fuelled by human trafficking which affects mostly the numerous ethnic minority groups along the Thailand-Myanmar-Lao PDR-China periphery (#UNESCO, 2004).

HIV infection among migrants

In several countries, particularly those with concentrated HIV epidemics, migrant and mobile populations are also often categorized, albeit somewhat inconsistently, as an at-risk population. Yet not all migrants are at higher risk of HIV infection, and migrants make up an extremely diverse sub-population, making generalizations regarding their behaviour patterns inexact. In most cases, vulnerability towards HIV infections is strongly linked to the risk behaviours taken by migrants. It is important to evaluate whether migrants are more likely to become involved in the same risk behaviours that make certain subgroups (i.e. FSWs, IDU and MSM) particularly vulnerable to HIV infection in Asia.

Some reported data on HIV prevalence and risk levels are presented in Table 1 and Table 2, respectively. Data from border regions with large migrant populations in and around Thailand show HIV prevalence among FSWs that ranged from 29 – 34% (Prey Veng Province in Cambodia, in 1998) (#Andriote M, 2003), and more recently between 2003 and 2004, ranging between 2% (indirect sex workers near the Myanmar border) to as high as 39% (direct sex workers near the Cambodian border) (#PHAMIT, *undated*). Data from various studies around Asia show that between 17 – 64% of migrant men visit FSWs. The level of condom use among migrant men when visiting FSWs varies across different regions. Among boatmen in Bangladesh, condom use was low at less than 5% (#Gazi R, 2008). Nepalese migrant returnees who had pre-marital or extra-marital sex reported 26% consistent use of condoms (#Poudel *et al.*, 2003). On the other hand, among truckers in India, 45 – 67% had used condoms at last sex with a FSW (#DFID & FHI, 2001). It has also been found that – in Thai provinces bordering Cambodia or Myanmar – while HIV prevalence among sex workers is relatively high, condom use among migrant workers is over 80% (#PHAMIT, 2009). Notably, these reports of high levels of condom use in India and Thailand were in areas were intervention programmes exists – the Healthy Highway Project in India and the Prevention of HIV/AIDS among Migrant Workers in Thailand (PHAMIT).

Few studies have directly compared HIV prevalence between migrant and non-migrant groups within the same population. A small study in Nepal showed that HIV prevalence was 10.3% among migrant returnees from Mumbai, compared to 2.5% among non-migrants (#Poudel *et al.*, 2003). On the other hand, a large scale study conducted in Mumbai in 2009 concluded that men who were not migrants or who migrated at an early age had higher sexual risk behaviour that those who were migrants (#Sanggurti N, *et al.*, 2009). In addition, migrant men whose wives resided in their region of origin, also had increased sexual risk behaviours and higher rates of STI infections (#Sanggurti N, *et al.*, 2009).

In Thailand, data on HIV prevalence among Thai and migrant women attending ante-natal clinics were varied. In the provinces of Chiang Rai and Ranong, there were no obvious difference in HIV prevalence between Thai and migrant women. In the provinces of Trat, Samut Sakhorn and Mae Hong Son, however, HIV prevalence among migrant women was roughly double that of Thai women (#UNDP, 2004).

In terms of occupational groups, HIV prevalence among migrants in Thailand ranged from 1.6% among construction workers in Samut Sakhorn to 6.4% among those in the industrial or agriculture sector in Chiang Rai, and as high as 9.0% among seafarers and fishermen, as found through the PHAMIT project (#UNDP, 2004; UNRTF, 2008).

Risk behaviours among migrants

The buying and selling of sex:

Sex work is one of the most important risk factors for the spread of HIV in several parts of Asia. Many FSWs themselves are migrants, primarily moving between Vietnam-Cambodia-Thailand, China-Hong Kong, and Thailand-Japan (#AMRC, 2001). In Thailand, over 16,000 sex workers have been estimated to be foreigners (#WHO, 2001). Some female migrants enter the sex industry due to limited alternative work opportunities in a foreign country. Others initially work as domestic or factory workers, but later take up sex work for various social and/or economic reasons (#AMRC, 2001).

In China, the skewed national sex ratio and increased migration (mainly from rural to urban areas) are believed to be contributing to the demand for sex work, and several studies have highlighted sexual risk-taking behaviour among some groups of migrants in this regard (#UNAIDS, 2008b). A 2003 survey in the southwest of China found that temporary female migrants were 80 times more likely than non-migrants to sell sex.

In Lahore, Pakistan, one in ten (11%) unmarried male migrant workers reported having had unprotected paid sex in the previous year (#UNAIDS, 2008b). Elsewhere in Pakistan, HIV infections have been reported among Pakistani seafarers from cargo ships travelling between Karachi, a major Pakistani seaport, and Bombay, India. These migrants often travel to other parts of Asia, such as Bangkok, and they often have paid sexual encounters. Thus Pakistani seafarers may be at a high risk of acquiring the virus and subsequently transmitting it to partners in Pakistan.

A link between high levels of HIV infection, sex work and migration may also be occurring in the Riau Archipelago of Indonesia. The islands of Batam, Bintan and Karimun became part of a Special Economic Zone in 2006, with the aim of enhancing economic development by capitalizing on the islands' close proximity to Singapore. In Karimun, there is an extensive sex industry which caters predominantly to working-class Singaporeans and Malaysians (#Ford & Lyons, 2007). The girls and women engaged in the sex industry almost always come to the Riau Islands from other parts of Indonesia – namely Sumatra, Kalimantan, Sulawesi and Java. In 2002, Riau Province recorded the fourth-highest rate of HIV infection in Indonesia after Jakarta, Papua and East Java (#Ford & Lyons, 2007).

Another migrant group – that is, women and girls trafficked into the sex trade – face especially high risks of infection due to sexual exploitation (#UNAIDS, 2008a). Each year in India, between 5,000 – 10,000 girls and women are trafficked in from Nepal and another 3,600 from Bangladesh (#UNRISD, 2002). A study in Nepal's Terai region found HIV prevalence to be 4% among sex workers – 17% of those infected had worked in India (UNRISD, 2002). More recently, an HIV prevalence of 38% has been found among sex-trafficked females who have been repatriated to Nepal, while up to a half of the women and girls trafficked to Mumbai, India, who have been tested were HIV-positive (#UNAIDS, 2008a). In Cambodia, it was estimated that as many as 30% of sex workers were migrants or trafficked women from Vietnam (#WHO, 2001). The HIV prevalence in the late 1990s among Vietnamese sex workers in Svay Pak was 19% (#Busza J, 2004). In Thailand, HIV rates were estimated to be approximately two to three times higher among trafficked Burmese sex workers in Thailand, than among Thai women voluntarily working in the industry (#Beyrer, C & Stachowiak, J, 2003). Similarly, locked brothels and debt-bonded sex workers of Thailand and Cambodia have been reported to have high rates of HIV infection, as have their patrons, although the data to support this was not presented (#Beyrer, C & Stachowiak, J, 2003).

Injecting drug use:

Injecting drug use is a major risk factor in the epidemics of several Asian countries. Among migrants in Vietnam, high levels of injecting drug use (and sex work) were observed among young male migrant workers aged 16–26 years (#UNAIDS, 2008a). In a study comparing migrant and resident heroin users in Hanoi, migrants reported initiating heroin use later than young men from Hanoi; usually only after they had migrated and relatively soon after their arrival in Hanoi (#Giang LM, 2006).

Near India's National Highway in Manipur, HIV prevalence among injecting drug users was found to be linked with villages' geographical proximity to the highway (1.3% in villages closest to the highway compared to 0.2% in those furthest), which involved heavy movement of truckers across borders (#Sarkar K, *et al.*, 1997).

In a large-scale population-based study in China, while temporary migrants and non-migrants did not differ significantly in prevalence of drug use, including injecting drug use, migrants were more likely to share needles injecting drugs (40.7%) than non-migrants (30.4%) (#Yang X, *et al.*, 2004).

Intimate partner sexual contact:

A growing percentage of new infections occur among spouses and regular partners of people infected during commercial sex. Spouses and partners of migrant workers are especially vulnerable since there is a higher use of sex workers by migrant workers during long stays away from home (#ICDDR,B, 2005). In Bangladesh, for example, of the 47 HIV-positive cases detected at three Voluntary Counselling and Testing (VCT) units in 2002-2004, 29 were adult males who returned from abroad, seven were wives of migrant workers, and four were children of HIV-positive migrant workers (#ICDDR,B, 2005). A study of 703 married men showed that those who lived apart from their wives elsewhere in Bangladesh or abroad were 4.6 and 6.0 times more likely, respectively, to have had extra-marital sex compared to men who did not live apart from their wives (#ICDDR,B, 2005).

Men who have sex with men:

While data on MSM population's HIV prevalence and risk behaviour is still scarce in Asia, this is an increasing mode of transmission for HIV. One study conducted among active heroin users in Hanoi, Vietnam found that 15.2% who were migrant workers had some exposure to MSM sex work, compared to 4.6% among those who resides in Hanoi (#Giang LM, 2006). In the Bangladeshi study on married men, those who had been abroad or lived elsewhere in Bangladesh reported having had sex with men at 6.1% and 8.5%, respectively. This is higher than the 2.5% among men who had not lived apart from their wives (#ICDDR,B, 2005). Another study in India, on the other hand, showed that among male factory workers in Kolkata, 7.4% of migrants have had sex with men, compared to 13.5% of the local workers (#Deb AK *et al.*, 2009). All reported never using condoms with male partners (#Deb AK *et al.*, 2009).

Table 1: Key findings from selected studies in the region on HIV prevalence among migrant groups.

Country	Study	Year	Populations	HIV prevalence	Reference
Cambodia	Prey Veng Province – the origin of many Cambodian seafarers in Thailand	1998	Direct sex workers Indirect sex workers	29% 34%	(#Andriote M, 2003)
India	Survivors of sex trafficking, 2002 - 2006	2007	Survivors of sex trafficking *N = 61 (48 tested for HIV)*	45.8%	(#Gupta J, *et al.*, 2009)
Nepal	Migrant returnees from Mumbai in the far western district of Doti	2001	Migrant returnees *N = 97* Non-migrants *N = 40*	10.3% 2.5%	(#Poudel *et al.*, 2003)
Thailand	PHAMIT[1]	n/a	Migrant fishermen	9%	(#UNRTF, 2008)
	HIV prevalence among sex workers at border provinces	2003-2004	Direct sex workers Myanmar border Cambodia border Indirect sex workers Myanmar border Cambodia border	 2003: 10.3 – 25.0% 2004: 4.0 – 28.8% 2003: 23.5% 2004: 38.7% 2003: 1.7 – 4.0% 2004: 2.6 – 7.3% 2003: 3.3% 2004: 6.6%	(#PHAMIT, *undated)*[2]
	Migrant workers from Myanmar at Samut	2001	Migrants workers from Myanmar	1.4%	(#PHAMIT, *undated)*[3]

[1] Prevention of HIV/AIDS among Migrant Workers in Thailand.
[2] citing *Ministry of Public Health, 2003-2004.*
[3] Citing *Bhumiprabhas S, 2001.*

Sakhorn Province					
Mae Tao Clinic in Mae Sot	2003	Women (including migrants) attending ANC *N = 2,435*		1.4%	(#Mae Tao Clinic, 2004)
Ante-natal clinics	2001	Pregnant women, by province:			(#UNDP, 2004)
		Trat	Migrant *(89)*	6.7%	
			Thai *(305)*	2.0%	
		Samut Sakhorn	Migrant *(93)*	4.3%	
			Thai *(2,029)*	2.0%	
		Chiang Rai	Migrant *(467)*	2.4%	
			Thai *(1,619)*	2.5%	
		Mae Hong Son	Migrant *(198)*	2.5%	
			Thai *(238)*	0.4%	
		Ranong	Migrant *(102)*	0.0%	
			Thai *(385)*	1.0%	
Anonymous HIV testing of migrant workers applying for permits, selected provinces	1996	Province, occupation group			(#UNDP, 2004)
		Samut Sakhorn	*Construction (363)*	1.6%	
		Phangna	*Agriculture (250)*	2.4%	
		Tak	*Agriculture (793)*	1.9%	
		Chiang Rai	*Industry/Agriculture (700)*	6.4%	
		Kanchanaburi	*Agriculture (727)*	3.2%	

Table 2: Key findings from selected studies in the region on HIV risks and vulnerabilities among migrant groups.

Country	Study	Year	Populations	Key findings	Reference
Bangladesh	Boatmen in Teknaf – The Naf River border crossing ‘bridge’ group	2005	Boatmen	Had sex with FSW (while abroad): 17% Had sex with another man: 19% Condom use (last month): 0 – 4.7%	(#Gazi R, 2008)
	Cross-sectional survey of married men and women in two rural areas	2005	Married men *N = 703*	Had extramarital sex: Returned from abroad: 67.0% Returned from elsewhere Bangladesh: 59.8% Not lived apart: 25.6% Had sex with FSWs since marriage: Returned from abroad: 58.7% Returned from elsewhere Bangladesh: 49.6% Not lived apart: 15.2% Had sex with a man since marriage: Returned from abroad: 6.1% Returned from elsewhere Bangladesh: 8.5% Not lived apart: 2.5%	(#ICDDR,B, 2005)
Cambodia	Seafarers FGD	-	Seafarers	Had sex with FSWs: ~ 60%	(#Andriote M, 2003)
China	Population-based, southwestern China	2004	Males *N=3,465* Females *N=2,007*	Ever had sex with non-regular partners Temporary migrants: 37.2% Non-migrants: 17.7% Ever had sex with non-regular partners without condoms Temporary migrants: 27.2% Non-migrants: 11.3% Had sex with non-regular partners (last 30 days) Temporary migrants: 14.2% Non-migrants: 4.5% Used condoms with non-regular partners (last 30 days) Temporary migrants: 72.8% Non-migrants: 88.7% Involved in selling or buying sex	(#Yang X, *et al.*, 2004)

Country	Study	Year	Population	Findings	Reference
				Temporary migrants: 14.8% Non-migrants: 3.8% Drug/alcohol induced during sex Temporary migrants: 18.3% Non-migrants: 12.1% Sharing needles (among IDUs) Temporary migrants: 40.7% Non-migrants: 30.4%	
India	IDUs near the National Highway in rural Manipur	1997	Villages along the National Highway	IDU prevalence Villages closest to the highway: 1.3% Villages furthest away from the highway: 0.2%	(#Sarkar K, et al., 1997)
	Healthy Highway Project: Behavioural Surveillance Survey	2001	Truckers *N = 4,811 drivers, 1,200 helpers, 1,201 stationary.*	Had sex with FSWs: 36 – 47% Always used condoms: 29 – 43% Used condom at last sex: 45 – 67% Had sex with non-regular partners: 12 – 25% Never used condoms: 51 – 62% Used condom at last sex: 26 – 36% Awareness HIV/AIDS: 85 – 95% STIs: 61 – 77%	(#DFID & FHI, 2001)
			Highway female sex workers *N = 1,504 FSWs*	Condom use with client: Always used condoms: 52% Used condom at last sex: 76% Awareness HIV/AIDS: 87% STIs: 73%	
	Male migrant workers from 21 districts in 4 high HIV prevalence states	2008	Contracted migrant workers *N=3,880*	Had sex with FSWs: 17% Inconsistent condom use with FSWs: 40% Non-spousal or FSW partners In migration destination: 10% In place of origin: 31%	(#Saggurti N, *et al.*, 2008)
	Behavioural and biological	2001 -	Migrant men	Had sex with FSWs	(#Saggurti N, 2009)

	surveys in three communities in Mumbai	2007	*N = 2,074* Non-migrant men *N = 3,056*	Migrant ≤5 yrs: 1.4% Migrant >5 yrs: 2.1% Non-migrants: 2.5% Had one or more extra-marital partner Migrant ≤5 yrs: 4.2% Migrant >5 yrs: 6.1% Non-migrants: 8.4% STI prevalence Migrant ≤5 yrs: 9.1% Migrant >5 yrs: 7.1% Non-migrants: 8.8%	
	Male migrant factory workers in Kolkata	2009	Migrant workers *N = 402* Local workers *N = 402*	Had sex with FSWs Migrants: 37.9% Locals: 57.2% Never used condoms with FSWs Migrants: 48.3% Locals: 34.0% Had sex with other men: Migrants: 7.4% Locals: 13.5% Never used condoms with men Migrants: 100% Locals: 100%	(#Deb AK, *et al.*, 2009)
Nepal	Migrant returnees from Mumbai in the far western district of Doti	2001	Migrant returnees *N = 97*	Had sex with FSWs: 63.5% Had pre- or extra-marital sex: 79.2% Always used condoms: 26.3% Prevalence of syphilis: 24.7%	(#Poudel *et al.*, 2003)
			Non-migrants *N = 40*	Had sex with FSWs: 17.5% Had pre- or extra-marital sex: 62.5% Always used condoms: 44.0% Prevalence of syphilis: 15.0%	
Pakistan	Migrant workers aged 20-49 in Lahore.	2006	Migrants *N = 590*	Had non-marital female partners: Single men: 19.5%	(#Feizal A & Cleland J, 2006)

Country	Programme/Study	Year	Population	Findings	Source
				Married men: 5.4% Had sex with FSWs: Single men: 11.4% Married men: 1.8% Had sex with other men: Single men: 2.9% Married men: 0.4%	
Thailand	PHAMIT Programme Migrant Workers	2004-2008	Coastal Myanmar	Condom use at last sex with FSW[4]: 2004: 90% 2008: 97%	(#PHAMIT, 2009)
			Northern Myanmar	Condom use at last sex with FSW: 2004: 78% 2008: 80%	
			Coastal Cambodia	Condom use at last sex with FSW: 2004: 96% 2008: 97%	
	Health exam screening for obtaining work permits	2004	Migrant workers tested *N = 817,254*	Prevalence of syphilis: 5.5% Prevalence of tuberculosis: 9.9%	(#PHAMIT, *undated)*[5]
	Mae Tao Clinic in Mae Sot	2002	Migrant patients	Prevalence of syphilis: 2.7% Teen pregnancies 2000: 18.8% 2002: 26.0%	(#PHAMIT, *undated)*[6]
		2003	Pregnant women (including migrants) *N = 2,435*	Prevalence of syphilis: 2.5% Prevalence of Hep B: 8.5%	(#Mae Tao Clinic, 2004)

[4] Percentage values are approximates obtained from bar charts.
[5] Citing *Office of Administration Commission on Irregular Immigrant Workers, Min. of Labor & Social Welfare – as of Dec 15 2004.*
[6] Citing *Ekachai S, 2003.*

	Myanmar migrants at Chiang Mai and Ranong	2000	Myanmar migrants	Prevalence of any STI (self-reporting of symptoms) Female (abnormal vaginal discharge): 21% Male (difficulty urinating): 30%	(#PHAMIT, *undated)*[7]
	Myanmar migrants at Samut Sakhorn	2000	Myanmar migrants	Prevalence of any STI (last 6 months): 7%	(#PHAMIT, *undated)*[8]
Vietnam	HIV/AIDS Behaviour Surveillance Survey, Can Tho Province	2002	Migrant workers	Condom use, last act with FSW: 73.9% Consistent condom use, with FSW (12 months): 62.1% Condom use, last act with casual partner: 26.7% Consistent condom use, with casual partner (12 months): 13.3%	(#UNAIDS, 2008c)
			Injecting drug users	Condom use, last act with FSW: 57.1% Consistent condom use, with FSW (12 months): 38.1% Condom use, last act with casual partner: 25.0% Consistent condom use, with casual partner (12 months): 9.1%	
	Active heroin drug users in Hanoi	2006	Migrants *N=132* Hanoi residents *N=921*	Exposed to MSM sex work Migrants: 15.2% Hanoi residents: 4.6%	(#Giang LM, 2006)

[7] Citing *Caouette T et at., 2000. Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand.*
[8] Citing *Tin E, 2000 (unpublished). Risky Behaviours Related to HIV/AIDS and the Practice of Family Planning among Burmese Migrant Workers in the Central Part of Thailand.*

Vulnerabilities:

Based on current understanding of the conditions and circumstances surrounding migration, it is believed that HIV infections are likely to be higher in sub-groups of the migrant population as compared to the general population (#UNRTF, 2008); however, this short descriptive review has found limited data to support any generalization about increased HIV infection among migrants. The specific context of migration in each country needs to be assessed before concluding about increased risk behaviour of migrants. Indeed, while migrant workers face many challenges and risks, there are several specific vulnerabilities in the migration process and in the environment or circumstances that they are in that may place them at a higher risk of HIV infection, depending of specific contexts.

Work situations and circumstances faced by migrants that increase their vulnerability to HIV include (#ILO, 2001; #ILO, IOM & UNAIDS, 2008):

- Travelling regularly;
- Separation from spouses, families, partners and familiar social and cultural norms;
- Working in geographically isolated environments with limited social interaction and health facilities;
- Sub-standard and exploitative working conditions;
- Single-sex working and living arrangements among men;
- Work that is dominated by men, where women are in a small minority;
- Language barriers;
- Vulnerabilities in terms of poverty, hardship, loneliness and exclusion.

These vulnerabilities may lead or not to increased tendencies of drug use, buying and selling of sex, or engaging in sex for survival. More direct exploitation and abuse, such as rape, may also occur (#UNRTF, 2008). These factors may also contribute to inadequate access to HIV prevention information, services and tools and fear of being stigmatized for seeking such information or services.

Transport sector and routes

A presumed link between the spread of HIV and sexually transmitted infections (STIs) and major transport and infrastructure projects is often made (#ADB, 2008). In India, a study in 1997 on IDU prevalence in rural Manipur showed that villages closest to the National Highway had the highest IDU prevalence (up to 1.3%) compared to 0.2% in those furthest away from the highway (#Sarkar, 1997). An HIV prevalence rate of 16% was reported along one particular route in southern India, while the national rate was less than 1% (#ILO, 2005)[9]. In Bangladesh, those with the highest prevalence of HIV were long-distance truck drivers. In the People's Republic of China (PRC), truckers' STI rates were between two and four times higher than the rates in the general population. Indeed, the Yunnan Province of China is considered the 'birthplace' of HIV/AIDS in China, with the first group of 146 HIV cases in China found there. Since 1995, HIV has spread along truck routes to most parts of Yunnan and the rest of China (#UNESCO, 2004). The increase in HIV cases in Yunnan is especially noticeable along highways leading to the Myanmar border, such as the Mandalay-Muse highway built in 1997 (#UNDP, 2001). A year after the completion of the Mandalay-Muse highway connecting Yunnan with Myanmar, HIV prevalence among IDUs in three provinces in Myanmar rose (#ADB, 2008). In 2002,

[9] The original report of this study was not found. These statistics were cited by the ILO *Guidelines for the Transport Sector,* 2005 as being quoted from a high-level UNAIDS meeting.

Yunnan accounted for 32% of the national HIV cases. Infections were predominantly among IDUs along the Myanmar-Yunnan border, although HIV prevalence among spouses of IDUs in Yunnan has increased from 3% in 1990 to 12% in 1996, a trend that is also leading to increasing reports of mother-to-child transmissions (#UNESCO, 2004).

In Pakistan, migrants – including truck and bus drivers who traverse the country and are typically away from their homes for long periods – are at high risk of HIV infection as they may engage in casual sexual relations with commercial sex workers and/or other partners (#Khawaja, 1997). Their wives are also believed to be at risk of contracting HIV when the infected men return home. A small study conducted among 40 truck drivers attending a sexually-transmitted disease (STD) clinic in Karachi found that 40% of them reported sexual contact with female commercial sex workers and 90% of these had sexual contact with more than one female sexual worker. Moreover, 53% reported multiple homosexual contact (#Khawaja, 1997).

Sexual abuse and sex trafficking

Female migration is on the increase. In Sri Lanka, for example, women make up more than 60% of migrants and are employed primarily in the domestic service sector (#ILO, 2002). Female migrant workers are most vulnerable to exploitation, and are at higher risk of being sexually abused, or being forced into the sex trade. Many women enter domestic service, but most countries, like Nepal, consider this an informal sector, making it is far less regulated. Exclusion from labor laws leaves these workers especially open to abuse, with little-to-no legal recourse. These women are often vulnerable to sexual or physical abuse. This in turn puts the women at increased risk of HIV infection.

Asia is also a large source and destination for trafficked women. Women are abducted for the purposes of sex trafficking and can sometimes be trafficked after arrival in destination countries. Countries in which trafficking of women occurs for the domestic sex industry include China, Russia, India, Thailand, Cambodia, and Myanmar. Myanmar, for example, is a source country for thousands of women and young girls who are trafficked into the commercial sex industries of neighbouring countries (#Beyrer, C & Stachowiak, J, 2003).

Stigma and discrimination

In many instances, particularly for unskilled and/or undocumented migrants, there is a stigma associated with being a migrant. Such stigma, and in some cases the discrimination that comes with it, has an indirect impact in terms of access to healthcare services, provision of basic human rights and marginalisation which could all lead to increased vulnerability towards risk factors of HIV infection. Individuals who are involved in clandestine migration may fear reprisal if they make use of preention programs or health care. Moreover, as discussed, migrants sometimes become cross-categorized in other highly-stigmatized groups including sex workers, IDUs and MSM.

Internal migration, displacement and mobility

Although labour migration is often associated with the crossing of international borders, often the risk and vulnerabilities faced are also present among the mobile populations within a country as a result of internal migration (e.g. labour migration from rural to urban regions) and displacement (e.g. conflict and natural disasters). These vulnerabilities are often compounded by the fact that internal

migration is less well regulated than migration that spans international borders, making internal migrants difficult to reach with targeted programs.

In relation to rural-to-urban migrants in China, for example, it has been reported that these migrants are young, poorly educated, sexually active, and have little access to – or knowledge of – information concerning HIV prevention (#Yang T *et al.*, 2009). They frequently work in construction, live in single-sex dormitories and work long hours in substandard conditions. Nearly 30% of migrants reported having had multiple sexual partners or paying for sex at least once during their temporary city residency (#Yang T *et al.*, 2009).

Lack of awareness on health care, risks and access

When policies and implementation of migrant welfare services are weak, migrants are provided with very little health information before departure or en-route. In such cases, migrants are not informed about health risks, including risks for HIV infection, and do not know about their health access opportunities or benefits. In destination countries, language barriers, abuse by employers, fear of being found unfit and deported, lack of health insurance, lack of awareness, and lack of money can also prevent migrant workers from accessing local health care or local health programs.

Illiteracy and language barriers

Data from the Thai National Census in 2000 indicated that among migrants from Cambodia, Lao PDR and Myanmar, the illiteracy rates were 30%, 40% and 76%, respectively (Caouette T, et al., *undated*). Illiteracy was particularly high among Myanmar migrants, reflecting that most are from ethnic minority groups. In Bangladesh in 1999, 95% of women who were rescued from trafficking were illiterate, and in Delhi 92% of sex workers interviewed in 1991 had illiterate parents (#UNRISD, 2002). Illiteracy creates a susceptibility to abuse and is a barrier in the form of the inability to dictate precautionary behaviours such as condom use during sex. The migrants are also unaware of their rights and are not able to access HIV (and other health aspect) intervention programmes and services.

Spouses and children of migrants

Spouses and regular partners of migrant workers are at an increased risk of HIV infection. Many returning HIV positive migrants are either unaware of their status, or unaware of the methods to prevent their partners from getting infected (#UNAIDS, 2009). Furthermore, women left behind by their migrant husbands may engage in risky behaviours in order to survive, thereby increasing their risk of contracting HIV (#UNAIDS, 2009).

During the late 1980s and 1990s, an increasing number of Pakistani male migrant workers were returning home with HIV infections. Upon their return, some of them subsequently infected their wives, and through them, to their children (#NACP, *undated)*. In India, women now account for 39% of all HIV infections, and in most cases, married men have acted as a 'bridge' between high-risk populations and the general population. However, there are no numbers on how many of the spouses were migrant workers (#UNAIDS, 2008d). In Nepal, spouses or female partners of migrant workers and clients of sex workers now account for a fourth of all adult infections (#NCASC, 2008).

Policy Review

Given that Asia includes many countries with developing economies, labor-sending countries are numerous. Some countries have long-established labor-migration programs, while others are currently experiencing a transition in migration patterns. Still others are altogether new to organized labor migration.

National Strategic Plan for HIV and AIDS

In most countries, National Strategic Plans for HIV and AIDS do not specifically identify migrants and mobile populations as a population at-risk (#UNRTF, 2008). This exclusion is often translated into an absence of direct HIV intervention action plans responding to the risk of HIV infections among this vulnerable group.

Lack of policies/compliance

All countries of origin face challenges in protecting migrant workers from exploitative recruitment and employment practices, and in providing appropriate assistance to migrant workers in terms of pre-departure, welfare and on-site services. They also face the challenge of increasing cooperation with destination countries for the protection of migrant workers, access to labor markets and the prevention of irregular migration.

The lack of official policies remains another major challenge in fighting the HIV epidemic in Asia. Some countries have very few policies regarding international migrants, like China and India. Others have policies regarding only certain aspects of the process, like Vietnam where legislation tries to control the testing aspect of the migration process, but does not address referral and treatment services for people found to be HIV positive.

Some countries have very few policies or legislation regarding migrant workers, and their health. In many instances, there are guidelines that are not enforceable – as is the case in China and India, or the policies and legislation already in place are not actively enforced by the relevant authorities, as in Indonesia. However, there are some countries with strong legislation and policies protecting the migrants and their health, both in the source and destination countries. Countries in the process of developing and implementing strong policies include Thailand and Sri Lanka. Lao PDR offers another example of this, in that it is signing bilateral agreements with destination countries to help prevent irregular migration.

Lack of data

The most salient feature in the research on this topic is the lack of data available. Most governments do not monitor the health of migrants, and most research done on HIV/AIDS tends to pay very little attention to the risks that migrant workers face, and to the risks that they pose to the wider HIV epidemic in each country.

Many countries do not have surveillance for migrant workers, and despite the documented higher risks of HIV infection faced by migrants, prevalence data is hard to come by. In some instances,

among people with HIV/AIDS there is a higher percentage of people who have been migrant workers, or have been spouses of migrant workers, indicating a higher prevalence among migrant workers, but hard data does not exist. Even where research on HIV/AIDS in the country is conducted, there seems to be very little attention paid to the risks posed by a migrant population.

In many instances HIV among migrants are reported as the proportion of known/reported HIV cases in the country. For instance, Nepal reported that labour migrants make up 46% of the total known HIV infections, followed by clients of sex workers at 19% (#WHO, 2007). In the Philippines, 35% of registered people living with HIV were returning migrants, as were 30% in Lao PDR (#UNRTF, 2008). Such reporting, while informative, needs to be looked at with some caution about case detection and the surveillance and reporting systems.

Although many countries do not have pre-employment HIV testing policies, migrants are often subject to such requirements by destination countries/employers. Depending on the strength of surveillance and reporting in the general population and among other MARPs, the reporting of cases attributed to migrants/returnee-migrants may be disproportionate.

In the face of very little investigation into the size, status and potential risk of HIV infection for migrants, and subsequently the potential risk to the population at large, successful HIV/AIDS programs are difficult to create, implement and monitor. Before such programs can be created, the needs of the migrant population, including the various sub-populations within the migrant work force, need to be better understood. The needs of internal migrants, international migrants, male migrants, female migrants, and so on, may be different and programs targeted to those specific needs are required.

Undocumented migrants

A migrant population, by its very nature, is a difficult population to monitor. This task further complicated in the face of irregular travel, which many migrant workers resort to due to high recruitment fees, inconvenient and expensive medical testing (including for HIV), and long wait times.

Undocumented migrants may face a greater risk of HIV infection given the nature of their movements. They do not receive even the basic training on HIV that most documented migrants receive in pre-departure orientations. Undocumented migrants often take great risks and face danger when trying to illegally enter a country, and as such, their stays in destination countries tend to be longer. The longer separations from home, and families, leads to greater chances of high-risk behavior, like use of sex workers, injecting drug use, and men having sex with men.

Without legal documents, these migrants may not be eligible for healthcare services. Stigma, discrimination and fear of arrest also prevent many of them from seeking health care.

The bilateral agreements signed between some labor sending and labor receiving countries, in an effort to prevent illegal recruitment and migration, need to be enforced and followed up with ensuring that the standardised migration procedure is made less expensive, faster and transparent so as to encourage people to use it.

Health care services

In many countries, the healthcare system does not accommodate the migrant population. Medical testing sometimes requires prospective migrants to travel far, incurring the costs of travel and stay in addition to the often unregulated costs of medical testing. Language and cultural differences create barriers to access of healthcare services and HIV awareness and prevention programmes.

Mandatory testing of HIV

While many countries do have policies regarding the actual recruitment and migration process, very few have policies dealing with pre- and post-test counselling, referral and treatment services for those found to be HIV positive before departure, and for migrants deported for testing HIV positive while abroad.

Pre-departure and post-arrival mandatory health examinations are regularly implemented as part of the migrant worker recruitment process. Most countries do no have policies for mandatory HIV testing of outbound migrants. However, the majority of destination countries (with a few notable exception such as Thailand), do require mandatory HIV testing of migrants. As a result, many sending countries implement HIV testing under the justification of compliance to the requirements of destination countries and/or employers.

Mandatory HIV testing may breach migrants' rights, as per their country of origin's laws. Moreover, the practice of mandatory testing violates numerous international guidelines and best practices with regards to the human rights-based approach to HIV prevention, treatment and care. As such, there needs to be better control of the processes involved: to ensure consent, confidentiality of results, the provision of supporting pre- and post-test counselling, the provision of or referral to treatment access, and to mitigate the implications of a positive HIV status (disclosure, welfare, loss of employment and deportation). In a review by CARAM Asia, it was found that under conditions of mandatory health testing, the standard components of HIV testing are discarded or overlooked in both origin and destination countries. There is no explicit consent taken before undergoing testing; migrants do not receive any pre-test or post-test counselling; migrants have no control over the confidentiality of their results, often with results given directly to recruitment agents or employers; and although there are health services available, migrants, prospective migrants and returned migrants are not referred to those services when they are found to have an exclusionary condition, including those who are HIV positive (#CARAM Asia, 2007).

Restrictions on entry, stay and residence

Of the 186 countries in the world for which data are available, 66 governments currently impose some form of restrictions of entry, stay and residence for non-nationals living with HIV and AIDS (#Amon & Todrys, 2008).

Deportation process

Migrants are often required to undergo retesting in destination countries at regular intervals after arrival. In many cases, they are not aware of these testing requirements beforehand. There is usually no informed consent for the medical tests, the results of which are given to the employer. There is

usually no pre or post-test counselling. In many countries, migrants found to be HIV positive are given no referral or treatment services. In fact, they are often not told of their condition at all, and are just informed that they are unfit and are to be deported. In many instances, they are treated like criminals, handcuffed, and held in detention centres, with no chance of retrieving their belongings or claiming salaries owed to them.

Many deported migrants arrive back in their home countries unaware of their HIV status, and therefore do not seek any treatment. Consequently, they pose a threat of infection to their spouses and partners. Migrants who are aware of their status often do not know where to turn to for help, as referral services are weak. Stigma in home countries also leads to some migrants hiding their status from their families, and failing to seek treatment.

Conclusion

Vulnerabilities often faced by migrants – including poverty, hardship, seclusion from social support structures and poor accessibility to healthcare services – put migrants at increased exposure to risk factors associated with HIV infection. These include the buying and selling or sex and injecting drug use. Use of condoms and knowledge of HIV transmission also appear to be low, although data on these indicators are scarce.

Although not abundant, data does exist to show that there are indications of increased levels of high-risk behaviours among migrant populations compared to non-migrants. Of note, however, is that areas where such studies on migrant risk behaviours and HIV prevalence tend to be conducted are those that are known to have either high HIV prevalence and/or are identified as highly vulnerable locations, such as the border populations around the Greater Mekong Sub-region. Other 'hot spot' regions include India's borders with Nepal and Bangladesh, as well as the rural-to-urban internal migration routes within China. It is possible that vulnerability and risk of HIV infection is varied within different migrant populations, and there are various location-specific circumstances that may determine these factors. The abovementioned recent study in Mumbai, for example, shows that sexual risk behaviour among men is more closely related to active mobility, rather than status as migrant or non-migrant.

While risks do exist among these identified populations, there is a need for more data covering a wider range of populations to be able to independently conclude that migration is directly linked to increased HIV vulnerability. In the meantime, with regards to the localised evidence presented in this paper, HIV-related interventions and programmes should target the identified populations and their respective risks. Examples of such interventions currently operating include the PHAMIT project in Thailand, and the Healthy Highway programme targeted at truckers in India. In turn the impact of these interventions needs to be periodically assessed.

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ANNEX: Summaries of country-level policies on migrant workers and HIV

***China:** few policies exist regarding migrant workers.*

China, despite being the second- highest recipient of migrant remittances in the world, has very few policies to regulate the movement of both international and internal migrants. There is no law prohibiting discrimination against people living with HIV/AIDS, and the National Epidemics Law categorizes HIV/AIDS as a "class B" disease, where persons with the diagnosis are to be held in isolation for a period to be determined by medical experts. The police can be used to enforce isolation if a patient refuses to cooperate. The Labor Contract Law of China, signed in 2008, is designed to protect worker's rights by ensuring written contracts for all employees, but there are still many challenges remaining in the implementation of this law.

There has been very little investigation done to understand the size, status and potential risk of HIV infection for migrants, especially those migrants who work in 'illegal' jobs. The needs and preferences of different sup-populations of migrants are not clear and the services that can meet their needs are not yet available.

***India:** few policies exist regarding migrant workers, and health of migrant workers. Bilateral agreements signed with some destination countries.*

India is the highest recipient of migrant remittances in the world, yet has very few enforceable policies in place to regulate migrant labor, with the majority of labor using irregular means to obtain employment in foreign countries. While the National AIDS Policy denies the public rationale for mandatory HIV testing, this guideline is not legally enforceable, and there is no policy or legislation regarding the mandatory testing of migrant workers. Those migrating through regular means have to comply with the testing policy of the destination country.

In a recent attempt to prevent illegal recruitment of workers and to eradicate mistreatment, India has signed several bilateral agreements with the United Arab Emirates, Kuwait, Qatar, Jordan, Bahrain, Oman and Malaysia. In 2007, India also placed a ban on the deployment of low-skilled women below the age of 30 years, with the aim of curbing sex-trafficking.

***Indonesia:** detailed policies exist for departing and returning migrants; poor compliance.*

Indonesia has detailed policies regarding the migrant process. Ministerial Decree No. 157/2003 states that employers must provide migrants with insurance while abroad, covering accidents in and out of the work place, cost of treatment and medicines, and death, including cost of sending the body back. Bill No. 39/2004 on the Placement and Protection for Indonesian Manpower in Foreign Countries lays out policies for the recruitment process (including pre-departure orientation and training), and medical testing. It prohibits the use of HIV results as part of the recruitment process. However, this has little bearing since most receiving countries require mandatory HIV testing. Bill No. 39/2004 also holds the recruitment agencies responsible for the reintegration of migrant workers, including the provision of health services to workers who may need them.

Despite policies dealing with every step of the process – from pre-departure to reintegration – compliance is poor.

Lao PDR: *signed Memorandum of Understanding with the Thai government to regularize migrant labor; important step in regularizing migration.*

The majority of Lao PDR migrant workers migrate to Thailand for contract work. Lao PDR signed a Memorandum of Understanding (MoU) with the Royal Thai government in 2002. The MoU was aimed at a two-phase process, with the first aiming to legalise workers already in Thailand, and the second phase aiming to develop a formal system for recruiting Lao workers to migrate to Thailand to work legally. Work on the two phases started in 2005.

Thailand does provide medical care – including HIV treatment – to migrant workers, but illegal migrants do not have access to such care. The MoU aims to shift the migration pattern towards regular migration, and is an important first step in making medical services more accessible. The next step is to make sure that the standardised migration system is inexpensive, fast and transparent, encouraging people to use it rather than resort to irregular means.

Nepal: *policies for migrant labor departure exist, but poor compliance. No policies for sick returning migrants.*

The Federal Employment Regulation, 2004, states that all foreign employment contracts must provide for health care of sick migrant workers. The contract agreement is also required to specify terms of employment, including salary, work hours, and medical facilities. The Federal Employment Regulation also details the migration process including requirements for pre-departure training and medical testing (including HIV testing). However, compliance is poor. Pre-departure orientation sessions are not required to provide HIV or other health data, and most sessions are often held only hours before departure and thus have poor attendance. Referral services for those found to be HIV positive are very weak.

There are no policies for reintegration of returning migrants, including sick migrants returning or deported home.

Pakistan: *lack of policies regarding migrant labor process, and health care. Migrant Welfare Fund provides some support services to migrants in need.*

The Emigration Ordinance of 1997 regulates the activities of overseas employment promoters and agencies by establishing procedures for licensing and recruitment, and provides for the protection of workers against malpractices and for the redress of workers' grievances. However, lack of official policies and lack of implementation of existing policies, continue to be a problem throughout the process, from the recruiting stage, to medical testing and referral services. Pre-departure sessions do not include information on health, health access, HIV and options available to migrant workers. There are no official policies for referral of migrants found positive during the application process, or those deported from destination countries for having HIV. Even though government and NGO initiatives exist to provide care for people living with HIV, lack of official policies lead to an underutilization of these services.

The Migrant Welfare Fund, developed in 1979, is an innovative and financially sustainable means of providing some support services to vulnerable migrants and to migrants in distress. It is financed by a fixed contribution of USD 25 per migrant. Funds are allocated towards covering consultancies, legal services, travel costs of migrants whose contract has been terminated due to physical abuse, contract violations and other reasons, and towards the repatriation of remains of migrant workers who have died while in the destination country. The fund is also used to establish scholarships, vocational raining and business loans for migrant workers and their families.

Sri Lanka: *attitudinal shift at high levels; comprehensive 2009 National Policy on Labor Migration. Agreement signed with trade unions in some receiving countries to provide support. Migrant Welfare Fund also established.*

Lack of official policies continues to be a problem, although there has been an attitudinal change among the policy-makers at the highest levels. The 2009 National Policy on Labor Migration is comprehensive and covers many details of the migration process, including pre-recruitment training, country-specific pre-departure orientation, and the monitoring of health impacts of migration and creating awareness of risks, rights, access and benefits. It also supports the inter-state cooperation between Sri Lanka and host countries to ensure workers' protection and rights.

Trade Unions from Sri Lanka, Bahrain, Jordan and Kuwait signed an agreement regarding the welfare of migrant workers in 2009, called the Colombo Agreement. It grants all internationally-recognized labor rights to Sri Lankan workers, with unions in receiving countries ensuring implementation. The unions must mediate disputes over wages, harassment and other similar issues. The agreement is based on a model developed by the International Labour Organization (ILO) and its Bureau for Workers' Activities.

Sri Lanka also has MWFs run by the Sri Lanka Overseas Workers Welfare Administration (OWWA) and are financed by contributions from departing migrants, fixed at around USD25 per person. The MWF is allocated towards covering consultancies, legal services, travel costs of migrants whose contract has been terminated due to physical abuse, contract violations and other reasons, and towards the repatriation of remains. OWWA also uses the fund to try and establish other services like scholarships, and vocational and business training for migrant workers and their families.

Thailand: *strong health care and HIV treatment policies in place for foreign migrants, as well as returning sick migrants. Bilateral agreements signed with Lao PDR, Cambodia and Myanmar to control irregular migration. Has a successful HIV program.*

As a major labor-receiving country, Thailand has strong policies in place for incoming migrants. The Code of Practice on Prevention and Management of HIV/AIDS in the Workplace, 2005, prohibits discrimination in employment on the grounds of HIV status, although it is to be noted that the Code is not legally binding. The Immigration Act, 1979, prohibits the entry of migrant workers with HIV/AIDS.

The Thai government has signed MoUs with the Governments of the Lao PDR (October 2002), Cambodia (May 2003) and Myanmar (June 2003). The three bilateral MoUs describe an elaborate system for the employment of nationals from one country in the other country. One country prepares a list of jobs to be filled and the other selects applicants for them. When the two countries have agreed on the workers to be hired, they cooperate to provide the workers with a visa, work

permit, health insurance, a work contract and contributions to a savings fund. (The MOU with Lao People's Democratic Republic does not specify that a contract is required.)

Documented and fit migrants are registered and included in the national 30-baht health insurance scheme, through which health services are available at a subsidized cost, and they are assigned a health provider. Antiretroviral therapy (ART), however, is not available to migrants at a subsidized cost, often making it financially inaccessible to them.

Thai migrant workers deported from other countries can access the government's subsidized ART, under the National Health Security Scheme.

Vietnam: *some policies exist on HIV testing. No policies for referral, counselling or treatment services for migrants before departure, or after return.*

The Law on HIV/AIDS Prevention and Control (No. 64/2006/QH1), at Article 16, addresses HIV prevention among migrant workers, laying out the responsibilities of government and private sectors. The Joint Circular No. 10/2004/11-BYT-BLDTBXHBTC of the Ministry of Health, Ministry of Labour, War Invalids and Social Affairs (MOLISA) and the Ministry of Finance guide the implementation of medical testing for Vietnamese migrant workers going abroad. It does not state that medical testing is mandatory for those who go to work abroad (this depends on requirements of destination countries); however, it does give a list of health standards for being qualified to go abroad and a list of diseases that are grounds for disqualification. The circular also indicates the steps that hospitals have to take to apply for permits to provide testing and issue health certificates, and the fees that can be charged. However, there are no clauses about monitoring these activities.

There are no policies for referral, counselling or treatment services for migrants before departure, or for those returning home.