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XVII International AIDS Conference
Mobile Populations and Globalization
August 4, 2008

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DAVIDE MOSCA, M.D.: Ladies and gentlemen, welcome to the session on mobile population and globalization. My name is Davide Mosca and I am Director of the Migrational Department of The International Organization for Migration. I am chairing this session.

Is helping me in this endeavor Dr. Jennifer Hirsch. Jennifer is an anthropologist focusing on population dynamics . She is currently associate professor of the sociomedical science at Columbia University, at the Mailman School Of Public Health. I now leave it for to Jennifer that will give us some rules for the session.

JENNIFER HIRSCH, PH.D.: Hi everyone. Good afternoon. There are a couple of things. Just to let you know, this session is being evaluated. We have been randomly selected to be evaluated.

Those of you who have evaluations near you have been randomly selected to participate in the evaluation. So if you have an opinion about the session, at the end, please fill out the evaluation and share it with one of the helpers at the back as you exit.

Each of us is going to speak for 10 minutes. After about nine and a half minutes I will start squirting speaker with a water gun. We are going to do our very best to keep to time.

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We will have questions afterwards. We are going to ask those of you who have questions to line up behind a microphone at the end of the last speaker, and we would like each of you, as you are thinking about your questions, to try to think about a question that is no longer than three sentences without 14 dependent clauses in each sentence.

So now I am going to pass the microphone back to my co-chair, Davide Mosca, who is going to say a couple words of introduction.

DAVIDE MOSCA, M.D.: Thank you Jennifer. First of all let me say that I am particularly honored and it is a privilege for me to be chairing this session and addressing you. The theme of mobile population and the health is one that interests very much our organization.

I wish to also bring the greetings and wishes of our Director General Brunson McKinley. I recognize also in the room the presence of our Deputy Director General Madame Ndiaye, Ndioro and the interest of our organization, the commitment in this thing.

Now just a few words to set the scene about globalization and mobility. Globalization is certainly the main paradigm to explain the current change in this world. Certainly the economical socialcultural technological force that drive my globalization have changed our world for the better and maybe also the worse.

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Anyhow, probably some of the major promises of globalization that is not yet met, such as reducing economic symmetries, social inequalities and poverty that still affect large part of the global population. I myself probably got between the north and the south as grown in the country, inequalities in poverty are still affecting large part of the population, and I might say also in different regions of the world, not only the south. So we see workers in less protected part of the society that are lots of income social status and equity.

Now more and more local and national economies are pulled into the circuit of global trade and production, and are deeply changed socially and culturally in this process. Sometimes this type of change requires what might be interpreted as a definitely negative, when we consider the impact on the environment and the resources.

But sometimes it takes even an inhumane, strongly negative things when even people, individuals in commodities, and I am referring to the human trafficking that is one of the aspects of the global modern migration in this era.

Now this is a social transformation not only affect economic sphere but I might say that since the 80s we have seen an increasing displacement, violence conflicts and the violation of human rights that goes significant force migration. So all these inequalities, transformations social transformations are staying, causing migration world wide.

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Now in the past 25 years, probably migration has doubled. I mean that of 2005 report 190 million migrants, but it is very difficult, really, to have an exact figure. Many of those are workers that leave the south and are going to the north looking for greener pastures, better possibilities.

Now they have contributed with an estimated $199 billion dollars in remittances. And by doing that, contributed to the security and stability of their families and communities and also largely they have contributed to the welfare, the provision of services in the countries where they are they are, the productivity, particularly those countries experience a shortage in human resources and in experience of demographic decline.

Now so migration is then an integral part of this process of globalization. We believe that as such, as a phenomenon, an unstoppable phenomena that needs to be however managed somehow. So building on the positive aspect of migration and minimize negative aspects. In this context, the relation between health and mobility has grown in global understanding of the importance of it as a factor for again minimizing the negative aspects of migration.

We are going to talk about migration and health; we believe that it should be seen beyond the provisional approach of managing diseases. It should be seen in the global context of addressing the social determinants of the world.

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And this means refer to the legal status of a migrant in the country where they are, considering the working condition, the housing conditions, access to services. May alter factors that really determine the vulnerability of migrants to have and then also the risk-taking behaviors that can be used by the conditions in which people find themselves living.

Now consider this multisectoral context of the all determinants or else it is feared the solution cannot be seen and found in that sector alone. And needs a large multimodal approach that mobilizes different forces and resources.

Now I might say that this year we have seen some positive trends. As you know in May this year, World [inaudible] has passed a resolution on migrants' health. It is an important achievement because COLFAMS is to affirmative action advocating and providing for right and access for rights for migrants.

I should mention also that the international task team on international travel jurisdiction was created to address the issue of known discrimination and also stigmatization in relation with travel, work, and people living with HIV. I want also to mention in a policy brief that has been launched yesterday by ILO, IUN, and UN/AIDS. The focus is actually the rights and needs of international labor migrants irrespective of their legal status and whether they stay in the country for short or long periods.

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Anyhow, we believe there is still much to do. There is a lot to do in terms of prevention of stigmatization and a lot of work needs to be done in order to achieve in countries support and changing laws and conditions for improving [inaudible]. So with this, I will now leave the work to Professor Manuel Angel Castillo for next presentation. [Applause]

MANUEL ANGEL CASTILLO: Buenos tardes. [Speaking Spanish]

JENNIFER HIRSCH, PH.D.: Gracias, Professor Castillos. We didn't actually get a chance to introduce Professor Castillos to you, so just that you know who he is, now that he has spoken.

He is a professor at the Center of Demographic Urban Environmental Studies here in Mexico City at El Colegio de Mexico. He is the director of the well known journal, *Estudios Demographicos Urbanos.* He coordinates the publication of the Center. He is coordinates the publications of the Center. He is also the Technical Secretariat of the group Guatemala Mexico Migration Development, a citizen initiative sponsored by the Ford Foundation.

So, our next speaker is Phoebe Yona Wobi. Phoebe, as you walk up to the podium, I will introduce you. It is probably easier for people to hear you. If you start chanting her name, maybe she will stand up.

PHOEBE YONA WOBI: Okay. Thank you.

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JENNIFER HIRSCH, PH.D.: Okay. Phoebe is very interested in community development work, especially in southern Sudan and in the diaspora. Her passion includes working hard helping organizations that provide and promote social wellbeing, particularly targeting women.

She wrote in her biography that when she was informed of her HIV positive status, she was just like you all, bubbling and enthusiasm, hope and ambition for a good and happy life. She is keen now to take on a position where her current qualifications and work experience could be used to help the organizations and people that she serves on a daily basis.

She has been visiting refugee camps in Nairobi and Uganda on a voluntary basis without pay. She has three diplomas and she joins us today from Nairobi, where she currently resides.

PHOEBE YONA WOBI: Thank you. [Speaking in a foreign language] I become a refugee in Nairobi in 1995. At the time I come from Nairobi, already Sudanese women have found an women have an organization called called Sudanese Women Action Network. I have joined that organization.

I am working with them. And in 2004 that is the time I already affected. I am still working with those people, visiting them in camps. And I be going also to southern Sudan.

Being a refugee, it is really a bad thing. Migration of the families from their wives is at great risk for the young women and for all of the women. It is a risk because a young

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lady, she will stay alone for two three years without husband, without somebody that can support her. At the end of the day, she will go for unprotected sex because she did something to take care of her children and her family.

At the same time also children are become the head of their families, children and the grandmothers, because the dear one already dead because of the HIV. Nobody is taking care of the family. You get at the head of the family a young boy or a young girl that is the one heading of the family. If the mother is not there, the grandmother is the one taking care of the family.

Forced marriage. This forced marriage, it is something in Sudan because some of the families, they say you have a lady she married for somebody have the cows. It does not matter if that person is positive or that person is work, but if he has the cows, the family will force that girl to marry because they want that business in the family.

And also the families, because they have forced their ladies for marry, they end up having HIV.

Another thing also is stigma and the discrimination. In Sudan, people can not talk about the sex. They say this one is a taboo because of the culture of the Sudan. You can not talk about sex. And people can not talk about sex and now the risk of the HIV among the young and among the people.

And many refugees who I see outside Sudan, like the place I have been going to, they will walk distance to look for

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the ARV. They would walk distance to get something for themselves. And that one also is true because they are refugees. ARV in other places are given free. But for the refugees, they are buying. If you not buy for yourself, you will die any time.

And also there is discrimination. I will give example with myself. After the peace agreement have signed in Sudan, people are going back. They are starting to appoint people for positions. They turn me down, you see, because most of my people are not in Sudan holding unique position. They tell me now, where you be a member of the family? I say okay. I wait for two, three days. I find out I already have— they have tricked me.

And also for example, they told me, they say we are going to give you a supervisor. I say okay. Sometimes they train me. At the end of the day, I get, but they do not want to appoint me or they do not want to give me the job because of my status. They say they have given me the job. I have done— after one month or after two, three days, that place is vested. So the discrimination in the place of job, it is there.

And also discrimination in the families. If a young girl, she get pregnant and sometimes she has HIV, you find that the family can send her away from the house. And then she does not know where to go.

And sometimes she will be breastfeeding the child. She does not have money to buy milk for that child. And most of

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them, in the refugees camps, in Uganda, in Kenya, many places, and even now some of them are displaced inside Sudan. These all have problem fitting refugees and young ladies and women.

There is no proper health care facilities, especially in the camps. No visiting places, and no at risk for them. Like I have said, they are going far. That is all contribute a problem for them.

What I went visit I went visit places. I went to 10 different places. Camps and inside Sudan. I spoke for 400 women. Most of them are widows. But for these 400, one only is one [inaudible] and tell me her status. She was positive. The husband has died. But most of them living in silent.

They have that fear because of the discrimination, because of the stigma. They saw other people are going. They do not want to come out. By living in silent. But they are dying.

Walking distance like I say, people from camp you can go up to Uganda to look for the ARV. All this problem is really affecting a mobile people, refugees people who are living outside their country. And right now, even inside the Sudan, because the Sudan only got the peace recently. They do not have their city. They do not have any ARV. That is all contributed for their problem.

Last is not least, because they are telling me my time, I wanted to come out with this solution that I know in this room we have many people that have had heart of the helping and

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they have that sympathy. Really. For me, I want the governments and the national NGOs to come out and go to visit these places and to see our business for themselves. How they are going to help them. Especially business centers. They are building many business centers to train those women. Refugees women. To train them how to come to counsel themselves and how to do home visit for themselves.

Because most of them, they are not trained. They do not know what to do. But if somebody have incentive to go and train them, they will do something for themselves.

My last request for the conference, I give thanks for this conference to invite me to come here to give my this request, that I am not going to forget Sudan, that they put Sudan in their program, to move for this ones and to come out with something in Sudan. Thank you. [Applause]

DAVIDE MOSCA, M.D.: Thank you, Phoebe. Thank you. Your intervention remind us the problem that experience many millions of people in refugee camps and displaced by conflict and other conditions. And definitely they experience stigma, discrimination, and violence, where they are, particularly if sometime because of their HIV positive status. Family disruptions, social network, support that is lacking— all things that we need to consider and provide also HIV prevention, care and support also in emergencies.

Now I will call next speaker. It is Dr. Rene Leyva-Flores. He will speak about AIDS immigration and progress and

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challenges between the Mexico and the U. S. Doctor Rene has a Ph.D. in sociology and health from the University of Barcelona. He is a senior researcher and department head of the Research Center for Health Systems, National Institute of Public Health. Dr. Rene, please.

RENE LEYVA-FLORES: Thank you. I am trying to speak to you in English, then supplement in Spanish some time a lot of— I am trying to understand you and also you can try to understand me. I would like to dedicate my presentation to Myra and Jessica, that is a better woman that is trying to push medicines for people from Central America to Mexico. [Applause]

Many people is coming from Mexico and Central America to U.S. Many numbers. There is about— how many people is? This number is a number like many others. No? But many people are fighting to cross the border. The place where they are coming is poor in socioeconomic development. Immigration, migrants, are one of the most important forms of economics income to developing countries like Mexico and Central America.

In [inaudible] incomes. In Mexico is the second important incomes after the petrol export. And the complex composition of the migration process has included children and women. Now it is the people at high risk.

The other [inaudible] is provision progress and challenge related to moralized groups from Central America and Mexico to U. S. The method will view many researches carried

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out in Central America and Mexico and we are trying to present what we know, what we are doing about the resources and maybe next test.

What do we know about the immigration process? We have many information about the situation in this region, a region that is characterized by unclearly social inequalities. The U.S. is very different from Mexico and Mexico from Central America. And between them all are different. Many people are confluent, many people is changing, and now we do not know who is who.

But we know who is migrants. And maybe is one of the situation that would like to know, to present you in this conditions. Migrants [inaudible] sex as a principal way to cross the borders.

In people that is undocument and trying to cross Mexico, many of them is reside sexual length like women. Maybe 50-percent of the women end up during the trip to U.S. and transactional sex and violent sex is one of the kinds that have to do to cross the border. I don't know whether is the stigma that this problem is for migrant persons and also is harder to estimate.

And the immigration process increase the number of sex partners and the migrant in U.S. during the transit have risk of sexual practice with low condom use. What we know about the reason because the moelle [misspelled?] groups do not use condoms. One of the principle reason that people said is trust

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in the partner. You can see that woman migrant partners that stays in the communities they do not use condoms because of trust in their partners.

Sexual workers also like moelle population and transient migrants also. Migrants that work in home service also and seasonal workers and the same way.

What we do? We experiment service, we make informations. Information and informations and informations and very low condoms, of course. We do not try to go all the information and can complete around the world with information. But we do not know the result of this information.

And what we do about access to health service? Well, we have very difference between governmental NGOs and migrants. Governmental health service have serious restriction to access. Also migrants perception is to use governmental services the possibility to be deported in U.S. The NGOs have a complex network that is very difficult to migrant use this.

There is scarce coordination between NGOs and governmental health service. There is no relation this health service with social migrant needs. And is diminished capacity to solve health problems in this organization.

What population to attend the health. Is one of the principle ways to self care. Many projects are implemented in central America and Mexico. We need money. The international immigration organization, the IOM calculate $100 million at this to change these problems in central America and Mexico.

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What is the result of this money that is supplied in the countries? We do not know. But you can see many projects with children [inaudible]. One of the project is the project for malarial population in central America you can see where is the project and is right in the road for migrant from central America trying to cross Mexico to go to U.S.

But is very difficult to know what is result about the consequence of this project. The result in reason to the people what is happening to the benefits to the people none of the measure of the prevalence of HIV. In a sample of 400 migrant and they doesn't [inaudible] border of Mexico Guatemala was so the person of HIV prevalence. And some the story in U.S.-Mexican border 3.4-percent of the total people living with AIDS were Latinos.

But what is the meaning of these numbers? What is the relationship of this number with the action that we are trying to do in our countries? Also we do not know. Some of the children that would like maybe would like to play to together but how is the problem, no? Whether we try to make coordination and collaboration and we do not have really results of these actions.

Many of the testers of the presentation about meetings like this is like this the coordination and collaboration: how to implement this recommendation remains a problem. Until one is NGOs plus governmental organization so we do not have any

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evidence about good reasons to push the formula like on exodus formulas.

We do not know also which is the road and how it is moving an international organization that is trying to implement or to design project implement to this prevention. Many complex interests, many different programs, different approach. And the people is the same.

How to respond is the people maybe is the way the problem that we have to try to understand and then to resolve. Because vulnerable population are facing new challenges in popularity for HIV. Thank you. [Applause.]

JENNIFER HIRSCH, PH.D.: Our next presenter, Malu Marin. Malu is the executive director of Action for Health Initiatives, otherwise known as ACHIEVE. Malu represents ACHIEVE as convener on the task force on empowered migrant workers and spouses living with HIV for the regional network of Coordination of Action Research on AIDS Mobility in Asia.

Malu is also board member of the Asia/Pacific Rainbow, a regional network of LGBTQ organizations undertaking HIV and LGBTQ rights advocacy. Her paper today is titled "Virus, Visas and Violence: the Impact of Health Testing on Migrant Workers."

MALU MARIN: Thank you Jennifer. Okay, I would just like to read two stories of migrant workers. The first one is Sheila, she was a domestic worker who worked in Singapore. And in the process of renewing her work permit she was required to undergo an HIV test. And in the test, she was tested positive,

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and she was told she had to go home immediately. And her employers would also not fight, so as soon as possible she had to leave, to go.

A second story is Louis, who went to Dubai on a sponsorship visa from his sister. And on his 6th month, he was able to find work, but he had to undergo HIV testing because it is requirement, again, for a work permit. And he was tested positive for HIV.

And he was sent to a government hospital and he was placed in a room which was like a holding area or like a detention center for migrants of various nationalities who had failed the medical tests. So these were different tests. And he stayed there for two weeks without knowing what was happening and whether he would be set free or whether he would be sent home. . And after two weeks he was brought to the airport and immediately deported to the Philippines.

These are just two stories of migrant workers. And you know that really, migration is a means to seek employment abroad to a place of economic and financial status of most people. Unfortunately, when you have an HIV diagnosis, your dreams, and your future, and your hope for a comfortable life come to a full stop.

Population ability migration have become commonplace; it is a rapidly globalizing world. The U.N. estimates about 191 million migrants who live and work outside their countries

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of origin in 2005. And 1 out of 30 persons worldwide is considered an international migrant.

In the Philippines, we have 8.2 million Phillipinos overseas, and of these 3.8 were temporary workers, 3.5 were permanent workers and 870,000 were considered irregular. These are only the recorded numbers. Okay.

The movement of people across borders has been subjected to stringent regulations, mostly by host or destination countries. Apart from the supposed threat of terrorism an emergent reason for border control is the spread of infectious diseases and viruses, including HIV.

Approximately 60 governments have established health screening procedures upon application, arrival and renewal of work permits. And failure of medical tests result in being banned from entering the country or being deported to the country of origin.

Organized labor migration has integrated mandatory health screening in its procedures for preemployment application. Before migrant workers get their contracts, they have to undergo mandatory health screening, which includes all the following. So they have the physical exam, they have x-ray, they have optical checkup, complete blood count, blood typing, routine urinalysis, psychomatic evaluation within fidalicies [misspelled?] and dental checkup.

Sometimes there are also other tests that are required. And pregnancy testing is often required for women applicants,

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particularly those in the service sectors, such as domestic workers. Some applicants are required to undergo additional tests and these include HIV tests, hepatitis screening, leprosy tests malarials mirror, liver function test, VDRL or venereal disease research laboratory, drug and alcohol tests.

In recent years, HIV testing has become more and more of a requirement for most migrant workers. In fact, it has become routine test. And how does it happen in the context of labor immigration? It happens as a pre-employment requirement at the pre-departure stage. So that is before they have to leave or before they get their work contracts, they have to go through a medical screening.

And then in some countries or in most countries now, in the Middle East particularly, in the country of destination they also have to go through HIV testing. And then third, when they are at the venue their work contracts. This is either annual or on a biannual basis.

Sometimes there are also spot checks being done, especially among seafarers if their vessels come from so-called HIV hotspots like Brazil or South Africa.

Okay, what are the violations when talk about HIV testing of migrant workers? CARAM Asia did a research of the state of health on mandatory HIV testing in 16 countries last year, in 2007. And the violation is really in the three “C”s of testing.

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So the first one is on consent. And when we talk about consent for migrant workers, it is a tricky issue. Because some governments argue that migrant workers apply for work overseas are cognizant of the requirements, which include HIV testing, and so if they pursue their application they are presumed to be already giving their consent. Unfortunately there are many migrants who are not even aware HIV testing is being done. And sometimes consent comes in the form of a paper that they sign, often without explanation of why they are signing one, too.

The second "C" is counseling, pre and post test counseling. And more often than not, HIV testing is done without counseling. Medical clinics rationalize that the standard algorithm of health testing there is no space to undertake counseling. They argue that because of the sheer volume of tests they have to do, and that is maybe 100 a day, they say it is impossible to observe the universally agreed upon standard protocols of procedures in HIV testing.

And even in the Philippines, where we have an AIDS law that explicitly requires pre- and post- test counseling, this is not observed. So mandatory enforcement of the law remains something.

The third one is confidentiality. And what happens is that the test results are forwarded by the domestic laboratories to the recruitment agencies. So sometimes even before the migrant worker sees the result, they are already

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forwarded, or more often or not they are forwarded to the agencies or the employers.

Okay. So what we see is that mandatory testing contradicts national laws on testing. And it also violates migrants' right to privacy.

When we talk about the testing business, it has become a huge industry. This is evidenced by the inclusion of HIV testing for migrant workers even if it is not required by their employers or principals, as in the case of seafarers. In Bangladesh, for instance, recruiting agencies get commissions from medical clinics for every migrant worker they bring in for HIV testing.

So why do countries continue to test migrant workers for HIV? And there are two main reasons that they recite. They talk about the fear that HIV positive individuals could potentially infect the host population if they are not identified. But you know already that HIV is not transmitted through casual contact. And also it creates a false sense of security for nationals of the host nation, because in reality HIV is already present among the local population. Testing also does not guarantee identification of HIV cases especially for those who are in the window period.

Second reason is that to avoid excessive demand on health care and on social services as well as other economic costs perceived to be generated by HIV infected non-nationals. So in the case of migrant workers, there is no opportunity for

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them to have access to treatment because they are immediately deported.

The impact of mandatory testing. I will give you two quotes. These are from two migrant workers, also in the Philippines, saying that, it's like the moon exploded, they couldn't accept it, they wanted to be alone. And problem was they wanted to still work but because they tested for HIV, they could not any more.

So impact of mandatory testing is economic. It renders a person unfit to work. It bars any migrant worker from employment in destination countries that require it. It results in economic dislocation and a drastic change in a standard of living.

And then we have the deportations. Sometimes the deportation takes longer, because they get detained for one to two weeks. Or it is immediate upon diagnosis, within 24 hours to three days.

It is inhumane. They get handcuffed; they get escorted, treated like criminals. There is no referral into the country of origin. Most of the foreign missions do not know that the deportation is actually taking place. There is no counseling, which leads to psychological trauma.

Okay. Stigma, discrimination upon return. So there is, in cases like in Bangladesh, for instance, there were migrants who reported being isolated in quarantine and exposed to the media. There is the burden of informing the family,

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especially because they have been separated from their families for some time. And disclosure is very difficult.

At the macro level, what it does is leads to skewed epidemiological data. Because what gets highlighted are the cases of migrant workers who are tested more than the general population. So we can see Pakistan reports 80-percent, Bangladesh 40-percent and Philippines 34-percent of total HIV cases.

Okay, what is being done? There is evidentiary data gathering that is being done by organizations like CARAM Asia. ILO and IMO also did a study on mandatory testing. There is regional advocacy. We are going to have a forum on mandatory testing with the UN Regional Task Force On— this is a very long name, but this is— an Intergovernmental Multisectoral Body in the Asian Region Working on the Reduction of HIV Vulnerability among Migrant Workers. And then of course the newly formed International Task Team on HIV Related Travel Restrictions convened by UN/AIDS and IOM.

We also have a local ILO crafted statements against testing. I would just like to end with a statement from Justice Michael Kirby, who is a justice in Australia. And he says indeed there are still two epidemics. The epidemic of the virus and the epidemic of the mouth.

Can we reduce both? But at this time we are stuck with both at the same time. There is no pill that can be popped by an individual that cures the social alienation and measures

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that lies at the heart of stigma: xenophobia, racism, homophobia, denial, ignorance, fear, and violent anger. Muchos gracias.

DAVIDE MOSCA, M.D.: Thank you, very much, Maria, you have bought us a very important topic and there is increasing use of this mandatory methods in particular against migrant workers and many other types of migrants. And indeed I think with the Task Team on the Travel Restriction I think should also address the, we need the task team to address the discriminatory approaches in the workplace.

Now it is I would like you to welcome Jenny Hirsch, who is presenting a report. Jennifer is a researcher, an associate professor, and she will talk today about the Production of Marital Risk, Labor Migration and the Social Organization of Infidelity in Five Countries. Jennifer, please.

JENNIFER HIRSCH, PH.D.: Thank you. This paper draws on a five country comparative study developed in collaboration with a team of four other anthropologists. Our goal for the NIH funded project was to explore how gender inequality, economic organization and changing ideas about love and marriage combined to shape marital and extramarital sexuality.

Our data collection involved a combination of ethnographic methods. Two principle ones were 20 to 30 marital case studies at each site and participant observation. For more details on the study method I refer you to our recent articles in the American Journal of Public Health. I have some

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copies to share after the session ends along with our policy brief.

Today I am going to focus on presenting the concept of extramarital opportunity structures, which analyzes extramarital sex as a product of social organization rather than men's inability to control themselves.

Our point is not to justify extramarital sex— and of course, I would kill my husband if he did it— or say it is men's nature. Quite the contrary, we are trying to call attention to the social and contextual factors that enable infidelity in order to develop community and structural level programs that would be effective in preventing heterosexual marital transmission.

Labor migration is of course not the only aspect of social organization that facilitates multiple partnerships. In our published work we describe how masculine and feminine ideals, men's patterns of socializing, heteronormativity, homophobia, and even the organization of marriage itself makes multiple partners a sort of default practice in many contexts.

In all five sites, work-related ability was often compelled as people tried to provide for their families in the face of severe economic hardship. This same mobility facilitates access, extramarital sex in diverse ways. In Nigeria, approximately half of all the cases of extramarital relationships described in marital case studies occurred in situations where work-related mobility was a factor.

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Men whose work took them away from their wives and families appeared more likely to have extramarital relationships, and those same men attributed their behavior to the opportunities and the hardships produced by those absences. For example, a 47 year old civil servant whose postings frequently took him away from his family explained a relatively long term relationship with a woman in one of those places he was transferred.

He said, I stayed a long time without my wife. But eventually this woman befriended me. She was a widow and a very nice woman. She cooked for me and provided companionship. Later I was transferred back home. So it was over. His words underline the social nature of these extramarital partnerships, reminding us that migrants seek partners not just out of lust but also out of loneliness, the need for social report and a desire to find a woman to replicate the gender division of labor to which they were accustomed in their residence of origin.

Men seek sex not just for pleasure, but also for solace. I remember being quite struck at the words of one Mexican labor migrant, interviewed in Atlanta, who said that in the face of a dehumanizing demoralizing experience of being a labor migrant, having sex with a commercial sex worker was the only time he felt like a human being. [Speaking in Spanish]

This need for solace is especially acute because of the meager options of diversion in the community in which labor

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migrants are concentrated. As I have seen in both Atlanta and New York, those Mexican migrants in the United States who are not interested in spending their time either at church or playing soccer have little to choose from either than a cantina a dollar dance hall, or a brothel.

Facing loneliness and alienation, it makes them hungry for human warmth. And in a social geography that provides few health enhancing ways of finding that warmth, new migrants learn the tricks of survival for those who have more experience. An example from the Papua New Guinea site underlines the relationship between men's long term labor related migration and what might be called men's extramarital sexual debut. That is, their first experience at extramarital sex.

As one man said:

After I was married, I left my wife and children and went to Goroka [misspelled?] for work. And it was there that I had sex with another woman. This was the first time. I went with another man. It was his idea. He was my boss, and I was the driver. He said, let us go around and find some women. I'll pay for some food and I'll pay for the guest house room.

So I did this the first time because I was with him. We took a car and we went together. We impressed the women by riding around in a car. Lots of working men do this, pressure each other to go drink and have sex with prostitutes. He continued, it was especially hard for me because I worked as

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the driver. So they expected me to drive them to hotels and other places and it was hard for me to say no.

In Papua New Guinea as in the four other locations, men's narratives of the extramarital relationships they had during the course of labor-related migration typically emphasized acutely missing one's family, a simultaneous feeling of exuberant freedom from community scrutiny, predominantly male work places where drinking and buying sex was the norm at the end of a long and arduous work week, and the fact that women tended to gather outside popular bars on men's paydays.

The relationship between migration and sexual risk may be a sexual determinant of sexual risk. But these social structures are produced, and can be changed, by organized social action. We found evidence of clear ways in which modifiable political and economic factors exacerbate the intersection between migration and sexual risk. This is sort of the "what you can do" part.

In Vietnam, men negotiate for success in the emerging market economy in contexts in which providing colleagues with alcohol and purchased sexual pleasure is frequently a key part of the game. And, as my colleague points out in her article, Hanoi's engagement with the market economy has winked at, or even exacerbated, men's reliance on purchased sex as a cost of doing business.

The unspoken goal of United States migration policy is to guarantee a flow of low cost laborers. But an unintended

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and very important result is to identify migration sexual risk. Denied a path to legislation, legalization and family reunification, undocumented laborers are separated from their spouses for months or even years at a time.

Military conflict as we saw in Uganda provides a sort of domestic parallel situation in which government-directed mobility places men in contexts of sexual risk. In Uganda, my colleague heard a soldier returning from the war recount his liaisons over the course of his long term inscription.

He framed them as a product both of his extended separation from his wife and of the feeling that risk of sexual infection with HIV meant little in the face of his very real risk of dying in battle before the year was out.

Housing policy also frames the relationship between migration and sexual risk. In Papua New Guinea, mining companies do not provide family housing, guaranteeing that men and women are separated for long periods of time. In essence, the company's decision to economize by housing only the workers is passed along to the workers' families in the form of HIV risk.

Policies regarding migrant labor figure prominently not just in terms of housing but more broadly in the extent to which minimum benefits are guaranteed to workers when, as with Mexican workers in the United States, migrants are seen as dissociable bodies, sort of cannon fodder in the global wars of capitalism. Many opportunities for primary prevention, for HIV

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testing and for access to care are missed because the jobs at which migrants work provide no health care.

Similarly when migrants are shunted off into trailers, crammed into company shacks or crowded into neighborhoods with little in the way of community services, the absence of any explicit policy to create opportunities to build human capital amount to a de facto community development policy of deliberate underdevelopment.

In none of these situations is there a specific policy goal of creating HIV risk for migrants, I hope. However, by not acknowledging that the labors are rendered by humans with complex needs that with [Speaking in Spanish] as we would say in Spanish, the result is essentially an implicit policy that permits the situation. In all of these situations, the relatively low price of goods and services provided through migrant labor is predicated upon a hidden cost, the cost of sexual and HIV risk, borne not by the company that takes the profit nor by the consumer who enjoys the product but by the laborer who produced it.

The analytic purchase afforded by being able to look at this problem broadly across five very different contexts leads us to see some specific policy solutions. The first step is a more accurate social diagnosis. That is, to raise awareness of HIV as a hidden cost of goods and services produced with migrant labor or by mobile populations. And to make consumers aware of the role that we play as avid beneficiaries of a

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global system of production which relies heavily on migrant labor.

The economic sector that benefits from this low cost labor must be a part of the solution, which lies in part in a sort of social entrepreneurship that would brand and promote products generated in healthy and human workplaces. HIV risk needs to be an articulated element in discussion of labor policy. Regulations that stop a race to the bottom by requiring multinational corporations to provide family housing, basic medical care, workplace HIV education, and structured recreational activities could all serve to disentangle the migration/HIV nexus.

The migration HIV nexus also needs to figure in conversations about migration policy, since long separations of workers from their families play such a prominent role in shaping migration related risk.

I feel like it’s a little cheesy to end with a call for more research, since that just seems like a full employment program for researchers, but to end, I really do think that we need to do a little bit better in generating evidence bases about the kinds of structural interventions that I am recommending.

This sort of structural intervention to be the focus of deliberate assessment and evaluation, is only by building up a science base to demonstrate the effectiveness of this sort of intervention that we can hope that they will take the place

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they deserve along individual programs intended to raise awareness about HIV and sexual risk among migrants.

And I just want to leave you with one image to underline the connection between the food we eat, pretty much all over the world, and the HIV risk that is produced along with it. Thank you. [Applause]

DAVIDE MOSCA, M.D.: Thank you Jennifer, very interesting. This presentation. Surely there will be lots of questions at the end on all these topics. I want to give now the floor to our last speaker. He is Braham Press.

Braham through his experience at the last five [inaudible] nation has worked on HIV issues and Thailand the greater sub region for almost 10 years. He will speak about Increasing Migrant Workers' Access to HIV Prevention and AIDS: Lessons from Thailand. Braham, thank you.

BRAHAM PRESS: Thank you. So, it is estimated that there are between 1.8 and 2.5 million migrants working and living in Thailand. They mainly come from the three neighboring countries of Burma, Cambodia and Laos.

Their reasons for coming include economic and security reasons. These people may leave their families behind or families may follow.

Actual numbers of migrants in Thailand have stayed the same or increased; yet the number registering has decreased. If you look at a slide you can see that the number has actually dropped by almost half since 2004. Part of the problem is that

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registration only allows annual renewal, without allowing new migrants to enter the system.

The registration period is short, and those who have been registered have seen no improvement in their situation. Formal recruitment channels that have been developed and used are too expensive.

More registration, supposedly registration provides equal status and includes health insurance. But employers often withhold ID cards; registration is linked to the employer. Little is done by the government to protect migrants' rights in the face of exploitative conditions. Those who are not registered or fall out of the system then become susceptible to arrest or more likely to work in the worst conditions. These people also lack access of health services due to these conditions.

So the conditions that increase migrants' vulnerability to HIV are as follows: migrants work in the least desirable jobs, such as the fishing industry, garment factories construction, domestic work, agriculture and sex work. The nature of the work makes them either highly mobile or places them in remote settings that makes it difficult to access sources of information.

Recently migrants coming to work in Thailand have been of younger age than, say, five years ago. Median age is now around 21. It used to be closer to 25. The problem is that

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these young people are less likely to be aware of HIV or how to prevent it properly.

Once in a new setting they come under the influence of the situation, which may encourage them to engage in risky behaviors. For example, fishermen are known to indulge in alcohol and seek out sex once they are on land. And young women may go through a string of boyfriends trying to find a good partner or trying to save on expenses.

Condom use is low in all relationships, regardless of whether those people have other partners, because trust is often overriding consideration. Barriers to information services the migrants face include language barriers, especially among groups from Burma, as there are many different ethnic groups that come from the country.

Health providers have negative attitudes towards migrants and see them as extra work, as a drain on finances and in some cases there may also be prejudice. This results in poor service, often characterized by impatience. Migrants may not be able to afford the extra costs of transportation or lost wages from taking off time from work, and services are usually inconveniently located and times conflict with work schedules.

They may also be arrested or harassed by police on the way to receiving services, and those who are unregistered are also susceptible to arrest.

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Now surveillance of migrants in Thailand is not systematic, so although there are some numbers currently available, they are not necessarily fully reliable.

For example, some provinces have shown prevalent rates higher than 3 percent among pregnant migrant women. In one province down in the south, In Katane [misspelled?] we have seen rates from 3-percent up to 10-percent.

Annual health screening as part of registration tests for TB, syphilis, malaria, elephantitis intestinal worms, leprosy and drug and alcoholism. However HIV is not tested.

These conditions are considered non-exclusionary. For the most part, they are treated. ARV is currently available to registered migrants. This is a recent development that occurred last October.

And although Thailand produces its own generic first line drug, that is not the one they are providing to migrants. They are using leftover from the Global Fund Round 1 that has recently been extended.

There is very low usership, however, of the program, and in part that is because of the other problems associated with accessing health services and its use of documentation.

Now I am going to talk about PHAMIT project. PHAMIT project stands for Prevention of HIV AIDS among Migrant workers in Thailand. It is a fighter project that has been operating since 2003. The local NGO, Raks Thai Foundation, which is the organization I work for, which is also a member of Care

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International, is the PR. The project is a partnership with seven other NGOs and the Ministry Of Public Health, specifically the Department Of Health Service And Support. And these are all SRs under our organization.

The project covers 22 of the 76 provinces in Thailand. Now the objectives are broad, increasing condom use and reproductive health, increasing access to health services, supporting community wellbeing and effecting change in the policy environment.

Beneficiaries are migrants, as I said, from Burma and Cambodia mainly, in the fishing industry, garment factories, and construction sex work, their families. I really only focus on the first two objectives.

Now, behavior change is primarily done through outreach. This is done through the use of migrant field officers and volunteers and the development of language and culturally targeted materials including videos. A network work of volunteers recruited and trained to distribute condoms and materials act as a linkage to the community to help organize activities and report as the eyes and ears.

Condom distribution relies on a two pronged approach. There is an active approach, which as I said uses volunteers and outreach. This promotes condom use as well as distributes them. And visitationary strategy were we place condom boxes in convenient locations that are discrete. And we also developed our own brand of condom, which is a grade higher than the

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public health condoms but not quite premium quality, for issues of affordability.

The main strategy that we use is increasing access to health services. The strategy relies also on an in and out strategy. The outreach strategy includes volunteers, as I said, who help referral when they find people in the communities. And mobile clinics supported by campaigns.

The mobile clinics are usually in cooperation with public health facilities or private clinics. A couple of [inaudible] support groups have even established, and this is done [inaudible] drop-in centers provide a place to relax for many of these migrants as they do not have their own private areas. And these drop-in centers migrants can come to to receive access and referral to services as well as follow up.

We have also been working with the public health on integrating training migrant health assistants into the hospitals. These people help assist receiving migrants and act as translators for the Thai health staff. The health assistants are now also giving HIV counseling, and this has contributed to Thai government’s decision to provide migrants with ART.

So finally, why is PHAMIT important? It is a rare example of an HIV prevention project for migrants in their destination country and is especially notable due to its skill. We have reached over 300,000 migrants with our activities.

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Coverage is not exclusive to immigration status, meaning that we reach both documented and undocumented migrants. And we use a community oriented strategy. That means that we also use human resources within these communities, which has overcome issues of cultural diversity and the different languages.

This strategy of outreach and in reach has overcome issues of access that characterize migrant worker situation and partnership with the ministry of public health has resulted in structural changes, namely the migrant health assistants, which has led to the provision of ART for migrants in their destination country, which is almost unheard of anywhere else. Thank you. [Applause]

JENNIFER HIRSCH, PH.D.: I would like to thank all of my copanelists, both for their wonderful presentations and for their amazing show of self discipline in keeping time. We have 15 minutes for questions or comments or rants. So if you have something to say, stand up to the microphone and say it. And until someone stands up, I will just keep filling the air time. Okay.

ANNA DIKU.S.IN: Hello, my name is Anna Dirksin [misspelled?] I work for RTF in Malaysia. I have two questions, one for my colleague Braham. At the beginning of this presentation you mentioned that you integrated reproductive health activities into your program, but I did not see any reporting the results related to reproductive health.

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So maybe you could share with us some of your activities and results?

And for Mari, given that, I am assuming mandatory testing is not going to go away for domestic workers or migrants from the Philippines, do you consider as an interim strategy working with the testing facilities to ensure that they are doing voluntary or well, it can't be voluntary, but at least proper counseling for the migrants? Thank you.

BRAHAM PRESS: Thanks, Anna. Yes, well actually I mainly focused on HIV just because of the conference today, but however, integrate reproductive health activities in all of the strategies that I mentioned.

So, for example, when volunteers go out in the community, they rotate the topics they address, so it is not always HIV, HIV, HIV. They also address reproductive health issues, family planning as well as STIs and even other general health issues.

In the mobile clinics, sometimes child health including vaccinations we in some locations they follow up with migrants who are taking birth control. So they will go to each community with a checklist and make sure those people are maintaining their contraception.

And in the hospitals the migrant health assistants not only provide HIV counseling generally, the main focus is usually antineedle clinic. So when these women come in, they

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provide broader understanding about their health, internal health as well as HIV issues. I think that covers it.

MARI MALU: In response to the question with regards to working with the health testing facilities, yes, we do have that partnership. In fact we have conducted several trainings already with medical professionals from the testing clinics. We work in partnership with the department of health, although we also see it as an interim measure given that we cannot really get rid of mandatory HIV testing.

The other measure we are looking at is a sort of advocacy with the Bureau of Facilities and Standards. Because this agency actually asks the monitoring of how the clinics go about their business. So doing advocacy that impose guidelines regards to HIV testing. Because we do have an AIDS law that we can invoke.

JENNIFER HIRSCH, PH.D.: I see— actually in front, and then one back in there. The one in front.

STEPHANIE STERLING: Hi, I am Stephanie Sterling [misspelled?] from New York University. When you are dealing with migrant populations, some of the talks focused on doing awareness and prevention in the population that actually migrates from one community to another place.

I was wondering what was being done in the home communities that then have a population come back, maybe every couple years and if any awareness and prevention is being done in those home communities.

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BRAHAM PRESS: I can answer that. We have actually been working cross-border to some degree. There is one project I know of that is a direct linkage between the source community and the destination community. It is called the promban [misspelled?] project.

And it links communities on the eastern coast of Thailand, with the community being Cambodia, which is the Prey Veng province, which is actually on the opposite side of the country, bordering Vietnam.

And if they do provide HIV prevention information, they have training for the spouses of migrants who have left and teach them to negotiate for condom use and increase awareness of VCT and of ARV services and they have helped organize PLHIV groups in that community. So yes there are some scattered prevention in the origin communities.

JENNIFER HIRSCH PH.D.: Okay, now there is actually a lot of people who have questions. So green sweater, white jacket and to the other side of the room.

SHAUN LONG: Hi, my name is Shaun Long [misspelled?], and I would like to say for the children in southern Africa I have a question in general for anyone about how your programs address children, particular accompanied children who are migrating.

We find in southern Africa there is a huge and growing number of children who migrate, and in recent research we did at the border in South Africa, 30-percent of the Zimbabwean

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children coming into the country had recently lost a parent to HIV. And a huge number of those children were under extreme—had extreme experience of sexual exploitation and then going into sex work, going into highly vulnerable situations.

Children are almost always absent in migrant programs, in migrant policy, very largely because they are invisible and we do not really know where they are. So I would just like to know how those issues are getting addressed in your programs.

JENNIFER HIRSCH, PH.D.: That is an important point. I do not know if anybody would like to respond?

PHOEBE YONA WOBI: About the children, let me give example of this of the Sudanese children. They are many who are migrating alone, without parents. According to Sudanese tradition, those on who came alone without any relative. First of all, for Sudanese culture we try, that any person can take two or three people to stay with him as a dependents.

But at the same time it is not helping, because you have many dependent in your house and then you can not take care of them all. And that is the time that we go out and start doing the sex because where they live, that city, they have not getting enough food they are not getting enough things. So it is a difficult for the children.

But for the Sudanese culture, they try they live with us, they be the children to be dependents for some of the people. I don't know if I answer anyone, but some of the people do that a lot.

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JENNIFER HIRSCH, PH.D.: Okay, the next question is in front, here.

CHRISTINE LEE: Hi, my name is Christine Lee [misspelled?], I am from the University of Chicago. I have a question for anyone on the panel in terms of micro-implementation of the policies that you guys are talking about. So on a street level, bureaucrat level, what are the grand challenges that you guys face in terms of just the day to day workings of your work or the things that you do? I am just wondering.

JENNIFER HIRSCH, PH.D.: So maybe to reiterate, the grand challenges of microscopic implementation of the policies that you guys are trying to enforce. What are the challenging things you guys face? Not on an overarching development level but in terms of enforcing these things that you guys are talking about?

RENE LEYVA-FLORES: Well, the big challenge is not only to implement. The big challenge also is to find the different governments and also the different interests. Exist many conflicts. You come to visit from Central America [inaudible] with Mexico, and to try to push on, to harmonize the political of reasons to have good conditions for migrants on maybe they the political conditions will not facilitate to this indirection, no? If you go from Mexico to U.S., difference are really really very deep, no? You have structural situation that you can not move easy, no? Thank you.

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JENNIFER HIRSCH, PH.D.: Next question?

FEMALE SPEAKER: Jennifer, first I want to congratulate you on what I think is absolutely outstanding research, because it takes into account structural issues that impinge on HIV risk and I will try to say this in the most, the best English I can ask, but setbacks, having setbacks and that you believe do address globalization beyond migration.

You addressed capitalism as a form of producing HIV risk, in a very complex way.

Having recognized that from this part, I have one question. Do you have evidence that bringing spouses in would reduce the number of extramarital relationships? That is the first question.

The second question is a [Speaking in Spanish] slippery one. Is there not a fine line between this suggestion you have, which I acknowledge in the midst of more important suggestions, but isn't there a fine line between this and promoting monogamy as— ? Sorry.

JENNIFER HIRSCH PH.D.: That is an important and complicated question. And there is actually evidence emerging. There is actually an article coming out in one of the— in a sexuality— of a colleague of mine, it is being embargoed so I can not really tell you much about it.

But it compares the sexual behavior of men who have Mexican migrants in the United States who have brought their wives with them to the sexual behavior of Mexican migrants

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whose wives are at home in Mexico. And it does seem that the consumption of commercial sex is, not surprisingly, a great deal more frequent among men whose wives are back home in Mexico.

That being said, I do feel like in some ways we are sort of in the troubling position of adding the state to shore up their tradition of heterosexual marriage and in fact there are many ways in which having women toted along with their husbands when the men migrate could be profoundly disempowering to the women. So, any sort of social engineering solution will event 10 more problems than it solves.

But at the very least, I think, it is maybe less complex in a place like Papua New Guinea, where it is so clear that the lack of family housing really pushes men into consuming extramarital sex in a way that they would not necessarily.

And we are very much not recommending monogamy. I mean, personally, you can do whatever you want. But in terms of the whole A, B, C, thing, power and policy brief sort of takes apart the reason that suggesting that people should be faithful is not a good use of prevention dollars. I think there is one more question in the back and then we have to end.

LARA: Okay. Lara, I am not going to— okay. It is a question and a comment. And the comment is the health assistance do not know what it is on the other side of the border and I mean in Texas and the U.S. Mexico border, it does

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not mean it does not reflect all over the United States, and all over the world. The problems are the same. The providers do not know what exists on the other side.

And since the moving from treatment to prevention, we now that these migrants forget to take their medications get picked up, they end up on the other side of the border, not knowing where to access care and then they come back, legal or illegal, with more advanced disease.

So the problem does not end on one side or the other of the border. And creating linkages in HIV providers of the services and we do have an initiative like that AIDS Education and Training Center to educate providers across the United States on the services provided in Mexico. I think it would help, and I really believe that immigration reform needs universal action now, In every country. Thank you.

JENNIFER HIRSCH, PH.D.: Thank you. And with that rousing call to action, I think that we have to end the session. I want to thank you all very much for your listening and your enthusiasm. Please look around you for evaluation and fill it out so we can have more great sessions like this in the future. [Applause]

[END RECORDING]

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