HIV/AIDS AND MOBILITY
FROM THE EVIDENCE TO CRITICAL ISSUES

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HIV/AIDS and STIs in the migrant populations

1. Exploring the evidence

2. International mobility

3. Key issues and concerns

4. Ways forward
Mobility and HIV/AIDS: exploring the evidence

From the assumption...

“HIV spreads from person to person and then most likely follows the movement of people”

...To the evidence that

- Human mobility has impacted the spread of HIV
- Mobile groups are more vulnerable to HIV/AIDS
The scientific evidence

Countries reporting a high migration flow experimented a higher HIV prevalence rate.

Observational studies

Côte d’Ivoire—one quarter of the population was made of migrants from neighbouring countries. Côte d’Ivoire had the highest HIV prevalence rate in West Africa.

Similar association was found in relation to Southern Africa.

A recent publication confirmed this in relation to West Africa.

Decosas Migration and AIDS, Lancet 1995;
Legarde Int. Journ. Of Epidemiology 32, 744-52
The scientific evidence

Observational studies
Countries reporting a high migration flow experimented a higher HIV prevalence rate

Seroprevalence studies
Higher HIV prevalence among mobile groups vs. people who do not move.
HIV prevalence among mobile people

Sample = 7000 adults  
Country = Senegal

0.5 % (2 cases out of 414) among control group: those who never moved

27% among those who had travelled in other African countries

11.3 % among spouses of expatriated

Kane F, N Doyle. AIDS 1993
HIV prevalence among mobile people

Sample = 1913 adults

Country = Cameroon

1.4% those who never moved

7.6% among those who had travelled in other African countries

Lydie et al. J. of Acq. Imm. Syndrome 2004
The scientific evidence

Observational studies

Countries reporting a high migration flow experimented a higher HIV prevalence rate.

Behavioural studies

people on the move higher vulnerability to HIV/AIDS

- risk behaviour
- low awareness
- increasing partner-change rates

Seroprevalence studies

Higher HIV prevalence among mobile groups vs. people who do not move.
**Behavioural studies**

- **truck drivers in Africa and India**
  
  Carswell, AIDS 1989;

- **labour migrants North and Southern Africa**
  
  Decosas, Lancet 1995; 346:826-28

*The commonly held assumption was that the transmission of HIV is unidirectional, from infected mobile to uninfected resident.*

Some studies show now the evidence that *in the discordant mobile couple a relevant percentage it is the resident partner who is with HIV.*

- **non-mobile partner**
  
  Inter. Jour. Epidemiology 2003;32
  Lurie et al. AIDS 2003
Mobility and HIV/AIDS: exploring the evidence

1980s Global Distribution of HIV subtypes

Source: Italian National Institute of Health, Dr. Schinaia
Mobility and HIV/AIDS: exploring the evidence

Current Global Distribution of HIV Subtypes

Source: National Institute of Health, Dr. Schinaia
Mobility and HIV/AIDS: exploring the evidence

HIV infections newly diagnosed (2001):
Cases with partner from a country with a generalised HIV epidemic

<table>
<thead>
<tr>
<th>Country</th>
<th>Total cases</th>
<th>Cases with partner from a country with a generalised HIV epidemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Croatia</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Slovakia</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Slovenia</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: UNAIDS/WHO report n° 66
High HIV prevalence in the country of origin is frequently cited as one reason of higher vulnerability.

While this approach can be epidemiologically correct, it runs the risk of being perceived as stigmatising.

...Stigma creates barrier to effective response.
“It is not the origin or the destination of migration, but the social disruption which characterises certain types of migration, which determines vulnerability to HIV”.


Kane et al. *AIDS* 1993; 7:1261-65
Mobility and HIV/AIDS: exploring the evidence

Which are the roots of this vulnerability?

The Social science contribution....
Mobility and HIV/AIDS: exploring the evidence

**Structural factors**

- Poverty, marginalization → discrimination, xenophobia;
- Lack of legal protection;
- Work in isolated environment with easy access to CSWs;
- Lack of access to healthcare infrastructure, including prevention, VCT, care and support;
- Vulnerability to sexual exploitation, harassment;
Mobility and HIV/AIDS: exploring the evidence

Individual factors

- separation/distance from families and partners communities, norms
- alienation
- despair
- loneliness
- sense of freedom
- different perception of risks
Studies have confirmed that migration does play an important role in the HIV epidemic...

...revealing a more complex picture than expected and challenging some basic assumptions.
over the past 35 years the number of international migrants has more than doubled.
Migrants: who are they?

(In)voluntary MIGRATION Forced

Fleeing from countries struck by economic crises of transition, in search of a better life / education

- Migrant workers
- Families of immigrants
- Tourists
- Students

Conflict related ethnic, religious, politic persecutions natural disasters

- Refugee,
- Asylum seekers,
- Internally displaced person,
- Returnee,
- Environmental migrants
Reviewing International migration data: women

2.9% of the world population

48% are women.

Women are also disproportionately affected by the HIV epidemic.

African women (15-24 years-old) are 3.4 times more likely to be infected than their male counterpart - UNAIDS 2004.

Both migration and HIV epidemic are going along a process of feminisation.
Why are women more vulnerable to HIV infection?

Biologically:

- Larger mucosal surface; microlesions which can occur during intercourse;
- More virus in sperm than in vaginal secretions;
- As with STIs, women are at least four times more vulnerable to infection;
- Coerced sex increases risk of microlesions;
- Clinical management based on research on men;
- When in treatment may experience stronger side effects.

Source: WHO Fact sheet N°242 June 2000
Why are women more vulnerable to HIV infection?

Economically:

- **Financial or material dependence on men**
- **Financial needs**
- **Neglected of health needs**
Why are women more vulnerable to HIV infection?

Socially and culturally:

- **Lack of control** and negotiation over own sexuality and sexual relationships;

- **Harmful cultural practices**;

- **Stigma and discrimination** in relation to AIDS (and all STIs): much stronger against women who risk violence, abandonment;

- **Cultural Belief**: Men are seeking younger partners in the belief that sex with a virgin cures AIDS and other diseases;

- **Disclosure of status, partner notification, confidentiality**
Migration might imply discrimination, being migrant woman lead to a double discrimination:

- of category (being migrant)
- of gender (men vs. women).

Studies with a Gender perspective are fundamental within migration

Haiti 1996 © IOM 1996
700,000 to 2 million women/children are estimated to be trafficked each year.
IOM Kiev Rehabilitation Center (Feb 2002 to Apr 2003):

Assisted: 427 women / adolescents
Detected:
309 Pelvic inflammatory diseases (salpingitis, cervicitis, n-s vaginitis)
213 Mixed infections (2 or more STIs)
13 HIV positive, of them 2 pregnant
244 Mycoplasmosis
182 Chlamydia infection
87 Bacterial vaginitis
45 Trichomonas infections
29 Vaginal candidiasis
23 Syphilis
2 Gonorrhea
18 Unwanted pregnancies

* note: data includes trafficked persons for various reasons, but majority were trafficked for sexual exploitation
Mobile people and migrants: the ...evidence

- Migrants = population “left out”
  Migrants and Mobile populations have the least access to programmes and research as well as care & services.

- Highly stigmatized
  Migrants and Mobile populations are often perceived as abusers of the social welfare system, as criminals, and as the bridge of the infection.

- Hard to reach
  In terms of cultural barriers, languages as well as logistics

- Exact numbers of migrant populations unknown

- No data on HIV prevalence in this group
Research concerns

Science-based evidence is essential

Needs of longitudinal studies

but...

...experts reported several concerns about data on migrants in relation to the:

1. Quality

2. Use
Quality of data

Reliable data are very difficult:

- Lack of exhaustive lists to extrapolate an accurate denominator;
- Illegal migrant hard to reach;
- Qualitative vs quantitative research;
- HIV seroprevalence data is unlikely to reflect the real situation;
- Wide range of variables to characterize migrants or ethnic minorities;

Nationality, country of birth, country of origin, country of residence, date of infection, race, ethnic group, date of arrival in the country, refugee status.
Use of data

- Risk to have a partial picture of the phenomena influencing policy and practices in a wrong direction;

- Real dangerous to increase xenophobia and further discrimination;

- Create a false sense of protection amongst population stressing too much the attention to migrants;
Do we know the way forward?
1. Looking at the mobility process and not the migrants

How...?

Reducing Risk: individual level
- Giving information
- Promoting condom use
- Changing behavioral interventions
- Medical
- Empowerment

Reducing vulnerability: environmental level
- Improving governmental policies
- Improving living conditions
- Transfer into action policies

2. Integrated action with autochthon population!
The challenge is to develop policies and interventions that impact on the cultural, economic, social normative factors that make so many mobile groups vulnerable to HIV/AIDS.

**Behavioural studies vs. Epidemiological studies**

MacNeil, S. Anderson “Beyond the dichotomy: linking HIV prevention with care” *AIDS 1998*

Campbell and Williams, “Beyond the biomedical and behaviour.”
Way forward

- Epidemiological studies only when essential;
- Combine epidemiological/surveillance studies with behavioral studies;
- Readapt methods and tools according to the target and cultural contest;
- Mainstreaming gender analyses;
- Mobilizing communities of migrants and mobile people promoting participatory and community-based approach;
- Studies based on the principal of universal right to know rather than on a target risk group: integrated action with autochthon population;
- Need to increase access to health services
IOM and HIV/AIDS

More than 50 years of experience on mobile groups and migrants

• Memorandum of understanding with WHO- 1999
• Cooperation agreement with UNFPA- 1996
• Cooperation framework UNAIDS- 1999
• HIV/AIDS programme officers
MEDITERRANEAN CONFERENCE

“Reproductive Health: a new challenge for migration”

16-17 March 2006
University of Catania,
Faculty of Political Science,
Aula Magna

thanks