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Research Study on Migration and HIV Vulnerability from Seven South and North East Asian Countries

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This report is based on a study by Asia Pacific Migration Research Network (APMRN) in partnership with UNDP Regional HIV and Development Programme. The study was led by Dr. Robyn Iredale, Associate Professor, School of Geosciences, University of Wollongong and Director, APMRN.

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FOREWORD

In recent decades, countries in the Asia-Pacific region have experienced an increase in the mobility - that is, internal and international migration - of men and women in the region. This phenomenon has been accompanied by the relentless spread of the HIV/AIDS epidemic, which affects all countries, including smaller or somewhat isolated countries such as Mongolia and the Democratic People's Republic of Korea.

Although HIV prevalence is still low - except in Cambodia, Myanmar and Thailand - most developing countries in Asia are characterised by socio-economic features that can potentially lead to an explosion of the epidemic. Given the high population densities in many of these countries, even low prevalence rates mean large numbers. In India alone, there are more than 5.1 million[1] people living with HIV/AIDS, the second largest number after South Africa. In the region as a whole, there are 7.4 million people living with HIV/AIDS.

Migrants very often face poverty; discrimination and exploitation; alienation and a sense of anonymity; limited access to social, education and health services; separation from families and partners; and a sense of disconnect from the socio-cultural norms that guide behaviour. Many common underlying factors sustain mobility, such as an unbalanced distribution of resources, growing unemployment especially in rural areas, socio-economic instability and political unrest. Some of these pose a threat to safe migration, and thereby expose migrants and their families to heightened risk of exploitation, diseases and HIV.

Although the linkages between migration and HIV/AIDS have been acknowledged across the world, the Asia-Pacific region has witnessed only limited research and activity on migration patterns and routes, and HIV vulnerabilities related to unsafe migration processes.

The UNDP Regional HIV and Development Programme in partnership with Asia Pacific Migration Network (APMRN) commissioned this study in seven countries of the region - Bangladesh, China, Democratic People's Republic of Korea (DPRK)[2], India, Mongolia, Republic of Korea, and Sri Lanka - to undertake a systematic review of the existing knowledge on migration routes and processes, trafficking routes, the conditions under which men and women move, their living and working conditions, and their vulnerabilities to HIV/AIDS. The study also reviewed the legal and policy environments, and identified and analysed the gaps in the existing knowledge and areas for possible action. These seven countries are a representative sample: they show up the diverse aspects of migration in the region. (Countries such as DPRK and Mongolia were included to fill the vacuum in the existing knowledge and research on mobility and HIV within these countries.)

This study endeavoured to examine general migration trends and processes in the region in the context of HIV vulnerabilities based on secondary data analysis. It also drew on government policies on migration and HIV/AIDS.

1 National AIDS Control Organisation, Government of India, June 2004.

2 Also known as North Korea

Where secondary data was unavailable, the study bridged the information gap with the help of the perspective gained from interviews with domestic and international researchers, international agency workers, health officials and workers, and other relevant key informants.

In the absence of data and information on HIV infection rates and trends among certain mobile groups, the study used information on living and working conditions of migrant workers, their health risks and access to services and the incidence of infection in general populations to hypothesise about migrants' vulnerability to HIV/AIDS. It investigated the existing legal provisions, strategies and policies pertaining to HIV, migration and trafficking in order to provide background information to understand the political, social and economic frameworks for a cohesive and effective responsive to these issues. Current national responses and resources pertaining to migration, labour rights, trafficking and HIV were reviewed in order to recommend appropriate responses.

In view of the diverse definitions for migration, this study considers migration from one place to another as *a social movement of people in search of improved livelihood.*

The terminology used throughout this report reflects, as much as possible, the language acceptable to organisations such as the International Labour Organization (ILO) and the International Organization for Migration (IOM). The expression 'regular migrants' is used to refer to people who migrate through formal channels. The terms 'documented' or 'undocumented' have been used with caution: many migrants do carry documents, even though they may be forged or not the appropriate ones for their status. The terms 'legal' and 'illegal' have been used sparingly. However, in some cases, country reports consistently use these terms because this is how a particular movement is seen by both the source and destination countries. 'Trafficking' has been even harder to define; for the purpose of this study, it has been defined as the movement of people that involves some element of deception or force - as opposed to human smuggling, in which case a migrant may be a consenting party.

With a disturbing epidemic burden threatening to derail development gains in the region, there is an urgent need to address the vulnerabilities faced by millions of people who are on the move. Despite convincing evidence, migration is still not adequately addressed by national HIV responses of many countries in the region. I hope this study will help catalyse rights-sensitive and timely responses from the Governments and civil society organisations.

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EXECUTIVE SUMMARY

This report examines the unique factors or circumstances pertaining to HIV and migration in select countries of South and North East Asia that need to be taken into account while planning a response to the epidemic. It highlights an increasing level of mobility in all the seven countries, both within and across national borders. Although some of this mobility is 'formal', much of it is informal or 'irregular'. Further, the findings reinforce the fact that the type of population mobility and the context and conditions in which it occurs - whether under duress or distress, or in unprepared conditions - affects the vulnerability of migrants and their families to HIV.

The first chapter provides an introduction to the issue of migration and HIV in the region and establishes the need for this study in view of the large-scale, often unsafe and unprepared movement of men and women within and across national boundaries in search of better livelihood options. The chapter also outlines the research method.

Chapters two to eight are countrywise reports compiled in a common format and are presented in alphabetical order, with no other significance attached to their placement. The chapters depict the current HIV/AIDS situation, migration trends and patterns, the socio-economic and political contexts of internal and cross-border mobility, living and working conditions of migrant workers and related health risks, services and resources available and suggestions for future research that need to be undertaken in each of these countries. These chapters also include a summary table of migrant sub-populations that are most vulnerable to HIV/AIDS, the responses so far, and recommendations for future action.

Bangladesh is just beginning to witness a spread of the HIV/AIDS epidemic in the backdrop of extreme poverty and low socio-economic and human development indicators. Its overseas contract labour migrants, including irregular migrant workers, often live and work in exploitative situations. Of the greatest concern to Bangladesh are the conditions that impoverished Bangladeshis face when they cross into India and elsewhere to seek a means of survival. A large number of women from Bangladesh enter the sex industry in Mumbai. They are extremely vulnerable to HIV.

China, with an estimated 0.8 million people living with HIV/AIDS, is beginning to address the issue of cross-border mobility, especially in the North. Information on internal mobility has tended to focus on labour migration, and there is less information on the social and economic conditions facing the 'floating population'. Many of the latter are very vulnerable since they are young, single and marginalised, and away from traditional social support mechanisms. The numbers of commercial sex workers and casual sexual encounters have increased in the recent past with changes in the socio-economic and cultural situation in the country. The growth of major trading posts and towns on the borders with Mongolia, Russia, North Korea and Central Asia, and the simultaneous emergence of an underground sex industry, are potential factors that could accelerate the spread of the epidemic. The

arrival of refugees from the DPRK adds to the complexity of the situation. Their anonymous and hidden status leads to situations of exploitation and vulnerability to HIV/AIDS. In the South, work on internal and international migration and HIV/AIDS has largely been carried out by NGOs and international organisations.

The North Korean situation is probably the most delicate in the region. An analysis of the socio-economic context indicates that internal mobility is starting to increase at a time when the health system is failing and awareness about HIV/AIDS seems to be minimal. The growth in itinerant travellers, the uncertainties of transport systems and the absence of many accommodation options are all factors that may lead to a rise in casual sexual encounters. Even more disquieting is the exodus of men and women, mostly to China, where they must remain underground as they are not granted the status of refugees. They are extremely vulnerable in situations where they lack food, housing and employment. Protection may necessitate hiding out in the mountains; for women, it may mean travelling with a man for some security, often in exchange for sexual favours. Often, women take to sex work or allow themselves to be brought from North Korea to people in China, mostly men, many of whom subsequently resell them or hire them out for sexual services. North Koreans in China are in a very precarious position; on the other hand, those who move to Russia or Thailand are probably only slightly less vulnerable.

With about 5.1 million people living with HIV/AIDS, India faces, in terms of sheer numbers, the greatest challenge in the region. The complexity of the Indian situation is obvious, and the range of migrants, both internal and international, calls for a multi-faceted response. Stigmatisation has been a factor in 'isolating affected individuals from their families, medical attention and the society, in general' (Ghosh, 2003). Early prevention programmes have contributed to this development, singling out "high-risk groups" and describing HIV as a "killer disease". But the government is now taking the lead in implementing more sensitive responses to HIV/AIDS, including treatment, care and support in addition to prevention.

The inter-linkages between mobility and HIV have received only limited attention in Mongolia; what is known, however, is that mobility is increasing, both within and across borders. As a consequence of the shift to a market economy, more and more men and women are setting out to neighbouring countries in search of employment. Little information is available on particularly vulnerable sub-populations, and there are very few projects/programmes on HIV awareness and intervention. The situation in Mongolia is reminiscent of China a decade ago, when there was it was widely believed that HIV/AIDS was an "imported" problem. Shared borders with Russia and China, two countries where the epidemic is expanding rapidly, place Mongolia in a precarious situation.

The Republic of Korea (or South Korea) has a significant labour immigration programme: a majority of the contract labourers who come in are single men. Under the current immigration laws, migrants are not allowed to bring in their families. Despite an organised programme that promotes immigration, a majority of the migrant workers tend to be irregular. In fact, many regular migrants who enter as trainees take on better-paying jobs, even at the cost of their status becoming irregular. Stringent laws that call for deportation of migrant workers who test HIV-positive and deny irregular migrant workers access to even basic services, and the fact that a disproportionately high number of migrants are men, render migrant workers highly vulnerable. At the same time, South Korea has a significant organised sex trade with an estimated $2 billion turnover, which caters to the many male migrant workers who live alone. Many of the sex workers are themselves migrants or trafficked girls and women from Russia, the Philippines and China.

Since 1981, patterns of migration in Sri Lanka have seen a radical shift due to two developments: civil unrest in parts of the country, and the

systematic promotion of contract labour migration to overseas destinations as a major source of economic development. Currently, remittances contribute to 30 per cent of foreign revenue. Returnee migrants and internally displaced persons constitute a large segment of the vulnerable populations. Contract labourers comprised 50 per cent of the total of 264 persons with HIV/AIDS in a small sample study undertaken in 2002.

While the Sri Lankan Bureau of Foreign Employment has a well-designed pre-departure training programme, including an HIV/AIDS awareness programme, living and working conditions in the destination countries of West Asia expose the migrants, especially women, to multiple vulnerabilities.

Key Findings and Recommendations

1. Although all seven countries have started to acknowledge that the HIV/AIDS epidemic poses a serious challenge, there are huge differences in the extent of commitment of each country and the resources available to tackle the epidemic. Additionally, concerns and vulnerabilities of migrants do not figure as a major focus in the HIV/AIDS programmes of these countries. For instance, even though internal mobility is increasing in Mongolia, there is no countrywide pre-migration training programme. Commitment at the highest level is needed to ensure that migration becomes a safer process for both men and women, thereby reducing their vulnerability to trafficking and HIV.

2. The absence of studies, data and information that explore issues concerning vulnerabilities of specific sub-groups within migrant workers has contributed further to the lack of comprehensive responses directed at migrant workers and their communities. Research and micro studies need to be initiated to gather more detailed information on the migration process covering a migrant's journey through source, transit and destination areas. Mapping of 'hot spots', where there is a volatile mix of highly mobile people (traders, visitors) or temporary workers (industrial, miners, sailors and so on) and sex workers, is required.

3. The study found inter-country migrants to be, by and large, more vulnerable than in-country migrants because of a host of reasons. Their vulnerability stems from language barriers, a feeling of alienation, distance and long periods of absence from home - in places that usually have a drastically different socio-cultural environment (which reinforces their sense of isolation) - limited access to information and services, limited rights to organise and negotiate for better services and fear of deportation upon testing positive for HIV. The situation is worse for undocumented or irregular migrants who have no valid status in the host country. Three-quarters of migrant workers in South Korea are undocumented. They are usually denied legally enforceable rights, and access to health and other services. They are likely to work for lower wages and in more difficult working conditions than regular migrants. HIV is not a priority concern for them. Often, they have limited or no access to testing facilities, but even where these are available they are afraid to seek testing owing to the limited choices they have. It was also observed that labour-receiving countries assume no responsibility, once a worker is found to be HIV-positive. The situation of North Korean migrants in China, Chinese and other irregular Asian migrants in South Korea and Bangladesh migrants in India establish the distinctive vulnerabilities of inter-country migrants, particularly the undocumented ones. Inter-country dialogues and coordinated actions between source and destination countries involving both governments and civil society organisations are critical to address their concerns.

4. Even where they are available, services provided by government or civil society organisations are not especially geared towards migrant workers. Responses designed to address the vulnerabilities of migrant workers must focus on services that are

provided in appropriate languages through a range of outlets, in settings that are accessible to migrant workers. Health information, especially on HIV/AIDS, must be supplemented with additional information and services that address migrant workers' broader concerns and priorities, and thereby facilitate safe migration. In source areas, services and information must, in addition to the above, cover families and communities of migrant workers. Responses must focus especially on two groups: one, sub-populations that are most vulnerable to HIV, such as men who have sex with men (MSM), sex workers and young, single migrants; and two, 'bridge populations', which include partners of overseas contract workers, clients of sex workers and transport workers/traders and their partners/families. Moreover, since migrants, particularly undocumented and informal migrants, are often difficult to track due to the clandestine nature of mobility, the focus of some programmes should be on the workplaces and communities they live in.

5. Many countries such as Bangladesh and Sri Lanka provide pre-departure training for outgoing migrants. Similarly, some countries, including South Korea, offer post-arrival orientation programmes for incoming overseas migrant workers. The study found that these trainings either did not address HIV/AIDS - or did so only minimally. Efforts are, therefore, required to mainstream HIV into existing pre-departure and post-arrival training programmes. Additionally, it must be noted that people migrating through non-formal channels miss out on these trainings. The study recommends facilitation of pre-departure and post-arrival "preparedness" programmes in those geographic locations that are mapped as hot spots - that is, from where a large number of men and women are known to migrate or places in destination countries where most irregular migrants are known to stay. Detailed studies must be undertaken to identify these locations. Specific workplace interventions are also required in settings that employ large-scale informal migrant labourers - for instance, manufacturing units in South Korea or free trade zones in Sri Lanka, which employ/house large numbers of informal/ irregular migrants.

6. As women and young populations are now migrating in large numbers, there should special emphasis on their concerns in all programmes. For instance, in South Korea, Russian, Filipino and Korean Chinese women were found to be more vulnerable to HIV because of the higher probability that they were engaged in the sex industry. This, coupled with their low-socio economic status, makes it imperative to mainstream their concerns in all HIV prevention programmes.

7. Although some initiatives exist at a national level to address issues of in-country migrants, there is a dearth of regional responses. Holistic dealing of migrant issues requires coordinated action throughout their journeys in source, transit and destination countries. This can be done only through concerted regional responses that bring together a range of stakeholders and service providers among a cluster of countries. It is critical to form a regional body or a mechanism to co-ordinate such responses; additionally, a regional strategy must be developed to reduce the vulnerability of cross-border migrants to HIV/AIDS. The Greater Mekong Scheme region is one such initiative that can provide valuable lessons in this direction.

8. Overall, the study found a very small number of models of good practice. Where they do exist, they are limited in their scope and impact. The experiences of some of the more effective programmes can serve as models to manage projects. The Yunnan experience, for example, shows how a collaborative effort between government, civil society, community and international organisations can be successful. It also illustrates innovative ways of working among one-day visitors and overnight border-crossers through the public security and the customs departments. Additional resources, both financial and technical, are urgently needed to upscale small, successful initiatives or put in place innovative and replicable models.

The costs of care and treatment and the debilitating effect of HIV/AIDS have already been demonstrated in Africa. Unless Asian governments and international organisations respond quickly, the effect of the epidemic in the region could be devastating. The study makes a case for an urgent and comprehensive response to contain the spread of the epidemic and mitigate its effects on individuals, communities and nations based on a rights-sensitive approach towards migrant workers.

CHAPTER 1

INTRODUCTION

1. Migration: The Process

Migration of people within and across national borders is a key process shaping the world in many complex ways. There are an estimated 175 million[1] international migrants in the world today; that is, one out of every 35 persons in the world is a migrant.

This large-scale movement of people has been accentuated by globalisation processes that are, on the one hand, creating livelihood opportunities in some pockets of the world and, on the other, diminishing choices, particularly in rural settings and less developed regions, prompting greater human mobility. The migration process, a reflection of the structural socio-economic realities of today, has become considerably more multi-faceted, impacting the lives of not only migrants, but of communities and nations in several complex ways.

Most people move for economic reasons such as poverty and lack of livelihood opportunities; still others migrate to escape persecution, discrimination, human rights abuses, ethnic tensions and displacement because of natural disasters, violence and war. The factors that attract migrants to particular settings are a booming economy, livelihood opportunities and favourable immigration laws, or free agricultural land in the area to which the migrant is moving.

By and large, migration has been a beneficial process for individuals, their host and home communities - the source and destination areas - and the economies of nations. Better livelihood and economic opportunities meet the needs of the migrating individuals and their families; their remittances are known to play a decisive role in the development of their communities and nations by strengthening the local and national economies. According to the International Organization for Migration (IOM), worker remittances represent the second largest monetary trade flow globally, exceeded only by the petroleum industry.

Recent years have witnessed an increasing feminisation of the migration process. It is estimated that 48 per cent of all migrants across the world are women[2]. Women migrants in Asia constitute the largest number of unskilled migrant workers in labour-receiving countries. The acute gender bias in the continent makes women migrants, particularly vulnerable to exploitation and abuse.

Besides the regular labour migration component, there is an equally important unregulated or 'irregular' component of migration. A recent study coordinated by the Scalabrini Migration Center (SMC) in Manila states:

High levels of irregular or unauthorized migration have accompanied the rise of intra-regional migration in Southeast Asia. During the period of economic expansion, irregular migrants moved to the more prosperous economies to take up jobs vacated by the local population and were

1 Facts and Figures on International Migration, Migration Policy Issues (International Organization for Migration), No. 2, March 2003

2 Ibid 1

generally tolerated… By themselves, preventive approaches taken by countries of origin, and border control and sanctions undertaken by countries of destination proved to be limited in curbing irregular migration (Battistella and Asis, 2002: xi).

Wickramasekera (2002: 16) refers to the 'explosive growth in irregular migration' due to a combination of increased pressure to migrate and restrictive migration policies. It is estimated that irregular migrants account for 30-40 per cent of the estimated 5 million migrants in Asia (Wickramasekera 2002: 16-21), and their importance cannot be disputed.

Migrants, however, often land in abusive and exploitative situations. People, especially those who move in distress situations, often migrate with little or no preparedness or information, and are defenceless against the complex situations they face on their journey.

Migration and HIV

This multifarious movement of people across the world has become interlinked with the HIV/AIDS epidemic. As the epidemic spreads across the continents, the linkages between migration and HIV are being recognised globally. A recent study by UNDP, in partnership with people living with HIV/AIDS (PLWHA) groups in the Asia-Pacific region, establishes this beyond all doubt. Nearly 67 per cent[3] of PLWHA who participated in the study said that unsafe and unprepared migration was the main factor that rendered them vulnerable to HIV, and that better access to information and services would have protected them. What is more, a majority of the people on the move in search of livelihoods are in the productive age group (15-49 years), the group that is most vulnerable to HIV/AIDS. These statistics only make the link between unsafe migration and HIV even stronger.

The world has in the last few years witnessed a 'feminisation of the epidemic'; almost 45 per cent of the world's PLWHA are women[4]. As more and more women migrate within and across countries, there is a compelling need to address their vulnerabilities to the epidemic. Apart from biological reasons, their vulnerability arises from their low socio-economic status in society, lack of access to information and knowledge about their sexuality and limited access to information. The problem is worse for undocumented women workers. Well-intentioned attempts by governments to protect women by limiting or banning their migration through legal channels ironically only heighten their vulnerability as they are forced to move through illegal channels and depend on dubious middlemen who exploit them and may, in many cases, traffick them.

The relationship between migration and the HIV/AIDS epidemic is not linear. Many of the same inequalities that drive some men and women to migrate under duress, distress and unsafe conditions also drive migrants' vulnerability to HIV. Although the widely held societal perception is that migrants bring HIV when they enter countries, evidence suggests that migrants are more vulnerable to HIV/AIDS than the local populations. The vulnerability of migrants to HIV/AIDS is related to the conditions and structure of the migration process, poverty, exploitation, separation from families and sexual partners, lack of social support, isolation resulting from discrimination and differences in languages and culture, a sense of anonymity, lack of access to health and other services and disengagement from the socio-cultural norms that guide behaviours in communities.

At source areas, there is little or no information about the destination areas; even where information is available, there are only limited options for making informed choices, given the

3 A rapid survey conducted electronically in 2004 among people living with HIV/AIDS (PLWHA) networks across the Asia-Pacific by UNDP Regional HIV and Development Programme, New Delhi (UNDP REACH), and the Asia-Pacific PLWHA Resource Centre (APPRC). Going beyond proxy indicators of vulnerability associated with unsafe mobility, this study reached out to PLWHA to identify the factors that made them vulnerable.

4 Global Epidemic Update, UNAIDS, 2004

unrealistic expectations, pressure from peers and family, situations of distress and the lack of adequate preparedness. This leads to situations where the migrants may be pushed, cheated, lured, tricked or trafficked into situations of vulnerability. Situations of selective migration, where women are usually not allowed free movement or denied permission to accompany their spouses, create even greater vulnerabilities.

Similarly, at transit and destination areas, there is inadequate supportive infrastructure; given the wholesale denial of basic rights, migrants don't have the opportunity or the power to negotiate or bargain collectively for basic services and rights. The restricted access to information and services only adds to their vulnerability.

Living away from families, home communities, and familiar socio-cultural norms can lead to a feeling of isolation and loneliness, which is often exacerbated by discrimination. In such a context, migrants become vulnerable to HIV largely because of their human need for companionship, intimacy and sex. The social and economic conditions in which migrants live and work - uncertainty about employment and even their legal status - only add to this vulnerability. In addition, the absence of social nets and norms that usually inform and shape human behaviour heighten their risks. Faced with these situations and in search of emotional, physical or sexual gratification, many migrants slip into alcoholism, drug use and multi-partner sex. In the absence of adequate services and information, including information about HIV/AIDS, they not only become vulnerable to HIV but also unknowingly become a link in the transmission of the virus to others, including their spouses, to whom they return at periodic intervals.

HIV-positive migrants carry a double burden, since the epidemic reinforces and deepens existing inequalities, furthermore, it increases their vulnerabilities. Rising costs in healthcare, job loss and stigma and discrimination can wreck their lives. Besides affecting them severely, HIV infection also has a huge impact on their families, host communities and countries; it affects income flows and increases the burden of healthcare and leads to loss of valuable social capital.

Addressing the vulnerability of migrants is crucial to checking the spread of the epidemic, which is one of the severest development crises facing the world today. Worldwide, there are more than 37.8 million people living with HIV/AIDS; an estimated 4.8 million became newly infected in 2003 alone[5]. This is more than in any single year before[6].

Asia: Migration Trends

The global processes witnessed across the world are reflected fairly faithfully in Asia as well. The continent witnesses large-scale migration within and between countries; the migrant stock was estimated at 49.7 million in 2000[7].

Internal rural-urban migration has escalated as more and more people leave farms and rural areas in search of work or a 'better life' in cities and large towns. Industrialisation, economic reforms, income disparities and modernisation have all led to an escalated level of internal mobility. India, China and Bangladesh are currently experiencing very large flows of people in this direction. These flows may not always be to cities; on occasion, these could be to other rural areas where land or food is available. The food insecurity in the Democratic People's Republic of Korea (DPRK) has forced people to migrate elsewhere within the country in search of food or a livelihood. In the past, this would have been impossible due to the strict control over movement, but that restriction has been relaxed in response to the crisis. Similar planned migration programmes exist in other countries to deal with environmental challenges, developmental needs and poverty alleviation; these result in temporary or permanent relocation of people from one region to another. For instance, China is encouraging the movement of people to Xinjiang in the North West and

5 Global AIDS Epidemic, UNAIDS, 2004
6 Ibid 5
7 Ibid 2

elsewhere to relieve population pressure in the East; Han populations are being induced to settle in the Western 'frontier' regions.

The magnitude, direction and character of international migration in the Asian region have changed substantially over the last two decades. The region experiences varied types of international migration flows (Zlotnik, 1999): migration into and within the region takes many forms - tourists, students, refugees, family reunion, labour and business. But it is migration for economic reasons, particularly temporary labour migration, that is growing the fastest.

In North East Asia, cross-border flows, especially from the DPRK to China and Russia and to the Republic of Korea and other parts of Asia, and between China, Mongolia and Russia have escalated markedly in the past decade. These flows consist of people moving for trading or other business purposes, tourism, family visits, people fleeing persecution or poverty, contract labour migrants and undocumented migrants. In South Asia, labour migration from Bangladesh, India and Sri Lanka and refugee movements have increased substantially in recent years. All are labour-surplus countries and the remittances sent by labour migrants are significant for the national economies.

The current contract labour migration systems in Asia began to evolve in the 1960s, around the oil-producing countries of West Asia, but since the mid-1980s rapid economic growth and declining fertility have led to considerable demand for

Table 1.1 Average Annual Number of Migrant Workers Originating from Select Asian Countries, and Their Distribution by Region of Destination (%), 1980-99

Sending country/Receiving region	1980-84	1985-89	1990-94	1995-99
South Asia				
Bangladesh				
West Asia (Gulf)	92.0	95.9	83.5	-
Other Asian regions	1.0	0.5	15.6	-
Outside Asia	7.0	3.6	0.9	-
Number of clearances (land)	53,000	78,000	174,100	262,000 (95-98)
India				
West Asia (Gulf)	92.4	95.8	96.0	-
Other countries	7.6	4.2	4.0	-
Number of clearances	223,500	139,800	297,225	400,275 (95-98)
Sri Lanka				
West Asia (Gulf)	-	94.5	95.4	94.0
Other Asian regions	-	4.3	3.3	4.0
Outside Asia	-	1.2	1.3	2.0
Number of clearances	31,300	18,900	52,300	164,312
East Asia				
China				
West Asia (Gulf)	80.1	48.2	3.7	-
Other Asian regions	6.0	18.6	37.6	-
Outside Asia	14.4	33.3	58.6	-
Number of clearances	37,600	61,100	135,000	275,000

Sources: Zlotnik (1999), Stahl and Iredale (2001: 2), United Nations (2003), Wickramasekera (2002: 15) and Sri Lanka Bureau of Foreign Employment (2001: 4).

migrant labour in countries within Asia - Japan, Republic of Korea, Hong Kong, Malaysia, Thailand, Taiwan (Republic of China), Singapore and oil-rich Brunei. A key development in recent years has been the increasing feminisation of migration: over 1.5 million Asian women are working abroad and in many migratory movements they outnumber men. Table 1.1 shows the growth from 1980 to 1999 for Bangladesh, India, Sri Lanka and China. These figures represent only documented migration from these countries.

Need for the Study

While there is growing recognition of the need to address migrants' HIV and related vulnerabilities and to facilitate safe migration, there is very limited knowledge on these issues in the region, especially in countries of North East Asia and South Asia. In Asian countries, surveillance studies are rarely carried out among migrant communities; when they are carried out, the risk of stigmatisation is high. A sensitive approach that identifies migrant workers' vulnerabilities, rather than erroneously blaming them for the spread of the epidemic, is largely lacking. In addition to the micro picture, there is an urgent need to develop an understanding of the macro-level situation regarding migration patterns within and between countries in select sub-regions in Asia, the broader socio-legal environment that impacts their vulnerabilities and the existing resources in the region.

Aims and Objectives

The overall aim of the study was to understand the patterns of movement within and between select countries, identify gaps in the existing knowledge and recommend strategies for action to address the vulnerabilities of migrant populations.
The study specifically endeavoured to:

- Analyse vulnerability factors related to migration and HIV to improve the existing understanding of the relationship between HIV/AIDS and unsafe migration in the region
- Collect information on the existing services and resources in the region
- Provide information to design and implement responses in select countries
- Delineate gaps in knowledge
- Develop recommendations for policymakers and public health practitioners for future responses.

Principles

The following overarching principles formed the framework within which the research was undertaken and recommendations drawn:

- Mobility is an important survival strategy for many men and women. An assessment of their vulnerabilities must be carried out with the objective of facilitating safer migration, not measures that impact people's right and freedom to move.
- In the context of mobility, HIV must be analysed in a rights-sensitive way that does not project migrants as 'carriers' of the virus as this raises the risk of stigma and discrimination.
- Gender sensitivity must be an integral component of all policies and programmes. Mobile populations include both men and women. Responses must be mutually empowering for both groups.
- Human rights of migrants, including unregulated or undocumented migrants, should be protected at all times.
- Migration and mobility are not only national and sub-national phenomena but usually have a trans-border and regional dimension, which necessitate cross-border cooperation and multi-sectoral partnerships.

Methodology

Seven countries in Asia - Bangladesh, China, DPRK, India, Mongolia, ROK and Sri Lanka - were chosen for the study; these countries offer a representative sample of the migration patterns in Asia. India and China were selected because they account for massive migration flows. Bangladesh represents the experience of any medium-sized,

poverty-stricken Asian country with low socio-economic indicators. Sri Lanka provides a characteristic case of large-scale female migration. Countries in Noth East Asia - Mongolia, DPRK and ROK- were selected because there is very little knowledge on their migration patterns and HIV-related vulnerabilities related with unsafe migration.

For the purposes of this report, any person who is away from his or her place of normal residence was regarded as a migrant. Attempts at separating temporary, permanent and circulatory flows are flawed from the point of view of HIV/AIDS transmission. The length of stay may not be as significant a factor affecting vulnerabilities of migrants to HIV as the conditions under which migration takes place.

In partnership with UNDP Regional HIV and Development Programme, the research was undertaken by a team of in-country researchers, under the auspices of the Asia Pacific Migration Research Network (APMRN)[8]. It was conducted under the overall supervision and coordination of the Director. A team of two persons each were appointed to conduct the research in China and Mongolia and DPRK and ROK and one person was responsible for each of the countries in South Asia - Bangladesh, India and Sri Lanka[9].

The study was qualitative in nature. Secondary data analysis was combined with interviews of key informants[10] where the available literature was found to be deficient. A systematic review of the existing literature was carried out to explore migration routes and processes, trafficking routes (where applicable), vulnerabilities to HIV/AIDS, conditions under which men and women move, living and working conditions, legal and policy environments, and the existing resources. The researchers encountered scarcity of accurate data on various aspects of mobility[11]. There was a marked absence of accurate data on the prevalence of HIV/AIDS among migrant populations, including indicative studies on prevalence. This may be an indication of the low priority accorded to this sub-population in HIV responses.

In the first stage, the existing body of literature was reviewed and secondary data explored to identify and collect information on mobility patterns, including gender-specific mobility, within and between the countries. Secondary data was analysed to draw inferences on country migration as well as HIV/AIDS policies/strategies. Wherever adequate data was unavailable, key informants' interviews were conducted.

The next stage involved analysis of the mobility processes and patterns indicating geographic sites and specific areas of vulnerability for both men and women. Migrants' potential risk of being trafficked and of being exposed to HIV/AIDS was also addressed, although in most places information about trafficking is extremely scarce and unreliable. The aim was to generate practical and location-specific recommendations for future responses.

The existing national responses - legal provisions, strategies and policies pertaining to HIV, migration and anti-trafficking - were investigated to understand the political, social and economic framework for responding to issues.

Researchers also prepared a list of country-

8 APMRN has been in operation since 1995 and encompasses 16 countries/economies in the Asia-Pacific region. It is the major body involved in Asia and Pacific research. It incorporates top migration researchers from a variety of disciplines, and draws on a wide range of expertise. Its researchers often work closely with policymakers and NGOs, and have carried out research for international, national and local bodies.

9 China/Mongolia: Dr Zheng Zhenzhen, Population Institute, Chinese Academy of Social Sciences, Beijing, and Dr Ren Qiang, Population Research Institute, Peking University, Beijing.
ROK/DPRK: Prof. Jungwhan Lee, Dept. of Sociology, Chongju University, Seoul, and Prof. Sung Ho Ko, Institute of Political Education for Unification, Seoul
Bangladesh: Prof. Tasneem Siddiqui, RRMMU, University of Dhaka, Dhaka.
India: Dr Swati Ghosh, Economics Dept., Rabindra Bharati University, Kolkata.
Sri Lanka: Prof. A.J. Weeramunda, Dept. of Sociology, University of Colombo, Colombo.

10 These informants included domestic and international researchers, international agency workers, health officials and workers, and other relevant stakeholders.

11 T Internal migration measurement often depends on the definition of who is a migrant; this may on occasion be be an administrative definition. Rates of urbanisation are commonly used to measure internal flows. Many of the short-term movements are not documented or included in migration statistics. Many countries in the Asian region also lack mechanisms for collecting emigration and immigration data and this makes it difficult to be sure of the size of international flows. Often data are collected from receiving countries but this usually only includes 'legal' or regular migration inflows.

KEY QUESTIONS

The following questions guided the research:

- What are the major migration and trafficking routes and processes involving China, Mongolia, DPRK and ROK, and South Asia (Bangladesh, India and Sri Lanka)?
- What is the relationship between unsafe migration and the transmission of HIV/AIDS?
- What are the living and working conditions of immigrants in the countries of destination, which heighten their vulnerability?
- What legal and policy environments do immigrants face, which may heighten their vulnerabilities? For example, are they largely 'irregular migrants' and therefore denied access to services?
- In particular, what resources and services are available to them? Are there specific problems they face in accessing reproductive health information and reproductive health services?
- What are the key responses undertaken by the countries - existing NGOs, experts, institutes, projects, publications, tools etc?
- What can public health providers (both government-sponsored and private) do to improve the situation?
- What are the major knowledge gaps in understanding the relationship between migration and HIV/AIDS?

specific resources: this included community-based organisations, women's organisations, migrant associations and networks, AIDS prevention and care initiatives, research institutes, bi-/multi- laterals working on either HIV/AIDS and/or population mobility, government structures and experts to enable cataloguing of possible people/agencies that could be involved in future responses.

In addition to the research activities, in September 2003, a workshop was held in Beijing; among the participants were the North East Asian researchers, a representative from UNDP, and the coordinator of the project. The workshop was held to enable an exchange of information on trans-border movements in the region, identify various information sources, discuss sensitive issues in the region and suggest possible ways of tackling these challenges.

The research methodology was adapted to suit the specific situation within each country. Specific details of each researcher's method and the particular challenges they faced are included in individual country reports.

CHAPTER 2

BANGLADESH

Tasneem Siddiqui[1]

2.1 Background and Method

Bangladesh, with a population of 130 million in 2001, is one of the world's least developed countries: 25 million people (or 19.23 per cent of the population) live in extreme poverty. A section of those who are landless or who live below the poverty line move within and outside the country in search of shelter and livelihood. The country's population growth rate has declined from 2.1 per cent in the 1980s to 1.6 per cent during 1995-2000 (MHHDC, 2001), but its population density is one of the highest, exceeded only by the city-states of Singapore and Hong Kong. Literacy rate has improved from 23.8 per cent in 1981 to 40.8 per cent in 2001.

Women constitute 49 per cent of the population, and in every respect - ranging from health and education to nutrition and income - they are the poorest of the poor. Strikingly, life expectancy of Bangladeshi women is the same as that of men (62.6 years, according to WHO data), which makes it one of the few countries with that admirable demographic status. Since the early 1980s, a significant proportion of women, most of them young and unmarried, have migrated to urban centres - Dhaka, Chittagong and Khulna - to take up employment in the garment, food and manufacturing industries. Currently, 1.2 million women are employed in the garment sector alone. A quiet revolution has taken place in Bangladesh: it has resulted in increased mobility of women and rural-to-urban migration of women, not as spouses but as independent migrants. A section of them have also joined the international labour market.

Bangladesh is a labour-surplus country, and contributes significantly to the labour resource in the global market, mainly to countries in West Asia and South East Asia. On an average, more than 225,000 Bangladeshis leave the country every year to take up overseas contract employment (Abrar, 2002). A large number of Bangladeshis also leave the country informally in search of jobs in neighbouring India and Pakistan. In addition, a large number of women and children are trafficked to these countries and to West Asia. The men and women involved in the various types of migration may face a heightened vulnerability to HIV/AIDS.

This paper draws largely on secondary sources of information. It surveyed available conference, seminar and workshop proceedings, published books, training modules and reports. It also draws from expert group meetings organised by the HIV/AIDS and STD Alliance Bangladesh (HASAB) in June 2003. In addition, interviews were conducted with key informants: government functionaries, members of recruiting agencies, medical centres, NGO officials and representatives of development agencies[2].

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1 Professor of Political Science, University of Dhaka, Dhaka.

2 In particular, Shahudul Haque, Director-General, Bureau of Manpower Employment and Training (BMET); Nazrul Islam, President, GCC Approved Medical Centres' Association (GAMCA); Dr Hasrat Ara, Marie Stopes Clinic (MSC); Dr Rosella Morelli, Senior Programme Coordinator, UNICEF; Saiful Haque Asif, Vice-chairman, Welfare Association of Repatriated Bangladeshi Employees (WARBE); Ghulam Mustafa, Secretary General, Bangladesh Association of International Recruiting Agencies (BAIRA); Pam Baatsen, Country Director, Family

2.2 HIV/AIDS Situation in Bangladesh

The first person with HIV in Bangladesh was identified in 1989. By 1999, 10 persons living with AIDS and 126 persons living with HIV were reported. A recent newspaper report suggests that the number of people living with HIV is now 248 and that by November 2002, 20 persons had died of AIDS-related illnesses[3]. Independent estimates put the number of people living with HIV/AIDS (PLWHA) in Bangladesh much higher: the WHO/UNAIDS estimate is 13,000 (UNAIDS, 2002) and Chowdhury (2002) puts it at 30,000. The absence of a well-articulated HIV/AIDS prevention policy as well as inadequacy of resources to maintain confidentiality and ensure voluntary testing are to blame for such gaps in data.

In Bangladesh, as is elsewhere, HIV vulnerability is enhanced by unsafe sex in the context of sex work, and men having sex with men (MSM) and injecting drug use and needle sharing; the high rate of sexually transmitted infections accentuates this vulnerability (National Integrated Population and Health Programme, 2001). Of the 248 persons living with HIV, 43 (or about one-sixth) are returnee migrant workers or are from the greater Sylhet area, the source area for substantial migration (*Prothom Alo, 2003)*. There are 10 cases of local transmissions among women who were infected by their migrant worker husbands *(The Independent, 2002)*. But it must be borne in mind that migrant workers are perhaps the only group who undergo regular HIV tests; equivalent figures are unavailable for the rest of the population.

On the other hand, surveys establish that 50 per cent of the 225,000 truck drivers and their helpers visit brothels during their trips to various parts of the country (Kabir, 2001). Moreover, the international crew of the foreign vessels anchored in Mongla or Chittagong Ports too are highly vulnerable to infection as they are known to have sex with sex workers from brothels near the port areas (Husain, 2002)[4].

3 Daily Sangbad, 30 November 2002

2.3 International Contract Labour Migrants

Numbers

International contrant labour migrants are perhaps the most significant migrant group in Bangladesh. The Bureau of Manpower, Employment and Training (BMET) of the Ministry of Expatriates' Welfare and Overseas Employment maintains records of regular migrants. In the 1990s, there were an average of 225,000 outgoing migrant workers a year; the peak flow

(381,077 migrants) was in 1997. Most of the migrants are male, according to official data, but clearly more women are taking up overseas employment. Since women migrate through unofficial channels, their migration is not reflected in the government data: officially, they account for only 0.65 per cent of the total migrant labour force. Studies have established that the principal reason for such unofficial migration flows is the government ban on emigration of less skilled women (Siddiqui, 2001a). The BMET database is not disaggregated by age and education levels, but small-scale studies conducted in areas with high migrant exodus have established that most migrants are young (15-30 years of age) when they first migrate (Siddiqui and Abrar, 2000; Afsar, 2000; Murshid, 2000).

BMET classifies temporary migrant populations into four categories: professional (doctors, engineers, nurses and teachers), skilled (manufacturing or garments workers, drivers, mechanics, and heavy machine operators), semi-skilled (tailors, masons, carpenters) and less skilled (domestic workers, cleaners and all other kinds of labourers). Women are employed as nurses, garment workers, manufacturing labour and domestic workers. Table 2.1 shows the distribution of migrant workers by skill

4 See also NASROB 2002; National STD/AIDS Network 2002; QIP/SMC 2001; SEIU 1997; UNAIDS 2002; UNAIDS / WHO 1998; UNDP 1999; UNDP 2001; UNDP 2003; UNGA 2001.

Table 2.1 Annual Official Flow of Bangladeshi Workers by Skill Level, 1976-2002

Year	Professional	Skilled	Semi-Skilled	Unskilled	Total
1976	568	1,775	543	3,201	6,087
1977	1,766	6,447	490	7,022	15,725
1978	3,455	8,190	1,050	10,114	22,809
1979	3,494	7,005	1,685	12,311	24,495
1980	1,983	12,209	2,343	13,538	30,073
1981	3,892	22,432	2,449	27,014	55,787
1982	3,898	20,611	3,272	34,981	62,762
1983	1,822	18,939	5,098	33,361	59,220
1984	2,642	17,183	5,484	31,405	56,714
1985	2,568	28,225	7,823	39,078	77,694
1986	2,210	26,294	9,265	30,889	68,658
1987	2,223	23,839	9,619	38,336	74,017
1988	2,670	25,286	10,890	29,356	68,121
1989	5,325	38,820	17,659	39,920	101,724
1990	6,004	35,613	20,792	41,405	103,814
1991	9,024	46,887	32,605	58,615	147,131
1992	11,375	50,689	30,977	95,083	188,124
1993	11,112	71,662	66,168	95,566	244,508
1994	8,390	61,040	46,519	70,377	186,326
1995	6,352	59,907	32,055	89,229	187,543
1996	3,188	64,301	34,689	109,536	211,714
1997	3,797	65,211	193,558	118,511	381,077
1998	9,574	74,718	51,590	131,785	267,667
1999	8,045	98,449	44,947	116,741	268,182
2000	10,669	99,606	26,461	85,950	222,686
2001	5,940	42,742	30,702	109,581	188,965
2002	14,450	56,265	36,025	109,285	216,025
Total	**146,436**	**1,084,345**	**574,677**	**1,582,190**	**3,387,648**

Note: In 1997, Malayasia legalised the status of 150,000 Bangladeshi workers
Source: Prepared from BMET data, 2002

level from 1976 till 2002. In recent years, the proportion of semi-skilled and unskilled migrant workers has been higher than that of skilled and professional migrants. In 1997, there was an abnormal rise in the number of semi-skilled workers: that year, the Malaysian government issued legal work permits and visas to 150,000 Bangladeshi workers who were already working there as undocumented workers. Most of them were given semi-skilled work status.

Table 1.1 in the Introduction section establishes that while most Bangladeshi labour migrants still

go to West Asia, a growing proportion (16 per cent during 1990-94) go to other parts of Asia or elsewhere. Bangladesh sends contract migrant workers to 13 countries in West Asia and South East Asia. Eight countries account for more than 82 per cent of total Bangladeshi migrants: Saudi Arabia, United Arab Emirates (UAE), Kuwait, Qatar, Iraq, Libya, Bahrain and Oman. The largest Bangladeshi labour-receiving country is Saudi Arabia. From the late 1980s till 1999, Malaysia was the second largest employer of Bangladeshi migrant workers, but in recent years the numbers have fallen (Siddiqui, 2001b).

Table 2.2 Number of Women Migrants in Total Labour Migration Flow

Year	Total Number of Migrants	Women Migrants	
		Number	% of Total
1991-95	953,632	9,308	0.98
1996	211,714	1,567	0.74
1997	381,077	1,389	0.74
1998	267,667	960	0.36
1999	268,182	320	0.12
Total	**2,082,272**	**13,544**	**0.65**

Source: Siddiqui, 2001a

Despite the financial crisis in South East Asia in the 1990s and the subsequent restrictions on the entry of migrant workers in that region, the total number of Bangladeshis migrating for employment is on the rise. A large number of them also go abroad undocumented. To that extent, the actual number of overseas migrants will be much higher than what Table 2.1 shows. The focus of this report is only on those who go to West Asia, since very limited information is available about migrants to other regions.

In-migration to Bangladesh, especially from Myanmar, is a growing phenomenon, but there is very little information about it. Since these movements are irregular and undocumented, they are not reflected in official statistics. However, studies in Thailand have established that most of the migrants from Myanmar are ethnic groups fleeing the alleged persecution and rape of women by Myanmar police and army officers.

Source areas and migration routes

Dhaka, Chittagong, Comilla, Tangail, Sylhet and Noakhali are the principal source areas for Bangladeshi out-migrants. People from these places come to Dhaka city to have their papers for overseas jobs processed; in the capital, they stay in hotels or in their relatives' or friends' houses. *Dalals*[5], friends or relatives often accompany them. Recruiting agents process the papers and make travel arrangements. The employers pick them up from the destination airports; in some cases, migrant workers travel to the employers' places on their own.

Irregular migrants, however, do not go through the formal channels: most of them fly into the destination countries, often as tourists. A small number of them first go to India by the land route, and from there head out to West Asia via Pakistan. Since there is a ban on semi- and unskilled female labour migration, the rate of undocumented migration of female workers is higher (IOM, 2001). Most of the female migrants take the air route. Then again, as with irregular male migrants, a section of the women take the India-Pakistan-West Asia route as well (IOM and UNDP, 2000).

5 *Dalals* are informal agents and sub-agents who act as intermediaries between recruiting agents and potential migrants. Two important functions of recruitment - mobilising potential clients and transaction of money - take place through *dalals*.

Living and working conditions

Living and working conditions of migrant workers vary depending on the destination country and the type of job. Professionals are provided with reasonably better accommodation, healthcare facilities and working conditions. But the majority of the migrants work as semi-skilled or unskilled workers, and their living and working conditions are far from good.

Employers usually provide male maintenance workers, menial job workers and factory employees with accommodation - housing in nearby areas or, less commonly, accommodation within the factory premises. Some migrants rent their own accommodation and live with other migrants from Bangladesh. Typically, large groups of people are accommodated in small rooms, with little or no privacy (Siddiqui, 2003). In West Asia, those who take up agricultural or shepherding work live a particularly tough life. Some live lonely, isolated lives, and are provided food by the employer only once a week. Long working hours, even through the weekends, are the norm. Officially, in most of the countries to which Bangladeshis migrate, they are entitled to overtime wages - at 1.5 times the normal pay (during weekdays) and two times (during weekends). But few employers respect this provision. Besides, workers' mobility is seriously restricted because employers usually take away their passports and travel documents as a means of preventing desertions. There have been reports of contract substitution and payment of lower wages than contracted from countries in West Asia and South East Asia.

The working conditions of women migrants too vary according to their jobs. Some of the women who take up employment as domestic workers said they were satisfied with their accommodation facilities: they were given separate rooms and wardrobes and food. But some others reported that they were given no privacy and were made to sleep in kitchens (Siddiqui, 2001a). Many of them said they had experienced verbal abuse; some even complained of physical abuse. Women who worked in factories lived in hostels either within the factory premises or outside; the employers provided the accommodation in most cases. The weather, especially the oppressive heat, was a major problem for some women migrants; some others couldn't take to the local food.

Health risks

Health facilities provided to the workers vary from country to country. In Saudi Arabia, primary healthcare services are available in major cities, under the government's 'Health for All' policy. Everyone, irrespective of the worker's legal status, can access this service. In the United Arab Emirates (UAE) and Bahrain, migrants can avail of medicare in general hospitals, but they have to bear the costs. In some cases, companies/factories have their own panel of doctors. In Malaysia, Singapore and in West Asia, workers who are formally employed undergo an annual medical test. If a worker is unwell, the employer bears the cost of medicare if the worker's supervisor recommends it. In South Korea, the migrants have to bear the cost of healthcare, which is very expensive.

A small-scale study based on 100 interviews with migrant workers (equal numbers of men and women) revealed that only 14 per cent of migrant workers received health advice in the destination country (Titumir, 2003); 44 others - 30 women, 14 men - had access to regular medical check-ups at their country of destination.

Vulnerability to HIV/AIDS

As is well known, mobility and migration are not in themselves factors that enhance HIV vulnerability. However, failure to protect migrant workers' health rights, the difficult working conditions in the destination countries and the migrants' inadequate awareness of health risks renders them highly vulnerable to HIV infection. In the following section, the risk factors in the pre-departure phase and in the country of destination are discussed on the basis of two studies on vulnerability of migrant workers to HIV/AIDS (Akram, 2003; Titumir, 2003).

Pre-departure phase

Akram's study (2003) was conducted with 50 men and 50 women who were in the process of obtaining visas for overseas jobs. They were going for short-term migration for the first time and some of them had undergone medical tests and BMET briefing. The study showed that while in most cases, the migrants' sexual partners were their spouses, six men said they had sex with sex workers regularly; six others did so occasionally. A few of those who had multiple sex partners were unmarried. Among those who had had sexual experiences (67 persons), the rate of condom use was very low (six persons). The main reason for the low condom use was their dislike of condoms, which they saw mainly as a family planning aid. The study also revealed that most of the respondents (89 persons) did not know how to use a condom.

Migrants often faced vulnerabilities at transit points. One respondent said he had noticed sex work taking place in the hotel he was staying in, in Dhaka while his emigration papers were being processed.

During stay in labour-receiving countries

Titumir's study (2002) revealed a lack of basic knowledge about HIV/AIDS among migrant workers. Of the 100 respondents, nine had had paid sexual intercourse in the destination country: two of them used condoms regularly during paid sexual intercourse; two others used them sometimes; and the five others never used them. The main reasons for their not using condoms: they had to be purchased, were not easily available, and in any case they did not know how to use them. Three of the respondents reported that they had engaged in MSM activities. One said he had been forced to engage in MSM activities by his employer in the destination country. All three said they seldom used condoms.

The low level of knowledge about STDs in general and HIV/AIDS in particular suggests that health-related information had not reached migrants. Several factors account for this: the linguistic barrier in the destination countries; the low level of education in general, and sex education in particular, in Bangladesh; and the difficulty in obtaining written or oral information, especially in their own language. Conservative cultural norms in Bangladesh and in the destination countries make national HIV/AIDS and sex education and awareness programmes difficult to implement.

Titumir discovered that migrants knew they would be repatriated if they had certain notified communicable diseases or if they were pregnant. But they were uncertain which diseases counted as communicable. As a consequence, they would typically not disclose the nature of their diseases or would go to a traditional healer or a private clinic (if they could afford it), rather than go to a company clinic doctor or a doctor in a general hospital. This situation endangers their health and may make them even more vulnerable to HIV and STDs. Migrants claimed that doctors did not provide them with any information on counselling, testing and other such services, and that they therefore felt discouraged from asking for information during their subsequent visits. This, and the language barrier, meant they remained ignorant about diseases and their transmission routes.

2.4 Cross-border Migrants

For the sake of this study, cross-border migrants are defined as those who go to neighbouring countries in search of work, usually without authorisation from the destination countries, stay there for a short period and maintain their permanent residence in Bangladesh.

Numbers and routes

An unknown number of Bangladeshi people go to different states in India and Pakistan for work. Some stay on there, others use them as transit points for migration to countries in West Asia. Cross-border movements also take place from India to Bangladesh: they are temporary in nature, and both men and women are involved.

Most Bangladeshi migrants who cross over into

India use the land route. People from all over Bangladesh come to Greater Rajshahi and Jessore by bus or train. They enter India through Shovapur, Ashriadaha, Kanapara or Sharshabad, the borders of Rajshahi and Shalkona, Fulsara, Shikarpur, Raghunathpur, Goga, Hizli and the Rudrapur areas of Jessore. In some border areas, river routes are more easily accessible than land routes. Migrants cross the ghat, the point of migration, after paying the ghat owner a fee through a middleman. They also negotiate with border security guards, local muscleman and middlemen on their way across. The nexus between ghat owners, border security forces and middlemen makes it possible for them to cross the border on foot. After crossing, the migrants take a bus or a train to reach Kolkata and other West Bengal districts that border Bangladesh. Some migrants head out for Mumbai or Delhi by train from Howrah or Shialdaha stations in Kolkata. The choice of destinations is usually determined by social networks in the host country.

Cross-border migrant workers face many types of vulnerabilities. Often they are victims of 'push-back' and 'push-in'. They face harassment by law-enforcment agencies, local musclemen and middlemen. In 2003, Rozana Rashid conducted a micro-study on the vulnerability of cross-border migrants to HIV/AIDS[6]. It found that while some of them were so-called seasonal migrants - they migrated for short periods - others stayed for a relatively longer period (nine to 12 months). It also found that women migrated for relatively longer periods than men. The social network of cross-border labour migrants provides a major source of information and facilitates migration to neighbouring countries. Based on the findings of that study, the picture of vulnerability of cross-border migrants to HIV/AIDS has been presented below.

6 The study was conducted in Rajshahi and Jessore, two border districts of Bangladesh. Based on a semi-structured questionnaire, interviews were conducted with 100 cross-border labour migrants: 50 men, 50 women. Focus Group Discussions (FGDs) and interviews with experts on STDs were also conducted.

Living and working conditions

The majority of Rashid's 100 interviewees were engaged in labour-intensive jobs. Men and women chose different sectors to work in: most men were employed as construction workers, hotel boys, salesmen, electricians, hawkers and agricultural labourers; most women took up employment as domestic workers and factory workers in small manufacturing industries, such as glass factories and bangle making. Another study conducted by Therese Blanchét shows that a section of cross-border women migrants also voluntarily enter the sex industry in India (Blanchét, 2002)[7]. They work as sex workers and barwomen in Mumbai and some other large cities. They are a group apart from those who are trafficked.

Cross-border migrant workers live in various types of accommodation in India: rented houses, slums, brothels, construction sites, and so on (Rashid, 2003). The highest number (44 persons) said they used to live in jhopra patti (slums), which consisted of long rows of houses made of wood, mud and tiles. Most of the women said they lived in a rented room in the slum with their families. Those who did not have their family members with them shared rooms with fellow Bangladeshis, relatives or neighbours. Some others stayed in the shops where they worked, their employer's houses, on the pavements or in brothels. There is a correlation between the kind of occupation they followed and the nature of their dwelling units.

According to the interviewees, migrants who lived in slums were more vulnerable than those who lived in their employer's house or in rented houses Unlike homedwellers, slumdwellers had no privacy; also, prevalence rates of alcoholism, drug use and multi-partner sex were higher among slumdwellers. Female returnees who used to live in houses as domestic workers said they felt more safe and secure: the social interactions of these women were different in that they had to spend most of the time with their family. Their movements were more or less restricted to the houses where they

7 Some 496 persons were interviewed.

worked. They seemed far less vulnerable than those living on the pavements or other public places.

Health risks of migrants

The individuals' vulnerability to HIV/AIDS hinged on their social behaviour and the nature of the risk situations they found themselves in. Rashid's study (2003) showed that migrants spent their leisure time in the destination country in several avenues of recreation; the highest number (43 persons) spent their leisure time with friends. Others spent their leisure hours in gambling or drinking, spending time with their family or visiting neighbours and relatives. Seven male interviewees said they visited sex workers in the host country. None of the women interviewees said they had gambled or had sex outside of marriage. Male and female respondents demonstrated a marked difference in the way they spent their leisure time in the host country. It is, of course, entirely possible that the responses were influenced by the prevailing cultural expectations, which are different for men and women. Women might have been hesitant to acknowledge their sexual needs. However, as it stands, the study indicates a higher vulnerability for men than for women.

Vulnerability to HIV/AIDS

Pre-departure phase

Sexual behaviour patterns before migration are a key criterion for assessment of migrants' vulnerability to HIV/AIDS. In a micro-study of cross-border migrants, 10 out of 39 married men reported having had sex outside of marriage; their sexual partners included neighbours, relatives and sex workers. Migrants' vulnerability is also increased by their low level of knowledge and information about HIV/STDs etc.

During stay in labour-receiving countries

Rashid's investigation revealed that during their stay in the host country, a section of the migrants had sex with non-regular sexual partners. Condom use among them was very low: only eight men used condoms regularly.

The general level of awareness among irregular migrant workers about HIV/AIDS was very low. Only three - two men, one woman - among 100 interviewees had comprehensive knowledge about HIV/AIDS infection. A large number (60 persons) had absolutely no knowledge of the issue. Many of them said they had heard of the virus, but could not say how the virus spreads or how HIV infection could be prevented. Misconception abounded: some said the virus could be transmitted through mere physical touch or through sharing utensils (cups, plates) of a person living with HIV. Given the social stigma attached to the epidemic, persons living with HIV would typically not disclose their condition.

Irregular migrant workers do not have access to HIV/AIDS awareness campaigns on the electronic, print and other mass media. Even the message provided by television/radio advertisements did not make an impact as, in the popular perception. They did not convey the gravity of the epidemic. The general low level of awareness about HIV/AIDS can be traced to the limited level of NGO intervention on the issue in rural areas. Some 87 per cent of the migrants interviewed said there were no awareness campaigns in the host country about HIV/AIDS prevention.

Rashid's study noted that condom use among cross-border labour migrants was low and irregular, which renders them vulnerable to HIV infection. Only 19 of the interviewees - 15 men, four women - said they or their partners used condoms. The low use of condoms could be traced to a lack of awareness, misconceptions about their use and a perception that their use was prohibited by their religion. Women typically used other forms of birth control, such as pills or injectibles.

The prevalence of STDs deserves attention, given migrants' vulnerability to HIV/AIDS. Among 100 interviewees (Rashid, 2003), only 25 men and 23 women respondents stated they knew what an STD was. The rest of the interviewees were not even acquainted with the term. Twenty-five interviewees - nine men, 16 women - said that they had been infected with some form of STD in the past. However, only three of the infected persons had

been to a doctor. Others had not gone in for treatment, either because they could not afford it or because they were inhibited from going public with their medical condition.

2.5 Trafficked Women and Children

According to the UN Protocol 2000, 'trafficking' is defined as all acts involved in the kidnapping, abduction, capture, acquisition, recruitment and transportation of persons, specially women and children, within and across national boundaries with the aim of selling, exchanging or using for any illegal purpose such as commercial sex, servitude in the guise of marriage, bonded labour or sale of human organs by means of violence or threats of violence. Trafficking of women and children is one among different types of irregular movements of population. Over the last few decades, Bangladesh has become a source and a transit country for trafficking and human smuggling. This section analyses the vulnerability of trafficked persons to HIV/AIDS.

There are some micro-studies on trafficking of women and children in Bangladesh. One of these is Beyond Boundaries: A Critical Look at Women Labour Migration and the Trafficking Within, by Therese Blanchét (2002). The study underlined the plight of Bangladeshi trafficked persons in Kolkata and Mumbai. In 2001, the International Organisation for Migration (IOM) undertook a study, In Search of Dream: Study on the Situation of the Trafficked Women and Children from Bangladesh and Nepal to India. This empirical study identified cases of several girls trafficked in Kolkata, Delhi and Mumbai in India. In 1999, IOM published another study - Mapping Trafficking in Women and Children from Bangladesh (Shamim, 1999). It is a compilation of news reports on trafficking over a period. The Bangladesh National Women Lawyer's Association (BNWLA) conducted a socio-economic study on *Cause and Consequences of Children and Women Trafficking in Ten Villages of Bangladesh in 1999*.

These studies have highlighted the different types of vulnerabilities of trafficked women and children at different stages of the movement. This part of the paper is based on the data and information provided in the above studies. It is also based on the Refugee Migratory Movements Research Unit (RMMRU) anti-trafficking training module that was prepared in 2003 for public representatives at the lowest unit of the local government (Union Parishad) at Jessore and Greater Rajshahi regions of Bangladesh. During the preparation of the module, RMMRU gathered grassroots-level information on trafficking through need assessment programmes.

Numbers and migration routes

According to an estimate by the BNWLA, 10,000 Bangladeshi women and children are trafficked each year. Another NGO, Unnayan Bikalper Nitinirdharoni Gobeshona (UBINIG), claims there are 200,000 Bangladeshi women in Pakistan jails who are victims of trafficking. Recently, the US Information Centre in Bangladesh reported that 50 women and children are trafficked from Bangladesh every day. It is important to note that the above figures are not based on research or a census; they are based on secondary sources, including newspaper reports. Observations of rescued persons have demonstrated that a good number of them are not trafficked; they are irregular cross-border labour migrants.

Well-documented trafficking routes in the South Asian region include movement from Bangladesh to India and Pakistan. Bangladesh shares land borders with India on three sides, which renders it easy to cross over by land routes. The districts on Bangladesh's western border are the most trafficking-prone areas. Of these, Satkhira, Jessore and Chapainawabganj seem to have the most number of transit points and trafficking routes into India. Kushtia and Sundarban are two new transit routes for women and children trafficked from Bangladesh. Women and girls from all parts of Bangladesh are gathered and taken to the border districts by bus or train. The traffickers generally use much the same route as the irregular migrants.

Living and working conditions

Studies show that a large number of trafficked persons are sold into the sex or pornography industry (IOM, 2001). However, not all trafficked women and children are recruited for sex work: some others are driven into bonded labour or domestic work. Still others are taken on as third or fourth wife by those who bought them in the North West Frontier Province of Pakistan (Siddiqui et al., 2003). They are lured into marriage and made to carry out household tasks and offer sexual service. In many cases their 'husbands' sell them again.

Those who are sold into the sex industry generally live in congested brothels or brothel-type dwellings, along with their children and the men involved in the business. The living conditions in these brothels, which have inadequate water supply and sanitation systems, are unhygienic. Apart from conventional brothels, a few women, who worked as commercial sex workers in brothels earlier, run small-scale sex businesses from rented houses (Blanchét, 2002). Such women employ several girls (known as chhukris) and provide rooms from which they carry on their sex work (Blanchét, 2002).

Initially, women and children are coerced into sex work. Studies show that in the initial stages, trafficked victims in the sex industry are raped repeatedly to break their morale. At this stage, they have to entertain a high number of customers. They are not permitted to leave the brothel and they have limited, if any, control over their earning. After two or three years, they start working as adhiya (Blanchét, 2002), in which capacity they get to keep 50 per cent of their earnings after giving away half the proceeds to the malkeens, the women who control the business.

Health risks

Given the nature of the work and their dwelling places, trafficked women and children are more vulnerable to HIV/AIDS infection than many others. Their powerlessness only increases this vulnerability (UNDP, 2003). Victims of trafficking are placed in very vulnerable situations and have no control over their situation. Virginal Bangladeshi girls are in high demand in the Indian sex industry owing to a prevailing myth in parts of Asia, as in Africa, that sex with a virgin can cure HIV/AIDS.

STOP, a Delhi-based NGO that rescues and rehabilitates trafficked children and women, estimates that 60-80 per cent of trafficked girls contract some life-threatening disease; there is increasing incidence of HIV/AIDS among them (UNDP, 2003). STOP also conducts focus group discussions among those it has rescued, and in the course of one such discussion among 57 trafficked children and women, STOP found that 98 per cent of them had never initiated condom use although they had some knowledge of safe sex practices. It is manifestly clear that those in the sex industry, even those who had information on safe sex practices, cannot always negotiate condom use: it depends entirely on the customer's whims. Brothel owners typically expel a girl if they know she is HIV-positive.

Although the incidence of STDs among sex workers is high, there are hardly any recorded instances of their gaining access to healthcare. In Kolkata, social workers are active in some brothels, and sex workers can gain access to information through them (Blanchét, 2002). Durbar is one such association of sex workers in Kolkata. NGOs and associations provide services such as general healthcare, awareness campaigns about STDs including HIV/AIDS, treatment of STDs and counselling services. They also promote birth control measures such as injectibles and condoms. Trafficked persons who are engaged in bonded labour or other kinds of work have little access to such services.

Vulnerability to HIV/AIDS

Studies show that brothel-based sex workers are the most vulnerable to infections during the first six months of work, when they have absolutely no bargaining power to negotiate condom use and have to attend to more customers than others. It is easier for customers who are unwilling to use condoms to use force on new girls as they lack the bargaining power (UNDP, 2003). The young girls are also subjected to abuse and frequent rapes to

'break them in', which increases their vulnerability to HIV infection. According to one UN agency, the fear of infection of clients has driven traffickers to recruit younger girls (UNDP, 2003).

Although women trafficked into sex work are at the top of the list of vulnerable group, others who serve as domestic workers, in bonded labour or in pornography too are highly vulnerable and are also at risk of coercive sex. Those who have been bought as the third or fourth wife, often from Baluchistan, are frequent victims of sexual coercion and violation. Sometimes their husbands 'sell' them to brothels, where they undergo similar experiences as the trafficked victims in the sex industry.

Rescue, repatriation and rehabilitation of trafficked victims leaves them vulnerable to HIV/AIDS on other counts. In many cases, families and societies refuse to accept repatriated trafficked girls. Stigmatisation of these girls creates a new form of vulnerability; under such circumstances, some of them have little option but to migrate again to take up their old profession.

2.6 Prevention of HIV Infection Among Migrants: A Review of Existing Programmes, Policies and Interventions

Relevant legislation and policies on labour migration

Till 1982, the Immigration Act, 1922 framed by the British was the only law that related to emigration. In 1982, an Emigration Ordinance was promulgated; today, it is the key regulatory instrument in respect to migration. The Ordinance only allows persons with valid travel documents to emigrate, and only a letter of appointment or a work permit from a foreign employer or an employment or emigration visa from a foreign government counts as valid document. A person who is selected by a foreign employer through an organisation or a recruiting agent recognised by the government under an agreement between two governments too will be allowed to emigrate. Under the Ordinance, the government is authorised to grant licences to individuals and companies who wish to engage in organising recruitments for overseas employment. Illegal emigrations are punishable with imprisonment up to a year and a fine.

In the 1970s, the Bangladesh government had no official policy on women's migration. Bangladeshi women began taking up jobs in West Asia either on their own initiative or on an agency's initiative. However, since the early 1980s successive governments either completely banned migration of all categories of female workers, except professionals, or imposed restrictions on the migration of women under the unskilled and semi-skilled categories. Currently unskilled and semi-skilled women are not permitted to migrate by themselves, only when a male partner accompanies them.

Bangladesh has ratified the International Labour Organization (ILO) instrument, the Migration for Employment Convention, 1949 and the Migrant Workers Supplementary Convention, 1975. It has also signed the 1990 UN International Convention on Protection of Rights of All Migrant Workers and Members of Their Families, but it has not yet ratified it. The 1990 Convention, which came into force in July 2003 (with ratification by 20 countries), ensures full applicability of human rights legislation to all migrants. None of the major labour-receiving countries in West Asia and South East Asia have ratified or acceded to the 1990 UN Convention; only a few of them have ratified some of the ILO Conventions relating to migrant workers.

BMET is in step with the receiving countries' policy that migrants must undergo mandatory HIV tests prior to departure. When providing clearance for departure, BMET checks that such medical tests have been carried out. Once migrants begin their work in the destination country, they are subject to annual medical check-ups, which include HIV tests. If a worker contracts HIV/AIDS in the country of destination, s/her is immediately deported; the host country does not shoulder any responsibility for medical treatment. The Bangladesh government does not have any policy to ensure treatment of the worker concerned if

s/he contracts HIV/AIDS while s/he is in the destination country. That is, the 1982 Ordinance does not cover migrants' health rights.

Relevant legislation and policies on cross-border migration

Cross-border movements of people come under the 11 (C) clause of the Passport Act, 1973, under which anyone arrested while crossing borders or staying illegally without a visa is liable to a penalty of Tk 200 (about $3.5) or a few days' imprisonment. Cross-border migrants, once caught in India or Pakistan, are imprisoned under the Foreigners Act or the Alien Act, respectively. When adults are caught with children, they are separated. The adults are imprisoned; the children are sent to safe custody or shelter homes. No legal framework covers cross-border movements and HIV/AIDS.

Relevant legislation and policies on trafficking in women and children

The Ministry of Law has adopted the Repression on Women and Children (Prevention) Act, 2000. The law prohibits kidnapping, trafficking or trading of women for illegal and immoral acts, and provides for death penalty or 20 years' imprisonment for people convicted under the Act. Apart from this, there are the Penal Code, 1860, the Child Act, 1974 and the Prevention of Economic Trafficking Act, 1933. These laws also prohibit detention, abduction, slavery, forced labour, and the coercion of women aged less than 18 years into commercial sex. Human rights organisations point out that when trafficked persons are rescued, they are put into jail with the traffickers, which makes it difficult to ensure their protection. Another problem is that the police, in most instances, file cases under the Passport Act instead of the Repression on Women and Children (Prevention) Act; consequently, the trafficker gets released within a week after paying a Tk 200 penalty, whereas trafficked persons languish in jail for long, without anyone to pay their penalty.

Services available

Most people only have access to the general mass HIV/AIDS prevention campaigns that the Ministry of Health conducts on the electronic and print media through the National AIDS Committee.
a) In the case of overseas contract labour migrants, BMET is the nodal government organisation that processes migration applications, and is the only agency that offers pre-migration briefing on a regular basis (Malik, 2000; Haque, 2002). Currently, it does not disseminate information on HIV/AIDS and STDs and only provides general information on health issues and STDs. Nor is information given out in the printed handbook provided by BMET (BMET, 2002). Private recruiting agencies and medical centres too do not conduct any HIV/AIDS prevention programmes (Islam, 2002). Therefore, people who go abroad for employment do not have access to any information on HIV/AIDS.
b) Cross-border migration is not managed or encouraged by the state. No services are available for those who undertake such migration.
c) The Ministry of Women and Children's Affairs has undertaken a Coordinated Programme to Combat Child Trafficking (CPCCT), under which funds are channelled to NGOs that work to prevent trafficking and provide shelter facilities. However, there is no particular component that covers HIV/AIDS prevention programmes.

Medical services to people living with HIV/AIDS are currently provided by some specialised NGOs in Bangladesh. If a migrant worker is infected, s/he can avail of such services. Some NGOs are active at the grassroots level, even along the borders. Some run programmes on reproductive health care and safe sex that indirectly cover HIV/AIDS prevention measures; some programmes specifically target PLWHA.

2.7 Policy Gaps and Recommendations

Policy gaps

- The 1982 Ordinance does not protect migrant workers' health rights in the destination countries. Although it was ostensibly promulgated to protect migrant workers from all forms of fraudulent and

exploitative practices, the law itself has made migrant workers vulnerable. Under Section 24, a migrant worker is liable to imprisonment if s/he returns home without completing the employment tenure. This is in violation of all norms and rights to refusal to continue to work.

- Laws, rules and regulations pertaining to migrant workers do not address the issue of their protection in any significant way. The 1982 Ordinance, framed at a time when Bangladesh was actively promoting the export of workers, focusses mainly on the procedural and regulatory aspects of migration. While governments have taken a proactive role in promoting male migration by promulgating ordinances and other legislation, the government's actions are geared toward restricting women's out-migration as principal migrants. Such a policy discriminates against women and violates constitutional provisions that guarantee equality of opportunity to men and women. Restrictions on the legal migration of women have not stopped them from migrating; rather, they have made women migrant workers more vulnerable to being trafficked.
- Both government and civil society agencies appear not to consider it important to provide preventive healthcare services to all migrants during the formal migration process. If the government is keen to promote migration as an avenue for foreign exchange earnings, it is important to make migrant workers less vulnerable to HIV/AIDS and ensure their safe migration.
- Currently, recruiting agents play a major role in the contract labour migration process, but take no responsibility for managing the sector. On the government's part, there is no initiative to make the recruiting agents responsible for ensuring safe migration.
- There is a serious lack of co-ordination among different ministries and NGOs working in the area of labour migration. Similarly, there is no co-ordination among states in the region and among donor agencies. This has led to a duplication of programmes and imprudent use of scarce resources; also experiences of good practices are not widely shared, as they should be.
- There are serious gaps in research studies into different aspects of migration and the conditions of migrant workers overseas, including healthcare. Little is known about migrants' social and sexual behaviour in different destination countries.
- Migration within South Asia is a livelihood strategy for the poor. Migration of Bangladeshis to different parts of India has become an area of political concern between the two countries, but migration to Pakistan is not a serious political issue between the two states. There is a major research gap in respect of the magnitude, scale, nature, causes and consequences of cross-border movement. The extent of HIV/AIDS vulnerability of migrants remains unknown.
- Cross-border migration involves different states. However, a joint strategy or plan of action with regard to cross-border mobility is yet to emerge.
- The Bangladesh government is sensitive to the importance of combating trafficking of women and children, and has framed tough legislation on this. However, the implementation of the relevant laws is lax. Besides, since trafficking is also a cross-border phenomenon, South Asian governments must evolve common strategies to combat it.
- Donors have channelled a large amount of resources into conducting research on trafficking. However, the studies available are mostly micro-level analyses and thus far have had only limited success in capturing macro perspectives. Many human rights organisations and service-providing NGOs fail to distinguish between irregular migrants and trafficked persons, which complicates the problem of intervention further.

General recommendations

- Efforts must be directed to situate HIV/AIDS prevention responses in the overall gender and poverty context of the countries of the region that serve as source, transit and destination areas of various types of migrants. A multi-sectoral holistic approach needs to be taken in framing effective policies and actions.
- The agents of change among various sectors must to be identified so as to develop a common

vision and alignment on HIV/AIDS and migration. Opportunities must be created for national agents of change to interact with their counterparts from other countries of the region.

■ The National Planning Commissions play a critical role in the development planning of South Asian countries. The issue of migration, however, does not receive adequate attention in the planning documents. HIV/AIDS and migration issues must be integrated in the planning processes, and the Planning Commissions must be sensitised to the importance of these issues.

■ Comparative research should be undertaken using common research methodologies. Issues that must be addressed for all kinds of migrants are the type and magnitude of behaviour that enhances the HIV vulnerability of people from migration-intense areas of Bangladesh; people living with HIV in Bangladesh, focussing on their lifestyle, socio-economic condition, involvement in behaviour that enhances their vulnerability, the present situation and their perception of their rights; sources of vulnerability of labour migrants in the destination country; living and working conditions, leisure, entertainment and social behaviour of cross-border labour migrants in the destination countries; STD prevalence among irregular migrants; health services available at home and in the destination country for the prevention and treatment of HIV/AIDS and evaluation of the effectiveness of existing HIV prevention projects in Bangladesh; condition of trafficked victims in the sex industry and bonded labour in destination countries; socio-economic and psychological conditions of trafficked persons; the nature of intervention for trafficked persons in the destination countries; psycho-social state of repatriated and/or rehabilitated trafficked victims.

Specific recommendations

Contract labour migrant workers

■ *BMET pre-departure orientation must disseminate information on HIV/AIDS*

BMET's current half-day briefing programme should be replaced with a well-designed pre-departure orientation/training programme. This could be residential in nature and long enough to cover key issues that relate to migrant workers. HIV/AIDS and STDs awareness should be an integral part of the training. Experts should be invited to brief outgoing migrant workers and acquaint them with the consequences of behaviour that renders them vulnerable to infection. Among other things, lectures should cover the concept of 'safe sex' practices and the availability of medical and legal services in the destination countries.

■ *Involve migrant support groups in pre-departure orientation*

BMET alone cannot provide training to all outgoing migrants. Select specialised agencies, NGOs and migrant support groups must be involved to impart pre-departure orientation training. Each of the NGOs and migrant support groups engaged in pre-departure orientation training should conduct the training in four to six places. This way, the training programme will extend to at least 20 different locations covering major migration source areas of the country such as Chittagong, Comilla, Sylhet, Noakhali and Dhaka. Recruiting agents should encourage their client migrant workers to undertake such training from the government or NGO institutions.

■ *Provide pre-departure information in medical centres*

Information tools like leaflets and videos prepared by specialised agencies should be made available at the medical centres involved in the labour migration process. The information should relate to behaviour that enhances vulnerability to infection, the concept of 'safe sex' practices and the availability of medical services in destination countries. The medical centres should disseminate such information tools when outgoing migrant workers visit them for tests. Before conducting tests, the medical centres should inform migrant workers of the tests that they are conducting. Videos may be shown in the waiting rooms.

■ *Involve recruiting agents in pre-departure information dissemination*

Similar tools should be made available to recruiting agents as well. NGOs that produce and disseminate HIV/AIDS information should involve the recruiting

agents in the preparation of such information tools. The agents should be instructed on the advantages they derive by providing such training.

■ *Involve migrant workers' associations in pre-departure information dissemination*

The role of migrant workers' associations in disseminating information on HIV/AIDS and creating awareness is critical. It is important to capitalise on the trust that people have a have in such associations, through outreach programmes developed for people at the grassroots. Outgoing migrant workers may be made members of these associations and returnee migrants may be employed in briefing them on, among other important things, the proliferation and prevention of HIV/AIDS and STDs.

■ *Role of host governments*

Government and international organisations should encourage and support governments of destination countries to enable the sale of condoms and to enable appropriate information campaigns on HIV/AIDS in specific languages. Migrant workers should be helped to develop their own organisations - clubs, associations and unions - through which information can be disseminated.

■ *Role of foreign missions in Bangladesh*

The Foreign Ministry of Bangladesh may consider joining with other countries to provide 'Migrant Resource Centres' in labour-receiving countries. This could provide migrants with a forum to interact, share and solve mutual problems. It could also be the institutional framework through which missions run information campaigns among migrant workers on vulnerabilities to infection, the importance of safe sex practices, and healthcare facilities. Such awareness campaigns could also be conducted through community-based organisations such as mosques and clubs, which could play a positive role in raising awareness and promoting condom use and providing STD treatment to sex workers. The UNDP should extend support to community organisations that provide such services to sex workers.

■ *Receiving-country research*

Situations of vulnerability of labour migrants in destination countries need to be thoroughly researched at the micro level

■ *Cross-border migrant workers, trafficked women and children*

Detailed collaborative micro-level field research by South Asian scholars should be undertaken to develop a clear idea of the nature of vulnerabilities of cross-border migrants. International agencies can play a role in facilitating such collaborative research. Moreover, research studies could consider providing special focus to trafficked women and children, including the conditions that lead to trafficking and the situation of trafficked persons in the sex industry and in bonded labour, and their vulnerability to HIV/AIDS.

■ Civil society organisations and researchers in South Asia should work to depoliticise the issue of movement of people within the region. Networks among the South Asian academics and activists should be encouraged to incorporate HIV/AIDS awareness as an integrated part of their programmes.

■ HIV prevention programmes within countries must take into consideration the needs of trans-border labour migrants. Traditional mass awareness programmes on the prevention of HIV/AIDS in the destination countries may not be easily accessible to migrants due to language barriers. Programmes should be designed with such considerations in mind.

■ International and inter-governmental bodies such as the South Asian Association for Regional Co-operation (SAARC) and the UN system should support NGOs and trade unions that provide services to migrant workers.

2.8 List of Resources

Government of Bangladesh

Ministries: The Ministry of Expatriates' Welfare and Overseas Employment is the line ministry that oversees migration. It is vested with the power to implement the rules framed in 2002 under the Emigration Ordinance, 1982, and to promote, monitor and regulate the migration sector. The

Ministry of Home Affairs, the Ministry of Foreign Affairs and the Ministry of Civil Aviation and Tourism are the other important related ministries. Bangladesh missions abroad currently carry on the following functions in respect of labour export: (a) explore potential labour markets; (b) attest documents pertaining to recruitment; (c) provide consular services to Bangladeshi workers; and (d) ensure the welfare of migrant workers. The Ministry of Finance and Bangladesh Bank play a major role in the management of the migrant workers' remittances.

The Ministry of Law and the Department of Women's Affairs in the Ministry of Women and Children Affairs have taken strong measures to combat trafficking. The Law Ministry enacted the Repression on Women and Children (Prevention) Act, 2000. The Department of Women's Affairs has undertaken a 'combat trafficking' project, under which a large number of NGOs are involved in an awareness campaign and the rescue and rehabilitation of trafficked persons. Its current phase started in 2002 and will end in 2007. However, these programmes are yet to integrate HIV/AIDS awareness and medical assistance.

The Ministry of Health and Family Welfare (MOHFW), the supreme executive body that coordinates healthcare responses, has taken up strategies to prevent the proliferation of HIV/AIDS through the National AIDS/STD Programme (NASP). This programme provides migrant workers in Dhaka, Belkuchi and Sirajganj with information on HIV/AIDS/STDs, safe sex practices and STD prevention by promoting STD referral and condom use.

BMET: Bureau of Manpower, Employment and Training (BMET) is the executing agency of the Ministry of Expatriates' Welfare and Overseas Employment, which processes labour migration. It was created in 1976 by the government to protect the interests of labour export. It is also the agency that overseas the implementation of provisions of the Emigration Ordinance, 1982. Currently, BMET is involved in the control and regulation of recruiting agents, collection and analysis of labour market information, registration of job seekers for local and foreign employment, development and implementation of training programmes in the light of specific labour needs both in the national and the international labour market, implementation of apprentice and in-plant programmes in the existing industries, organising pre-departure briefing sessions, and resolving legal disputes.

National AIDS Committee: The National AIDS Committee (NAC) is the national advisory body that provides advice on all matters related to HIV/AIDS; it is a government body, but has representatives from NGOs and civil society.

Technical Committee: The Technical Committee is the technical arm of the NAC, and is made up leading experts from various sectors - health, media, education, demography and NGOs.

National Integrated Work Plan on HIV/AIDS 2002: The Work Plan for the period 2002-2006 was developed through an initiative by MOHFW-NASP and UNAIDS, with consultation and strategic review by all the development partners concerned, including the UN, bilateral agencies, the ministries involved, and civil society.

Private recruiting agencies

Since 1980, agencies have recruited people for overseas employment under licence from the government. The agencies collect information on demands and orders for foreign employment, recruit workers to match the requirements of the foreign employers, and then process their cases for emigration. Till 2002, 45 per cent of the total number of labour migrants went through such agencies. Over time, the recruiting agencies have become organised and formed the Bangladesh Association of International Recruiting Agencies (BAIRA). In 2002, the association had a membership of around 700 agencies.

BOESL

In 1984, the government set up the Bangladesh Overseas Employment Services Limited (BOESL) as a limited company to take up the role of direct recruitment. From its inception till February 1999, BOESL had recruited 8,900 workers, which

accounts for 0.31 per cent of the total number of those who went overseas though official channels. A thorough evaluation of this institution needs to be done to assess its strengths and weaknesses.

Civil society organisations

Although Bangladesh is a major labour-sending country, civil society institutions have not been involved in any major way in providing services and protecting the rights of migrant workers. Over the last few years, some human rights organisations and research bodies have initiated some activities that focus on labour migration. The Christian Commission for Development in Bangladesh (CCDB) was involved in a collaborative project with the Kuala Lumpur-based Caram Asia on HIV AIDS and mobility. SHISUK represents the Bangladesh chapter of Caram and has developed an association of migrant workers. Currently, SHISUK is involved in providing pre-departure orientation for Bangladeshi migrant workers going to Malaysia. The Ain-O-Shalish Kendra (ASK), the Bangladesh Legal Aid and Services Trust (BLAST) and the Bangladesh Society for Enforcement of Human Rights (BSEHR) provide legal aid to migrant workers who were cheated by recruiting agents.

A section of returnee migrants have formed their own organisations, and over the past few years, three such organisations have emerged. The Welfare Association of the Bangladeshi Repatriated Employees (WARBE) has been involved in organising returnee migrants since 1997. It acts as a pressure group for promoting and protecting the rights of migrant workers. The Bangladesh Migrant Centre (BMC) focusses its activities on returnees from Korea and the Bangladeshi Women Migrants' Association (BWMA) campaigns for the ban on women migrants to be lifted.

The international migration issue has drawn limited attention from researchers in Bangladesh. Researchers at the Bangladesh Institute of Development Studies have worked on some aspects of labour migration (Mahmood, 1994, 1996, 1998; Afsar et al., 2000; Murshid, 2000). The Bangladesh Unnoyon Parishad (BUP) has undertaken a study on the utilisation of remittances in the district of Sylhet (Ahmad and Zohora, 1997). The Dhaka University-based Refugee and Migratory Movements Research Unit (RMMRU) specialises in migration research; it has also conducted two advocacy campaigns relating to labour migration - one to get the ban on less skilled female migration lifted, and the other for ratification for the 1990 UN Convention on the Rights of All Migrant Workers and Their Families. In addition, the RMMRU has developed two training modules on migration: one for young academics and professionals on 'Social Science Research and Migration' and the other for information dissemination on 'Labour Migration Process through Community Leaders and Activists'.

A number of national and local NGOs are currently working to prevent the trafficking in women and children from Bangladesh. Some of the leading NGOs involved in different aspects of trafficking are: Ain-O-Shalish Kendra (ASK), Association for Community Development (ACD), BNWLA, Centre for Women and Children Studies (CWCS), Dhaka Ahsania Mission (DAM), Rights Jessore, RMMRU and UBINIG. A number of local NGOs - including ACD, CCDB, Rights Jessore - have undertaken anti-trafficking awareness campaign programmes in the border areas. Research organisations such as RMMRU and CWCS support such programmes with their research. BNWLA, DAM and ACD have shelter homes and work to repatriate and rehabilitate trafficking victims. BNWLA and ACD also provide legal assistance to victims of trafficking. ATSEC is a network of NGOs working on the prevention of trafficking of women and children.

The CARE-Shakti project, which is supported by the Department for International Development (DFID) (UK), has been implemented by CARE and six partner organisations since July 1995. It provides effective clinic service with the aim of preventing HIV/AIDS among three target groups - intravenous drug users, sex workers and MSMs in Dhaka and other major towns in Bangladesh. The National STD/AIDS Network is a forum of NGOs working since 1992 on different aspects of HIV/AIDS in

Bangladesh. It assists in policy formulation, analysis and advocacy. HASAB, supported by international organisations, extends support to NGOs and other community-based organisations that respond to HIV/AIDS issues. It is also involved in advocacy and behaviour change communication, and research and documentation on the issue. The Social Marketing Company, with support from USAID and DFID, has been involved in a client service programme that makes condoms available to its clients in brothels and slums through its 300,000 sales outlets.

Multilateral bodies

Until recently, not many international agencies had a migration component to their programmes in Bangladesh, although quite a few multilateral bodies are addressing HIV/AIDS prevention. Among the UN bodies and affiliates, the ILO and the IOM are the two that have mandates on migration. Over the years, ILO has commissioned two important migration-related studies in Bangladesh - the 'International Labour Migration from Bangladesh and the Trade Unions' and 'Migrant Workers Remittances and Micro Finance in Bangladesh'. Since 1999, when the IOM regional office was established in Dhaka, it has taken up different migration-related initiatives. IOM, Geneva and UN-INSTRAW jointly commissioned a study on the temporary labour migration of women from Bangladesh. In collaboration with UNDP, IOM commissioned and published five studies covering various aspects of migration. It provides support to migrant workers' associations to hold rallies and programmes during events such as the International Migrant Workers' Day. Currently, it has undertaken a project for capacity-building of the Ministry of Expatriates' Welfare and Overseas' Employment. UNDP is also involved in migration issues. It supported IOM with five studies, and had them translated into Bangla and published in both English and Bangla. Recently the Asian Development Bank carried out exploratory work on trafficking issues. So far, the World Bank has not undertaken any migration-related initiative. USAID made a major contribution to combating trafficking. However, like many others, it is yet to undertake any programme on labour migration or long-term migration. The Policy Division of the DFID, UK, recently commissioned five country studies in Asia, including Bangladesh, and organised a regional conference in Dhaka in June 2003, in which 80 experts from across the world participated.

UNAIDS of Bangladesh is the pivotal institution that spearheads HIV/AIDS responses. UNAIDS is co-sponsored by UNICEF, UNDP, UNFPA, UNESCO, WHO, World Bank, UNDCP and ILO. The heads of these eight agencies are represented on the UN Theme Group of HIV/AIDS in Bangladesh. UNAIDS provides assistance to different government and non-government organisations working on HIV/AIDS. The following table summarises the situation in Bangladesh and highlights the most vulnerable groups.

Table 2.3 Summary of Vulnerable Groups, Responses and Recommendations

Vulnerable Groups	Current Situation	Responses	Recommendations
A majority of the trafficked women are forced to work in the sex industry in India and Pakistan, and are extremely vulnerable.	IOM data suggests an average of 50 women and children are being trafficked from Bangladesh every day.	The Department of Women's Affairs in the Ministry of Women and Children Affairs has taken strong measures to prevent trafficking; including the enactment of the Repression on Women and Children (Prevention) Act, 2000. A large number of NGOs are involved in an awareness campaign and the rescue and rehabilitation of trafficked persons. However, programmes are yet to be integrated into HIV/AIDS awareness and medical assistance. Trafficked persons living with HIV can avail themselves of services through HASAB and STD/AIDS Network.	Community-based organisations in the host countries must be involved to promote condom and STD treatment among sex workers. Research should be conducted on the condition of trafficked Bangladeshi women in the sex industry in India and Pakistan.
A section of cross-border female migrants who work in the entertainment and sex industry in Mumbai and regularly visit Bangladesh are among the most vulnerable people. Cross-border irregular migrants lack information. A section of the women are disempowered, exploited and abused in domestic service or as wives.	60% of all sex workers in Mumbai live with HIV. Corresponding figures in respect of Bangladeshi sex workers are unavailable. Those who work as domestic workers and bonded labourersand those who work as guards or gardeners do not have access to any targeted intervention.	Some social workers provide information in brothels in India. The Bangladeshi government discourages irregular migration. It does not recognise such migrants; government services are unavailable to them.	An extensive awareness campaign on the risk of HIV/AIDS should be undertaken through NGOs in the border areas of Bangladesh. Research should be conducted on the sex behaviour of cross-border labour migrants, particularly in receiving countries.
The epistemological situation in West Asia does not put contract labour migrants at high risk of infection, but they are vulnerable due to lack of knowledge of HIV/AIDS and of safe sex practices.	Inadequate number of services/policies/Programmes. Labour-receiving states do not take any responsibility when a migrant worker is found to be HIV-positive. The Bangladesh government does not have any follow-up programme for returnee migrants.	The government does not provide any HIV/AIDS-related services to migrant workers at any stage: pre-departure phase, during the period of overseas employement or after their return.	Provide access to health services offshore. Implement innovative HIV/AIDS awareness campaigns. Develop resource centres offshore. Ensure coordination between IOs, NGOs and the government Research should be conducted into the sex behaviour of labour migrants.

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CHAPTER 3

PEOPLE'S REPUBLIC OF CHINA

Zheng Zhenzhen[1] and Ren Qiang[2]

3.1Background and Method

China is a large country with diversified characteristics, but the focus of this report is largely on Inner Mongolia, Liaoning, Jilin and Heilongjiang, as these are relatively lesser explored areas and significant from an inter-country migration perspective. These areas will be referred to as the 'study area' throughout the report. The geographic location of the area is marked in Figure 3.1 along with Mongolia, the Democratic People's Republic of Korea (DPRK) and the Republic of Korea

Figure 3.1 The Study Area in North East China

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(ROK), which form part of the cross-border migration scenario.

According to China's 2000 Census the total population of the mainland is 1.24 billion: that's 2.13 times that of the 1953 census, which reflects an annual growth rate of 1.62 per cent. The population of the study area in 2000 accounted for 10.3 per cent of the national total. From the 1950s to the middle of the 1960s, the annual growth rate for the population in the study area was the highest nationally, especially in Inner Mongolia and Heilongjiang, due to relocation and immigration facilitated by the government. However, Table 3.1 shows that since the 1990s the annual growth rate in this area was the lowest in China. This is because the economy lagged behind that of other areas and for this reason, many people moved to the eastern part of China, especially the South East.

The Chinese Han make up the single largest ethnic group in China: their population, 1.16 billion, accounts for 91.59 per cent of the total population. That apart, there are 56 minority ethnic groups in the country. In the study area, Chinese Hans account for 87.7 per cent of the total population; Mongolians, Mans, Koreans and Xibos are the principal minority ethnic groups here. Mongolians mainly live in Inner Mongolia; Mans and Koreans mainly live in Jilin.

The major information sources for this report were existing literature and tabulations from the 2000 Census. Important information also came from individual interviews with key informants and personal communication with experts in relevant areas. The research was based in Beijing, where most of the national information collection and literature review was done. Dr Zheng Zhenzhen undertook a field trip to Harbin to collect information on Heilongjiang, and a report by Zhang Kaining reviewed the Yunnan experience on intervention activity among the mobile populations in the South West border area during the past few years. They contributed information for two case studies in the report.

Given the fact that few studies have focussed on the study area and even fewer projects have been carried out there (comparatively, a lot more work is being done in the South East and South West parts

Table 3.1 The Population and Annual Growth Rates

Area	2000 Population (10,000)	Annual Growth Rate Between Censuses (%)				
		1953-1964	1964-1982	1982-1990	1990-2000	1953-2000
National total	124,261	1.57	2.10	1.50	0.95	1.62
Study area	12,818	3.56	2.16	1.15	0.59	1.98
Inner Mongolia	2,332	4.84	2.51	1.35	0.83	2.49
Liaoning	4,182	2.49	1.58	1.25	0.58	1.52
Jilin	2,680	3.02	2.05	1.12	0.84	1.86
Heilongjiang	3,624	4.90	2.73	0.94	0.29	2.40
North	12,257	2.01	1.63	1.75	1.14	1.63
East	35,885	1.37	1.94	1.44	0.84	1.49
Centre and South	35,066	1.35	2.17	1.64	1.25	1.69
South West	19,309	0.67	2.36	1.19	0.77	1.42
North West	8,926	2.05	2.44	1.73	1.16	1.95

Note: North includes Beijing, Tianjin, Hebei, Shanxi; East includes Shanghai, Jiangsu, Zhejiang, Anhui, Fujian, Jiangxi and Shandong; Centre and South include Henan, Hubei, Hunan, Guangdong, Guangxi and Hainan; South West includes Chongqing, Sichuan, Guizhou, Yunnan and Xizang; North West includes Shaanxi, Gansu, Qinghai, Ningxia and Xinjiang.
Source: Various censuses, State Population Census Office.

Table 3.2 Ethnic Groups in the Study Area, 2000 (%)

Area	Han	Mongolian	Hui	Korean	Man	Others
Study area	87.69	3.89	0.56	1.40	2.40	4.06
Inner Mongolia	79.20	17.15	0.90	0.09	2.14	0.52
Liaoning	83.96	1.60	0.62	0.57	1.29	11.96
Jilin	90.86	0.63	0.49	4.29	3.69	0.04
Heilongjiang	95.12	0.39	0.33	1.08	2.87	0.21

Source: 2000 Census of Population and Housing, State Population Census Office

of China), the difficulty in gathering information on this area was expected. Furthermore, information about cross-border activity is scarce, as is information on the living and working conditions of migrant groups of people. The 'illegal' status accorded to sex work and irregular migration made it more difficult to gain a better understanding of the populations involved. Therefore, the information summarised in this report is far from exhaustive. To have a clearer and more detailed picture of the mobile populations in the study area, further specific exploratory research will need to be done.

3.2 HIV/AIDS Situation in China

According to the Ministry of Health, till the end of 2002 the reported number of HIV-positive cases nationwide was 40,560. Up to the end of 2002, there were 2,639 people living with AIDS and a total of 1,047 AIDS-related deaths. A news release issued on 6 November 2003 puts out the latest official estimates: 840,000 people living with HIV, of whom 80,000 are living with AIDS[3]. Keeping in mind the limited coverage of the surveillance system, one can reasonably extrapolate from these figures and estimate that currently about one million persons in China are living with HIV. The reported number of infections has increased each year, and there is a possibility that the epidemic will spread into the general population.

Four characteristics define the HIV/AIDS epidemic in China:

1.HIV-positive cases are found mainly in rural areas;
2. Intravenous drug use is believed to be the major cause of infection;
3. Men account for 75 per cent of the people living with HIV;
4. More than 80 per cent of infections occur in people between the ages of 20-39 years.

According to available statistics, the major causes of HIV infection are intravenous drug use (68 per cent), blood donation through contaminated instrument (9.75 per cent), sexual contact (7.25 per cent), blood transfusion (1.5 per cent) and mother-to-child transmission (0.25 per cent). Prior to 1995, HIV infection among drug users was reported in just one province, but by 2002 it had spread to all 31 provinces/autonomous regions/municipalities. Drug use is clearly on the rise in China. About 901,000 drug use cases were recorded in 2001; an estimated 450,000 incidents of intravenous drug use happen every day in China. It is believed that drug use will continue to be the major cause of HIV infection in China. According to experts, infection through blood donation has largely been controlled and the probability of further spread has been minimised. Meanwhile, infections among sex workers have increased drastically in the past few years and will become a major challenge in the future. The HIV/AIDS epidemic has also spread among men who have sex with men (MSM) and it is almost inevitable that the general population will be affected too.

The above characteristics of the epidemic focus attention on one sub-population in particular: informal internal migrants or the 'floating population'. They are mostly from rural areas, they

3 Information source: China HIV/AIDS Information Network, www.chain.net.cn

are young, they usually travel without their families and two-thirds of them are men. They are a group of people who are often excluded by the community at their destination and treated as 'outsiders'.

Furthermore, given the unequal pace of development in different regions, cross-border activity has been increasing dramatically between China and its neighbouring countries. This mobility across provincial and national borders has given rise to the risk of HIV/AIDS infection spreading. In order to reduce mobility-related HIV vulnerabilities, this report will review existing knowledge about mobility, both within and across the borders of China, and identify gaps in knowledge and possible areas for action.

To serve the purpose of this report better, internal and international migration will be discussed separately. This profile, will mainly draw on the findings of the 2000 Census of China. A lengthy form was used to collect detailed information and this is the source for much of the information about migration.

3.3 Internal Migration

Until the 1980s China imposed restrictions on migration, especially movement between urban and rural areas. Currently, China has a large flow of internal migrants and a comparatively smaller, yet substantial flow of international migrants.

Numbers and migration routes

Since the1980s migration in China has been characterised by three main features:

1. Migration from rural to urban areas- Rural areas account for more than 70 per cent of the population of China. There are great disparities between the rural and the urban areas in their social welfare status and availability of benefits. An estimated 100 million migrants annually move from rural to urban areas;
2. Migration from western China to the East because of better job opportunities and higher incomes;
3. Several of the biggest cities such as Beijing, Shanghai and Guangzhou absorb many migrants from all over the country.

The strict government control of migration in China, especially rural-to-urban migration, has been relaxed gradually since 1978, freeing rural people to start businesses and to work in towns. This 'floating population' - migrants in cities who do not have urban household registration - is now estimated to be about 150 million.

China's 2000 Census indicates that most migrants movements occur over a short distance, that is intra-provincial: 73.3 per cent of migrants made an intra-provincial move (Table 3.3). But given the geographic spread of China, even an intra-provincial move may involve vast distances. The highest proportion of inter-provincial migration (35.9 per cent) was among those moving to central and southern China. Within the study area, the proportion of intra-provincial moves is much higher than the national average. The proportion of inter-provincial migrants is very low in four of the provinces, especially in Heilongjiang. The total number of migrants in the East, Central and South China account for 67 per cent of the total migrants in China; those in the study area account for only 11 per cent.

According to China's 2000 Census, the provinces/municipalities with the most out-migrants are Sichuan, Chongqing and Hunan, which accounted for 27.8 per cent of the total migrant population between 1990 and 2000. Henan, Hubei, Anhui, Jiangxi, and Guangxi are next in line; the number of out-migrants from these provinces/municipalities account for 21.1 per cent of the total. Migrants from Heilongjiang, Fujian, Guizhou, Jiangsu, Shandong and Shaanxi account for 18.1 per cent; the other provinces account for the remaining 33 per cent.

There are three main destinations for internal migrants in China:

1. Guangdong (mainly Pearl River Delta area);
2. Shanghai, Zhejiang and Jiangsu, an area that's also called the lower Yangtze Region;
3. Beijing

Guangdong province received 35.1 per cent of all migrants, chiefly from Hunan, Sichuan, Chongqing, Guangxi, Jiangxi and Henan. The economic centres of Shanghai, Jiangsu and

Table 3.3 Population by Current Residence and Place of Emigration, 1996-2000

2000 Residence	Inter-provincial	Intra-provincial	No. of migrants (10 thousands)
National	26.67	73.33	13,122
Study area	13.00	87.00	1,432
Inner Mongolia	11.99	88.01	311
Liaoning	16.53	83.47	500
Jilin	11.21	88.79	256
Heilongjiang	9.39	90.61	365
North	28.05	71.95	1,347
East	26.16	73.84	4,039
Centre and South	35.88	64.12	3,952
South West	16.40	83.60	1,507
North West	25.63	74.37	846

Source: 2000 Census of Population and Housing, State Population Census Office.

Zhejiang received 21.1 per cent of the migrants, mainly from Anhui, Sichuan, Chongqing, Henan, Guizhou and Jiangxi. Beijing received about 5 per cent of the migrants, mainly from Hebei, Heilongjiang, Henan, Sichuan, Chongqing, Hubei, Anhui and Shandong. In addition, Xinjiang, a new developing area, absorbed migrants from Sichuan, Henan and Gansu.

In-depth information on migration in the study area is scarce. But the 2000 Census gives a picture of the distribution of in-migrants in the area. Table 3.4 gives a profile of the size of in-migrant flow during 1996-2000. Provincial capitals, industrial or trading centres and border cities have a larger proportion of residents whose household registration is either in a different province or in another city or rural area of the same province.

According to the 2000 Census, migrants in the study area were, on an average, older than migrants elsewhere in China. As Table 3.5 shows, 16.6 per cent of migrants in the study area were aged over 45; the national average among migrants in this age group was 12.05 per cent. The proportion of men and women in the 15-24 age group among migrants in the study area was smaller than the national average among migrants.

Among five-year migrants, figures show considerable differences in the sex ratio, defined as the number of men per 100 women. For the 15-19 to 25-29 age groups, the number of women migrants across China is higher than the number of men migrants; but there were more male migrants than women in the 30-34 to 60-64 age groups. The age pattern varied a little in the study area. There were more women migrants in the 15-19 to 30-34 and 45-49 to 55-59 age groups, and there were more male migrants only in the 35-39 to 40-44 age group.

Nine possible reasons for migration are cited in the 2000 Census: labour and business; job relocation; assignment; study; demolition of old housing; marriage; moving with family members; moving after relatives or friends, and others. For ease of understanding, these can be classified into the following five groups:

- labour and business;
- job relocation, assignment and study;
- demolition of old housing;
- marriage and moving with family members;
- moving for relatives or friends and others.

This report will mainly focus on the first group, which is made up of almost all people who move from rural to urban areas to work. Meanwhile, since more and more migrants are travelling with their families, the issues of HIV vulnerability are also

Table 3.4 The Number and Proportion of In-migrants in the Study Area, 1996-2000 (only places where the proportion was close to or more than 50% are listed)

Province		Current Residents	Household Registration Different from Current Residence		
			From the Same Province	From Other Provinces	Proportion of In-migrants (%)
Liaoning	**Total**	6,482,242	1,261,242	1,045,165	35.6
	Dalian	1,311,383	230,065	404,533	48.4
	Panjin	238,968	82,134	44,254	52.9
Jilin	**Total**	2,949,320	635,675	308,605	32.0
	Yanbian	362,648	99,044	76,772	48.5
Heilongjiang	**Total**	3,768,411	1,407,081	386,641	47.6
	Jixi	240,805	88,871	33,141	50.7
	Hegang	143,089	49,399	22,377	50.2
	Shuangyashan	207,575	95,480	29,036	60.0
	Daqing	416,588	253,460	56,439	74.4
	Yichun	123,016	53,235	8,888	50.5
	Qitaihe	199,639	82,832	28,453	55.7
	Mudanjiang	135,437	48,619	20,786	51.2
	Heihe	201,020	85,932	17,400	51.4
	Daxinganling	93,743	55,960	15,207	75.9
Inner Mongolia	**Total**	3,827,825	1,225,488	547,923	46.3
	Huhehote	683,777	304,671	54,442	52.5
	Wuhai	98,460	39,892	26,471	67.4
	Hulunbeier	433,093	109,783	154,857	61.1
	Xilinguole	232,308	121,730	26,859	64.0
	Yikezhao	328,507	110,886	58,825	51.7
	Alashan	48,681	7,680	20,290	57.5

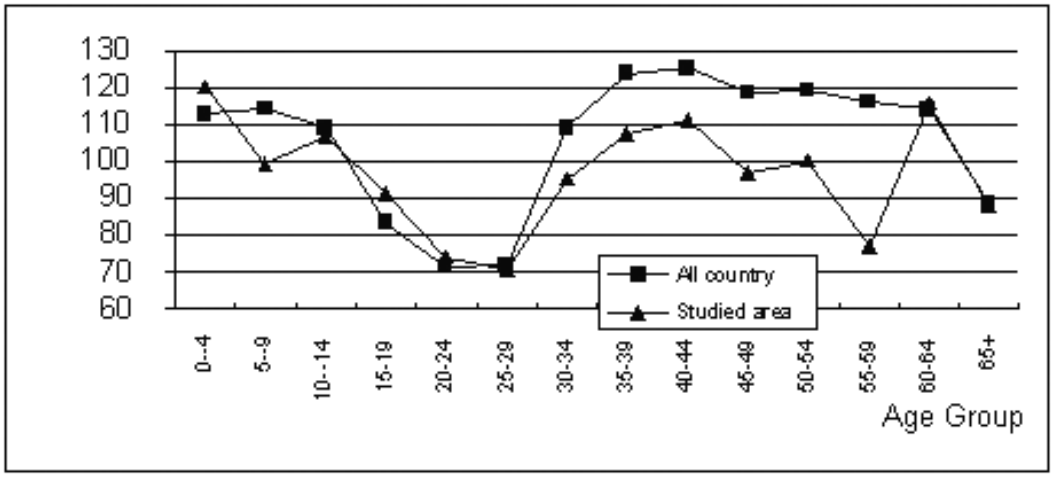
Source: 2000 Census of Population and Housing, State Population Census Office.

Table 3.5 Age Distribution of Migrants, 1996-2000

	National Average			Study Area		
Age group	Male (%)	Female (%)	Total (%)	Male (%)	Female (%)	Total (%)
Under 15	12.15	9.91	10.98	13.85	11.68	12.71
15-24	32.03	38.21	35.26	27.89	30.97	29.51
25-44	42.53	40.96	41.71	41.20	41.15	41.18
45-59	9.27	7.15	8.16	11.46	10.98	11.20
60 and above	4.02	3.77	3.89	5.60	5.22	5.40

Source: 2000 Census of Population and Housing, State Population Census Office.

Figure 3.2 Sex Ratio of Migrants by Age Group, 2000 (National Average and in the Study Area)



closely related to those who follow the migrant workers classified as the fourth and fifth groups.

Across China, the main reason for migration is labour and business, and the second is for marriage and moving with family members. However, in the study area, the major motivation for migration was found to be marriage and moving with family members, and the second was the demolition of old housing. In respect of age distribution, the same pattern emerges as above. Since the questions on migration motivation were answered by in-migrants, the information illustrates the relatively slower economic development in the study area (Table 3.6).

Table 3.6 Migration Motivation by Age, 1996-2000

Age Group	Labour and Business	Job Relocation, Assignment and Study	Demolition of Old Housing	Marriage, Move with Family Members	To Follow Relatives/Friends/Others
China					
<15	0.00	3.41	18.14	57.73	20.72
15-24	30.99	35.07	6.21	20.63	7.09
25-44	39.35	10.50	16.18	25.48	8.49
45-59	22.07	7.75	34.95	15.97	19.26
60+	30.35	19.18	13.99	26.32	10.15
Study area					
<15	0.00	2.43	23.41	53.91	20.25
15-24	13.26	43.42	8.04	26.61	8.67
25-44	20.36	8.01	28.03	30.58	13.02
45-59	16.51	4.75	39.96	16.85	21.94
60+	14.95	17.92	22.59	30.85	13.69

Source: 2000 Census of Population and Housing, State Population Census Office.

Nine possible reasons for migration are cited in the 2000 Census: labour and business; job relocation; assignment; study; demolition of old housing; marriage; moving with family members; moving after relatives or friends, and others. For ease of understanding, these can be classified into the following five groups:

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- moving for relatives or friends and others.

This report will mainly focus on the first group, which is made up of almost all people who move from rural to urban areas to work. Meanwhile, since more and more migrants are travelling with their families, the issues of HIV vulnerability are also closely related to those who follow the migrant workers classified as the fourth and fifth groups.

Across China, the main reason for migration is labour and business, and the second is for marriage and moving with family members. However, in the study area, the major motivation for migration was found to be marriage and moving with family members, and the second was the demolition of old housing. In respect of age distribution, the same pattern emerges as above. Since the questions on migration motivation were answered by in-migrants, the information illustrates the relatively slower economic development in the study area (Table 3.6).

An important aspect of the pattern of internal migration in China is the close relationship that rural migrants have with their home villages. They usually visit their home regularly, such as at Chinese New Year or in busy farming seasons. Most of them do not see the city as their home, partly because of the household registration system and partly because of the current land distribution regulation. Therefore, they usually move in a cyclical pattern and maintain close relationships with family members and relatives at home.

Living and working conditions

It is temporary migrants, not permanent migrants, who face major problems in living and working conditions. China's vast floating population not only endures a standard of living far lower than in the urban sector, they are also denied access to many social welfare benefits and social-mobility opportunities. They usually take up marginal jobs that are characterised by long hours, poor working conditions, low and unstable pay, and no benefits. The floating population and local urban residents participate in two completely different labour markets. For example, the 1990 Census indicated that only 3 per cent of all long-term temporary migrant employees were in professional/cadre/clerical positions, against 24 per cent for urban permanent residents (Yang and Guo, 1996). Some cities introduced local regulations to protect urban residents who are privileged in the city labour markets. Given the enforced labour market divisions, rural persons can only be employed in certain jobs. Although the Central government has asked for these restrictions to be removed, local practices are likely to take a long time to change.

A comparison of occupationwise distribution of migrants within the study area and across China throws up interesting patterns. Across China, most migrants work in the production and transport sectors; the second most popular occupation is trade and services; agricultural work comes third in line. In the study area, the proportions of professionals, government staff and agricultural labourers were higher than the national average (Table 3.7).

There is almost no data at the national level or in the study area to evaluate, in detail, the living conditions of the floating population. The 2000 Census revealed that migrants in urban areas had a poorer living condition than their neighbouring urban permanent residents. For example, they lived in more crowded rooms without a toilet and a kitchen of their own (Zhai and Zhang, 2003). Chinese scholars describe it as a 'marginalised living style' (Cai, 2001).

Wang and Zuo (1999: 277) used the example of Shanghai to understand the living conditions of floating populations:

Table 3.7 Occupation Distribution of Migrants, 1996-2000

Occupational Category	All China (%)	Study Area (%)
Government staff	3.2	5.1
Professional	11.8	15.0
Clerk	7.2	8.2
Trade and service	22.3	23.5
Agricultural laborer	15.9	17.8
Production and transport worker	39.6	30.3
Other	0.1	0.2
Total	**100.0**	**100.0**

Source: 2000 Census of Population and Housing, State Population Census Office.

(*In 1995) Over half of all rural migrant workers in Shanghai live in dormitories (27 per cent), shelters at the work site (7 per cent), the workshop itself (16 per cent), and other temporary facilities (2 per cent). The other half (46 per cent) rent or report that they 'own' housing (2.3 per cent). Among renters, per capita housing space is about half of that of local residents, 8.2 square metres. But for what they get (only about half of the living space of urban residents), they also pay much more than do urban local residents. The mean monthly rent for urban local renters is only 22.5 yuan, about 3 per cent of one employee's monthly income. The mean rent paid by migrant renters is 130 yuan, almost six times that of urban resident renters and 22.5 per cent of a rural migrant laborer's monthly income. Not only do rural migrants pay much more for much less space, what they get is often also inferior housing. Whereas over 60 per cent of local-resident renters have their own kitchen and over 50 per cent have a toilet within the housing unit, among rural-migrant renters, only 12 per cent and 6 per cent have these facilities.*

Migrant workers are usually paid less than their urban counterparts and enjoy fewer benefits. Even in large cities, such as Beijing and Shanghai, the most commonly reported problem in the workplace is overtime work. In addition, there are reports regarding poor working conditions in some industries, such as in footware manufacture, that greatly harm young workers' health. An investigation among migratory workers in the Pearl River Delta found that the greatest number of complaints about their workplace related to noise, ventilation and dust (Research Group of Rural Migratory Women Workers, 2000).

Health risks

Health risks vary greatly among different migrants. The health risks of migrants can be categorised as risks at the workplaces and risks after work in daily life. As mentioned above, the health risks come from poor working conditions as well as workplace injuries, due to the lack of adequate protection measures. The following were found to be some of the health risks outside of the workplace.

1. Unprotected sexual activity: As most rural unmarried youth have little knowledge of sexual and reproductive health and hardly any knowledge about contraception, they frequently go in for unprotected sex. The result of unprotected sex is usually an induced abortion (Zheng et al., 2001); it also increases the risk of infection through intercourse;
2. Poor hygiene in living conditions: This chronically harms the health of migrants and increases the chance of infection. For example, during the Severe Acute Respiratory Syndrome (SARS) crisis, following reports that several SARS cases were diagnosed among workers on a construction site, the Beijing

government directed the construction company to improve the living condition of workers; in this case, dozens of young men were living in a room with poor ventilation. A study reported a high number of respiratory tract infection (RTI) among young women workers in Guangdong, probably due to poor hygiene conditions;

3. Lack of access to urban health services: Migrants don't use urban health services, either because they have inadequate information about the services available (Zheng, 2002) or because they have concerns about the affordability, convenience, and confidentiality of the services. This inhibition sometimes put migrants' life in danger because of delay in the diagnosis and treatment. An investigation among migratory women in the Beijing urban area shows that when they need to see a doctor, most women prefer to go to small community hospitals instead of large hospitals.

Vulnerability to HIV/AIDS

In order to assess the migrants' vulnerability to HIV/AIDS, it is important to give greater attention to those who migrate without their family. Going by the earlier classification of migrants, this would include largely those who work in industry or service sectors. However, the existing corpus of information about them - in particular, their drug use patterns, MSM activities - is extremely limited.

The extent of vulnerability of migrants may hinge critically on the kind of living arrangements they are allowed. Large factories and hotels usually provide dormitories for unmarried employees, with certain management regulations - visitors cannot stay overnight in the dormitory, the gates will be shut at night etc. Given such restrictions, it would be impossible to have out-of-wedlock sex relationship or use drugs in such places. Vulnerability to HIV/AIDS among general migrant population could perhaps be higher among those who are not living with their family or are out of sight of their own society, as well as among those who are self-employed.

Brothel-based sex work is a growing underground business in China. Sex workers don't have access to health facilities since their services are considered 'illegal'; their vulnerability to STD/HIV infection has now become a major issue in prevention campaigns. The most vulnerable sub-population in sex workers was found to be those who migrated from rural areas and who are poorly educated. It is reported that a large proportion of sex workers are rural unmarried girls and the age of this group is becoming younger.

It is not just migrant sex workers who are highly vulnerable to infection. A study in Heilongjinag found that out of 393 women migratory workers in the service sector of several cities, 59.8 per cent had multiple sex partners and only 34.4 per cent of them used condoms (Sun et al., 2002).

Spouses or sex partners of migrants left behind in rural areas must also be given centrality in HIV/AIDS prevention programmes, since they are usually less aware of the health risks but are highly vulnerable to infection. Rural women with STDs were found to have been infected in most cases by their returning migrant husbands (Liu, 2004). Myths also abound among rural women: some of them believe that if they are sexually faithful to their partners, they will not be infected. Such beliefs render the wives of migrant returnees highly vulnerable.

3.4 International Mobility

Most migration in China has until now been internal, but there is an increasing trend towards international migration, including labour contract migration. In 2001, for instance, about 12 million person/times of Chinese mainland citizens went abroad. The destinations (in declining order of proportions): Hong Kong, Macao, Thailand, Japan, Russia, South Korea, America, Singapore, Vietnam, North Korea (Luo, 2003). There are different types of international migrants: (1) professionals/international students; (2) contracted labourers through legal recruiting agencies, who mostly go to Japan, America, Singapore, Korea, Israel, Mauritius, Russia, Germany and the Netherlands; (3) short-term visitors either for business, short-term work or visits to

family; and (4) undocumented migrants: they have not been enumerated but there are an estimated 400,000 a year (Luo, 2003).

There is a paucity of clear and systematic information about short-term and short-distance cross-border mobility. Scattered information could be gleaned from journal articles, mostly about cross-border trading. China has a long history of sending labour forces abroad, mostly from the South coastal area. After the opening up of the economy and the initiation of economic reforms, more young people went abroad from less traditional source areas.

The following patterns were discernible in the cross-border activity in the study area:

1. From Jilin Province (mainly Yanbian) and Heilongjiang Province to ROK and DPRK, Russia, Japan, and Malaysia, for work and trade. Women in Yanbian also migrated to ROK for marriage (Zheng, 1999).
2. From Jilin to Russia, mainly to work in agriculture, about 9,000 person/trips[4] each year (Yang and Yin, 1999).
3. In recent years, short-term cross-border activity for the purpose of trading has been increasingly reported in the border cities of the study area.

Table 3.8 lists the cities with the most frequent cross-border activity. The major source locations, that is, the villages or counties, need to be identified through a mapping process.

The focus of this report is on the highly mobile cross-border traffic associated with trading, visiting relatives and friends or picking up short-term 'unregulated' work. The major interactions covered here are with Mongolia, Russia, DPRK, ROK, Central Asia and South East Asia and returning Chinese contract labour migrants who were working on government-organised offshore contracts.

Cross-border mobility

Most foreigners come to China as tourists, which means they cannot stay for long or work legally. Most cross-border mobility recorded in available Chinese literature relates to trading and tourist travel, involving relatively short periods of stay. Reliable data regarding this mobility are scarce. Age and gender profiles and occupations of the populations are not clear. It is known, generally, that there are more men in these populations. The following information was mainly collected from journal articles, personal communications and other official and unofficial sources.

Table 3.8 Major Ports of Trading or Active Cross-border Activity Along the Border of the Study Area

Province/Autonomy region	City/Port	Related Countries
Inner Mongolia	Erlianhaut, Manzhouli	Mongolia, Russia
Liaoning	Dandong	DPRK, ROK
Jilin	Tumen, Huichun	DPRK, Russia, ROK
Heilongjiang	Heihe	Russia

Mongolia to China

According to the 2000 Mongolian Census, the number of Mongolian citizens in China was 866. They usually have long-term resident status. Most reported cross-border movement from Mongolia to China was undertaken for the purpose of trading. There is a trading zone near the border by the railway and there is a city on each side of the border, Erlianhaut and Zamiin-Uud, that attract merchants from the two countries. Prior to 2000, each year more than 220,000 person/trips were made across the border from Mongolia to China (Aurenqi, 2000); by 2003, the number was probably as high as 300,000. This includes visitors from Mongolia,

4 The data are usually reported by customs officials and only enumerate the number of passes, not the number of people or frequency of trips

Russia and other East European countries (Yang and Tumen, 2003).

Most Mongolian visitors come to China through the trading port in Inner Mongolia to carry on their trading business, and most of them stay for a short time. Since Inner Mongolia has a relatively high population density - about 20 persons per sq. km in 2000 - it is unlikely that Mongolians will find a job easily in this region. According to the Yearbook of China Tourism, the two border cities of Manzhouli and Erlianhaut received 91 per cent of cross-border visitors in Inner Mongolia. Most visitors were from Mongolia; the second largest group was from Russia (China Tourism, 2002).

There is a plan to build a free trading zone around Erlianhaut and Zamiin-Uud, as well as a new Trading Mall in Erlianhaut. This could have the effect of increasing cross-border activity between Inner Mongolia and Mongolia.

Russia to China

Most Russians come to China as tourists, and Heilongjiang is the province that receives most of them: 612,300 person/visits in 2001 (China Tourism, 2002). An estimated 35,400 person/trips were made to single port of entry (Heihe) in 2001, most of them for a one-day tour of Heilongjiang. However, some visitors stayed longer than they were permitted and took on a paid job. For example, there are Russian waitresses in some Harbin restaurants. Since such a stay is illegal, the precise number of those who have stayed on is unknown. Russians are also increasingly travelling to northern provinces other than Heilongjiang - and even as far off as Beijing, Shanxi and Shandong (Wang Binyou at Harbin Medical University).

Democratic People's Republic of Korea (DPRK) to China

Streams of people enter China from DPRK (see Chapter 4) and usually disperse throughout northern China. Since their movement is not formally permitted, the precise numbers of such migrants and the details of where they have settled down are not certain. With increasing trade links between China and DPRK, especially after the establishment of a Free Trading Zone by DPRK, cross-border movement has picked up even more. DPRK has started to build a new economic zone close to the border of China near Dandong City, which could lead to more cross-border activity in the future. China is currently developing the Tumen Region to encourage trading; again, this could lead to more cross-border activity with DPRK and with Russia.

Central Asia to China

Frequent cross-border activity is known to happen in border areas and the trading posts of Xinjiang, and there is a large stream of mobile people. However, there is no reliable detailed information on this. Xinjiang has allegedly become a major drug trafficking route that bridges the Golden Triangle and Central Asia. There are groups of drug dealers and users along the route who need to be reached by HIV/AIDS prevention responses.

South East Asia and South Asia to China

Yunnan is the centre of active cross-border trading and tourism activity with neighbouring countries. Residents from both sides cross the border for one to three days, to visit friends and relatives or finalise business trades. However, in recent years, more people are crossing the border from Myanmar, Vietnam and Laos to China and staying longer to work. Many young people from Yunnan went to Myanmar to build a freeway there during the dry season.

Other border cities and ports too have experienced frequent cross-border activity in recent years. For example, Hekou County in Yunnan, a port to Vietnam, receives 15,000 in-migrants, including 3,000 international in-migrants who stay longer than three months in Hekou. Most of them are women working in the trading, tourism and service sectors. A daily fleet of 49 scheduled buses and trains ferry a stream of 15,000 to 20,000 people through the port.

In recent years, countries in the Mekong Region have announced plans for joint economic and tourism development activity; this has speeded up

communication channels between the countries. There are plans for a new highway that will connect Kunming (capital of Yunnan Province) and Bangkok (Thailand); it too is expected to spur cross-border travel.

Vulnerability to HIV/AIDS

Informal and short-term cross-border movement is expected to increase in most areas, given the fast economic development of border provinces and cities, local policies that encourage cross-border trading and the construction of new roads across borders. Young women from other countries - from Vietnam along the Yunnan border, and from Russia, Japan, ROK and DPRK - are now sex workers in northern China. As a group, they tend to keep out of reach of the government. The increase in the number of sex workers around these areas is linked to the surge in economic activity and the enhanced level of mobility this triggers. This factor needs serious consideration when devising HIV responses.

Returned international contract labour migrants

International contract labour migration from China started in the late 1970s, with the opening up of the economy, and has surged in recent years. During 1995-99, there were twice as many international contract labour migrants as there were during 1990-1994 (Iredale et al., 2003). The growth in the number of migrants to European and other Asian countries is striking.

There are two major forms of overseas employment migration through the Bureau of Public Security: flows that are government-organised and sponsored - 'project engineering' and 'international labour cooperation' - and 'overseas employment of individuals' (Zhang, 2001: 127). The phrase 'project engineering' reflects the process of contracting and implementing engineering projects abroad for foreign governments, institutions, enterprises and individual employers, on the basis of international competitive bidding. From January to August 2000, new contracts to the value of $72.23 million were acquired. The term 'international labour cooperation' refers to the export of labourers abroad for economic, social and science/tech activities under contracts with foreign governments, institutions, enterprises, and individuals employers, with the intent to earn remittances. According to Zhang (2001: 129), this has been on for around 20 years, and between January and August 2000, new contracts to the value of $19.55 million were acquired for this work.

However, there isn't much by way of information about international migrants, only that contract labourers are offered some pre-job training and they are usually taken care of by the recruiting agencies. Little research has been done to get a better understanding of their lives abroad. Some scholars are opening up an area of study by interviewing returnee international migrants in southern coastal provinces (information based on communication with Han Jialing, a researcher from the Beijing Academy of Social Sciences).

These government-sponsored and managed schemes still face a range of challenges. According to Zhang (2001: 129-30), the main ones are:

- export of labour is not considered as important as trade, and so legislation and system to manage these projects are inadequate;
- the available labour export channels cannot quite meet the demand for people and so 'undocumented' migration grows;
- workers find it difficult to adapt to situations abroad;
- needs and interests of labourers are not protected effectively.

'Overseas employment of individuals', on the other hand, refers to individual movements that are managed by employment service agencies. This used to operate only on a small scale, but is now developing rapidly. By the end of 1999, over 70,000 labourers were employed abroad under these arrangements; 10,000 more were added in 2000. The destination countries are across the world, in Asia, Africa, Europe and America, and much of the labour needs are in the agriculture, garment, housing and catering service sectors (Zhang, 2001: 130). The main responsibility for handling these

workers rests with the overseas employment service agencies, of which there were 46 by the end of 2000. These agencies serve many functions: they provide labour market information, job recommendation and recruitment; sign employment contracts; provide technology and language training; assist with social insurance; and protect labour rights through mediation and legal action (Zhang, 2001: 130). In spite of regulations, such as the Regulation on Management of Overseas Employment Service, which was promulgated on 1 July 2002 (Zhang, 2003), there are numerous infringements of migrant workers' rights, and these are unlikely to end soon, according to Zhang (2001).

Outside of this 'controlled' labour migration, illegal agents or 'snakeheads' manage a large and growing undocumented element. News reports indicate that undocumented migration from China is 'far from spontaneous' (Scalabrini Migration Center, 2000). Human smuggling has been going on for over 20 years; an estimated 100,000 migrants are smuggled out of China every year, bringing in around $1.3 billion for the syndicates that orchestrate the entire process. Preliminary fieldwork by a researcher in Shanghai shows that rural women from villages in the coastal provinces of China were promised jobs in factories in Japan by 'snakeheads'. They teamed up and borrowed money for their travel and other costs and then were taken, via Bangkok, to Japan. Some did not make it past Bangkok and disappeared there; others, on their arrival in Japan, were trafficked and forced to work in the entertainment industry or brothels.

Vulnerability to HIV/AIDS

Instances of HIV/AIDS were reported among returned labour migrants from abroad. Those who go out at a very young age or are single and unaware of the risks of infection are unlikely to protect themselves against infection. Instances of HIV infection were more common among returned labour migrants who used drugs in Yanbian, Jilin (Cui et al., 2002). The ‘pre-departure training’ they are provided and the information they are given does not include any information on HIV vulnerability and related issues.

There is very limited knowledge and related research on the living conditions and health vulnerability of overseas Chinese, whether they are contract labourers or unregistered migrants. This area needs to be studied further so as to secure a better understanding of their status and to enable more effective preventive campaigns among them.

3.5 HIV Infection Prevention Among Migrants: A Review of Existing Programmes, Policies and Interventions

The focus group in this section are migrants, mostly from rural areas, who work in labour and business in cities on low-paid jobs. We also include their spouse and family members who may be travelling with them or who may have stayed back at home.

Services available

HIV infection prevention services can usually be classified under three heads, depending on who is delivering them: services from the government, from civil society organisations and from the private sector.

Governmental service is mainly provided by hospitals and clinics under the Ministry of Health (MOH); they principally provide diagnostic facilities and treatment. Another kind of health service, preventative healthcare service (including health education), is provided by a medicine network run by the Chinese Centre of Disease Control and Prevention (China CDC). Although the network covers almost the whole nation, the level of service provided differs widely across regions. Since the late 1990s, some family planning service facilities run by the National Population and Family Planning Commission (NPFPC) have extended their services to cover HIV infection prevention education and counselling. HIV/AIDS prevention is the main component of the ongoing reproductive

health/family planning (RH/FP) quality of care campaign nationwide. Given that the most vulnerable populations - sex workers and undocumented migrants, for instance - are outside the pale of services offered by the governmental sector, it is obvious that they have their limitation.

Ever since China opened up and institutionalised reforms, non-governmental organisations have spread their wings and registered rapid growth, but most of them are still in the nascent stage. The largest non-governmental organisation, the China Family Planning Association (CFPA), initiated projects in 1998 to implement peer education programmes among young students about HIV/AIDS prevention; it included content on HIV infection prevention (IPPF, 2001). More projects have been developed in recent years, including one in Hunan with rural families of out-migrants, to provide HIV prevention education among young migrants through their family members. The project reached out to more than 400,000 out-migrants in one county. In addition, the Family Planning Association in Shenzhen carries out a 'Life Skills Training and Education' programme among migratory workers in hotels, supermarkets and restaurants. Similar programmes are carried out among migrants in Guangxi and Fujian, according to the China HIV/AIDS Information Network. The Yunnan Health and Development Research Association (formerly Yunnan Reproductive Health Research Association) collaborated with the Family Planning Association, Women's Federation and Red Cross in Yunnan as well as international organisations on several projects that focus on migrant groups. They include information, education and communication (IEC) initiatives and service among low-income women migrants in Kunming City, improved maternal and child health (MCH) service, including HIV/AIDS/STDs prevention in less developed areas of the Mekong Region and a condom marketing project. A pilot initiative was undertaken in a district of Chengdu, Sichuan, to educate sex workers on protection from STD/HIV infection. For a list of civil society organisations that carry out HIV/AIDS prevention programmes in China, please refer to section 3.7.

There are a growing number of international and foreign organisations working on HIV/AIDS prevention programmes; these include UN agencies, governmental organisations and non-governmental organisations. They mostly collaborate with health departments at the provincial or state levels. Most of these intervention programmes are carried out in the West and the South of the country.

Most of the HIV/AIDS prevention services available currently are project-oriented and have not yet been institutionalised. Since most of these projects started in early 2000, it is too early to assess the sustainability of the services.

Up until now, the private sector had little to contribute to HIV/AIDS prevention services; many services do not meet the standards of protocol and some of the private clinics and doctors practice without a licence. However, vulnerable populations prefer to go to private clinics/doctors. But there is little or no private health/medical service specifically targeted at migrants.

There is a lack of both reliable information and comprehensive knowledge about how many of the migrants are intravenous drug user and how many of them are MSM; likewise, there is little information on the services available to them. This is partly because migrants who are drug users or who are MSM are wary of detection. The perception that only a small proportion of the population are IDUs or MSM needs to be validated with empirical evidence. Exploratory studies to assess and understand the problems and help develop appropriate responses are needed.

Relevant policies

The Chinese government made five commitments recently as a response to the HIV/AIDS epidemic nationwide: free treatment for people living with AIDS from rural areas and people residing in urban areas who have economic difficulties; increased coverage of and participation in education; strengthening of the law enforcement in the fight against drug use and smuggling, sex work and illegal blood collection.

The government has initiated a number of legislative and regulatory efforts relating to HIV/AIDS prevention and control measures. There are laws and local regulations about prevention and control of infectious diseases among the ordinary population and at the borders. There are no specific measures that relate to migrants except that authorities have been directed to monitor vulnerable populations, including returned migrants from abroad.

HIV/AIDS has been, and continues to be, a very sensitive issue in China. In 2000, the government initiated a nationwide campaign, mainly through the mass media, to raise awareness about HIV prevention. It had a significant impact. Furthermore, official reports about HIV/AIDS are issued more frequently and directly; this has helped check the spread of HIV infection among the general public. However, some local governments do not reflect the same heightened level of sensitivity to the HIV/AIDS issue.

Most large cities have specific registration and management systems for migrants, but the enforcement of these provisions isn't uniformly diligent. On occasion, it depends on the employment status of the migrants and the kind of jobs they have. For example, those who are without a regular job have no interest in registering themselves, and those who work in 'unregulated' businesses (including sex workers) prefer not to report themselves. Therefore, some migrants in urban areas remain out of the reach of any means of social support, including preventive health services and HIV/AIDS surveillance.

Another issue related to policy is health insurance: the system is still in the process of reform. Insurance covers only a limited population in urban areas, usually residents with regular jobs. The annual costs of HIV/AIDS treatment - clinical costs and in-patient costs - are about 2.6 times and 5.9 times the average income of urban residents, which puts them farther beyond the monetary reach of rural residents. At the height of the SARS crisis in 2003, some rural migrants who had been admitted to urban hospitals ran away from the hospitals for fear that they would not be able to afford the costs of treatment. In response, the Chinese government offered to absorb the costs of treatment for migrant workers. At that time, the advisability of lowering health insurance premiums for individual clients came up for discussion. But it's unlikely that this will happen soon, given the low priority accorded to migrants-related issues.

Providers' service capability and ability to reach out

The health and medical system in China has an admirable record in the areas of diagnosis and treatment, but the preventive aspect needs to be strengthened. Additionally, the health system does not reach out to sufficient numbers of vulnerable populations. These shortcomings were highlighted during the SARS crisis and some changes have since been introduced to strengthen disease control and prevention efforts. Implementing these changes across China will perhaps need more time, but in the battle against the HIV/AIDS epidemic, time is at a premium.

HIV/AIDS hotlines and online counselling services and interactive website facilities are available in cities. Since most counties, even those in remote border areas, have access to the Internet, this service could cover a variety of populations and a large geographic region.

A multi-sectoral response is gradually taking shape, with the active involvement of the government, civil society organisations and international agencies/stakeholders, as well as some private entities. Civil society organisations have the advantage of flexibility and can reach out even to the very vulnerable populations living on the margins of society. Several pilot projects have demonstrated that non-government organisations at the local level or national level can successfully implement initiatives among vulnerable populations, 'bridge' populations and the general population. Some examples: the HIV/AIDS prevention education programme that involves families of migrants (by CFPA); the promotion of condom use at train stations (by Marie Stopes

China); 100 per cent condom use promotion among sex workers (by WHO); and safe sex education among long-distance truck drivers (by the Beijing Union Medical University). However, there is a compelling need for regular and long-term services in HIV/AIDS prevention.

Two cases that represent two geographic locations and two different phases are presented here for information. Several organisations in Yunnan, both governmental and NGO, have done a great deal of work related to HIV/AIDS prevention; Harbin Medical University has also carried out a pilot project in HIV/AIDS prevention to deal with the special situation in the northern part of China. Both are models that are worthy of replication elsewhere.

Yunnan experiences

Several projects and programmes in the area of HIV/AIDS prevention have been carried out since the late 1990s by various organisations, on occasion working together; those that relate to migrants are introduced briefly here:

- China-UK AIDS Prevention Programme. A five-year programme jointly supported by the Chinese and the UK governments and managed by 10 Ministries and two international organisations. The programme office is located in China CDC. It focusses on vulnerable populations in Yunnan and Sichuan. The project has three aims: to strengthen the ability of public sector agencies to develop a more effective strategy to control AIDS/STDs; to improve vulnerable groups' access to public and non-public information and services, and to protect them from HIV infection; to explore a care model for people suffering from HIV related illnesses.
- STI/HIV Prevention Education and Service among Low-Income Migrant Women in Kunming. This project, a collaboration between the UK government and Yunnan Province, focusses on low-income migrant women, mainly from rural areas, who hold unstable jobs in the city. The intervention strategies are mainly: participatory, with an emphasis on empowering migrant women by inviting them to participate in the project process, including planning, implementation, management, monitoring and assessment; and community-based, to make the service more accessible. The range of services include counselling, training, developing and distributing IEC materials, and related IEC activities. Not only has it raised health awareness levels and added to their knowledge base, it has also ushered in an attitudinal change among the migratory women about the service - from suspicion to trust and willingness to participate.
- Condom Marketing Project. Financially supported by the Futures Group, technically supported by the Program for Appropriate Technology in Health (PATH), and implemented by the Yunnan Health and Development Research Association (YHDRA), this project focusses on condom retailers; specifically, it seeks to improve their capacity to educate their clients about HIV/AIDS prevention, and to expand the retail sale of condoms to non-traditional sites such as small stores so as to make condoms easily accessible, especially for migrants.
- Participatory activity among cross-border youth and children. A community-based participatory project in the areas bordering China, Myanmar and Thailand; it works with cross-border migratory youth and children to reduce their vulnerability. Carried out by Save the Children (UK).

The Yunnan experiences show that collaborative efforts on HIV/AIDS prevention, involving governmental departments, NGOs and international organisations, have met with success.

Exploratory research in Heilongjiang

A research team from the Department of Epidemiology, School of Public Health of Harbin Medical University, carried out an investigation among migrants employed in the service sectors in Harbin, Suihua, Mudanjiang, Daqing and Heihe. A questionnaire survey of 393 women shows that migrant women lack adequate knowledge about HIV/AIDS prevention methods and very seldom use condoms. The team distributed education materials among women workers in the service sector, and developed IEC material in Russian to distribute to tourists and Russian young women working in the service sector (Figure 3.3). The research team also interviewed more than 100 Russian young women

to gauge the extent of their knowledge about HIV/AIDS prevention; the Russian women were more knowledgeable than Chinese migrant women about HIV/AIDS prevention procedures.

The Department has a certified HIV screening lab that is open to the public. Department professors have participated in a training project supported by the China Medical Board, together with six of the most prestigious medical universities in China. They have framed a curriculum for training medical students on HIV/AIDS. Prof. Wang Binyou has also authored sexual health education textbooks for middle school, senior high school and college students.

the age group that is most active socially, economically and sexually. In China, rural migrants who move to urban areas remain at the margins of mainstream society even after years of living in the cities. The lack of information, knowledge and supportive policies makes them a sub-population that is vulnerable to HIV/AIDS infection.

Up until now, there were only a few projects or programmes that specifically targeted migrants. There are hardly any comprehensive investigations into understanding the size, status and potential risk of HIV infection among migrants, especially those who work in 'unregulated' jobs. The needs and preferences of different sub-populations of

Figure 3.3 An AIDS prevention education leaflet in Russian

3.6 Summary, Identification of Gaps in Knowledge, Policies, Services and Recommendations

The mobile population in China is growing in size, and is likely to continue to grow. More information is available on internal migration than on cross-border mobility, which has expanded in recent years. Critically, a significant proportion of the population of migrants or travellers, both within the country and across borders, belongs to migrants are not clear, and there is no great clarity on the kind of services that can meet their needs.

There is at best limited knowledge about the study area - North East China and Inner Mongolia - in respect of cross-border mobility: little is known about the frequency of movement, age, sex, occupation and education structure of the migrants or travellers, travelling status, whether they travel with their family or alone, how long they stay in the destination, how frequently they change places, how good or bad their living and working conditions are, whether they have access to social

support services at their destination, how much they earn, what they do and where they go after work, what kind of health services they use, how much they know of their entitlements and how much of it they access. These and other questions need to be answered before a programme can be designed. A recent study undertaken in Seoul and Busan in ROK by the Korea UNAIDS Information Support Center (KUISC) and supported by the UNDP Regional HIV and Development Porgramme, South and North East Asia analyses some of these issues from the destination perspective. This study conducted among four different migrant groups (Han, Korean Chinese, Mongolians and Bangladeshi migrants) found that Han Chinese are among the least informed migrant groups in matters relating to HIV/AIDS and have a skewed male:female ratio of approx 4:1 (KUISC, 2004: 41)

The recommendations put forward below are based on an analysis of the limited information available. There is a broad consensus that in order to limit the spread of HIV/AIDS in the general population, a relevant service or project should focus on not just the vulnerable populations but also the 'bridge populations' and the community at large. The so-called 'bridge population' are those who may have sexual contact with vulnerable populations (Thompson, 2003).

Recommendations for further research

■ *Improve knowledge about cross-border activity at both the macro and micro level*

The impact of cross-border mobility is felt not only on economies in the origin and the destination area but on the individual's life, development and health, as well as on the populations that s/he has contact with. HIV/AIDS knows no borders. There is therefore an urgent need to undertake collaborated systematic research on the cross-border mobile populations of China.

■ *Carry out further exploratory study, and map areas with a concentration of migrants, including migrant sex workers*

Background/baseline information needs to be collected about cross-border migrants, in potential 'hot spots' such as major ports, source areas and destination areas. The cities listed in Table 3.8 (Erlianhaut, Manzhouli in Inner Mongolia; Dandong in Liaoning; Tumen and Huichun in Jilin; Heihe in Heilongjiang) are appropriate candidates.

■ *Identify local organisations and resources available in the study area*

Most health projects in China, including HIV/AIDS prevention projects, have been carried out in the South of the country; non-governmental organisations seem less active in the study area. There is a need for community-based research to identify local NGOs and other resources available in the northern and western parts of China and evaluate their strengths.

■ *Conduct a reconnaissance study of overseas contract labour migrants*

There is a compelling and urgent need for a risk practice survey of overseas contract workers (OCWs). This would involve sampling from a cross-section of pre-departure and recently returned labour migrants from a range of destination areas.

Recommendations for future outreach programmes in the study area

■ *Outreach programmes should focus not just on vulnerable sub-populations of migrants*

Owing to the clandestine nature of many population movements, migrants are often difficult to identify. Since they are a vulnerable group, they should of course be the focus of some prevention programmes. Yet, it is also necessary to include their workplaces and the communities they live in, in prevention programmes.

■ *Interventions involving internal migrants should tackle source, transit and destination points*

Given the cyclical nature of much of the migration within China, interventions on HIV/AIDS prevention should take place in source, transit and destination areas. This way, a large proportion of migrants and their families can be covered.

■ *Cross-border mobility requires borderless responses*

A regional strategy must be developed to reduce the vulnerability of cross-border migrants to HIV/AIDS. The Greater Mekong Scheme region is

one area from which one may draw ideas that have worked effectively.

■ *Evaluation needs to be built into any programme*
Since mobile population move frequently, the impact evaluation of a programme can be very difficult. Therefore, an appropriate process and outcome evaluation method should be considered when the programme is being designed.

■ *Encourage local governments to become more active in HIV/AIDS prevention and care*
Local governments should be encouraged to formulate progressive public policies aimed at HIV/AIDS prevention among migrants. Their cooperation and commitment to create an enabling policy climate is crucial to the success of any programme.

■ *Enhance level of co-operation between government and civil society*
Both the civil society and the government can complement each others' efforts in prevention of HIV/AIDS by reaching out to people who are otherwise difficult to cover. For these efforts to succeed, the extent and level of co-operation between government and civil society organisations should be strengthened.

■ *Design local programmes to suit the needs of the different areas in northern China*
In a culturally diverse country like China, local traditions, cultures and beliefs differ greatly from one geographic region to another; interventions must, therefore, be carefully developed to suit the local socio-cultural environment. The effort must be to design local programmes, not blindly copy the successful experiences of, say, Yunnan.

■ *The private sector must be involved in future programmes*
In locations where public resources are limited and the populations in focus are difficult to reach, there is a case for bringing in private service providers working on prevention and treatment programes.

■ *Emphasise gender-sensitive components in programmes*
Gender equity and women's empowerment should be given special emphasis at all stages of the process, including design, implementation, and evaluation of the programme. Far too often, women are treated as a problem (such as sex workers) rather than a partner/participants in the solution.

■ *Learn from the experiences of southern China in multi-sector project management*
Programmes that have succeeded elsewhere can be useful role models, even if the specifics of the programme need to be given a local flavour. For instance, the Yunnan experience shows that multi-sector cooperation can make interventions more effective. It reflected a successful collaborative work pattern where government, civil society, the community and international organisations joined together.

Table 3.9 Summary Table of Vulnerable Groups, Responses and Recommendations

Vulnerable Groups	Current Situation	Responses	Recommendations
Young, single migrants who move alone within China Young women migrants working in the service sector Migrant sex workers	Internal migrants are marginalised due to registration system; 100-200 million 'floating population' Increasing number of young people engaging in unprotected sex Growth in underground sex industry - outside the formal sector - often not registered	SARS experience showed importance of providing medical services to migrants; the same model could be used for HIV prevention Australian Red Cross project to distribute condoms in S. China Most IO projects have been short term; outcome not clear. CFPA education projects	Focus intervention programmes on vulnerable sub-populations of migrants as well as their communities Target interventions involving internal migrants at the source, transit and destination areas Cross-border mobility requires borderless responses Build evaluation needs into every programme Encourage local governments to become more active in HIV/AIDS prevention and care Enhance co-operation between civil society and government Design programmes to suit local traditional and cultural characteristics of the different areas in northern China Involve the private sector in future programmes Make programmes gender-sensitive Learn from the experiences of southern China in multi-sector project management
Highly mobile cross-border traders Male contract labour migrants going abroad Women and children who are trafficked abroad	Little information about increasing level of temporary international mobility Government-organised and increasing amount of individual movement Increasing trafficking by gangs to many countries	See SW China examples with highly mobile populations One trial project on pre-migration education for contract labour migrants	Improve extent of knowledge about cross-border activity at both the macro and micro level Carry out exploratory study and map areas with a concentration of migrants and commercial sex workers Identify local organisations and resources available Carry out a reconnaissance study of overseas contract labour migrants

3.7 List of resources

Government

Ministry of Health

The principal functions of the MoH are to manage primary health and maternal & child health, control disease, and make related regulations and protocols. MoH plays a key role in HIV/AIDS prevention, testing and treatment.

Chinese Centre of Disease Control and Prevention

Among the Centre's tasks are assisting the MoH in policy-making, planning, and regulation development regarding HIV/AIDS prevention and treatment responses, providing technical guidance for STD/HIV prevention, and organising training and education programmes.

National Population and Family Planning Commission

STD/HIV/AIDS prevention is a very important component in reproductive health; the NPFPC has placed AIDS prevention on its education programme, which is carried out by the nationwide network. Family planning service station plays a referral role for those who need help.

Ministry of Public Security

Most matters pertaining to migrants come under the MoPS; it has an important role in keeping contact with migrants and their family; it could be a pivotal agency to advance some HIV/AIDS prevention progammes.

Ministry of Agriculture

The MoA is responsible for providing agricultural technical guidance, education, and training. It has a large technical training network, which can reach every village. This network can play a role in educating potential migrants from source areas.

Non-Governmental Organisations

All-China Women's Federation (ACWF)

The largest women's organisation in China watches over the rights and benefits of women and children. It also carried out a programme related to reproductive health and health education in rural and urban areas.

China AIDS Network (CAN)

The network has been actively involved in education and health consultancy of AIDS prevention, including publishing textbooks and education materials.

China Family Planning Association

CFPA has carried out health promotion/education projects nationwide, among various sub-populations, such as migrant workers, young adults and students. Its activities include HIV/AIDS prevention education/publicity, and condom use promotion.

China Foundation for the Prevention of STDs and AIDS

The Foundation supports STD/HIV-related research, education, and projects to establish public services.

China Population Information and Research Centre

As a key centre of population and social statistics collection and publication, the Centre offers policy-related consultancy and research. It is also involved in the national programme for family planning/reproductive health and quality of care.

Maple Women's Psychological Counselling Centre

The Centre provides health education to different groups of women, and has been invited to provide training to trainers of international projects. Its women's hotlines have a long history and a wide range of clients.

National Research Institute for Family Planning

With a national training centre and a reproductive health clinic, the Institute provides reproductive health education and counselling services as well as STD diagnosis and treatment facilities.

China Centre for Reproductive Health Technical Instruction and Training

Located in Shanghai, the Centre carries out training of trainers, reproductive health counselling, RTI/STD prevention/diagnosis/treatment and provide technical guidance to reproductive health service stations.

Shanghai Institute of Planned Parenthood Research (SIPPR)

Also located in Shanghai, the Institute is a major resource of research in reproductive health, with equally strong competence in medical biology, basic research, epidemiology and social medicine.

Yunnan Health and Development Research Association

Run by a group of professionals with medical and social science backgrounds, health practitioners and government officials, the Association carries out reproductive health research, and intervention and evaluation programmes. It works with people in less developed rural areas and with minorities, and has successfully carried out national, international, and local projects related to reproductive health and rural development.

Universities in the study area

The universities in the study area could play a role of research resource, their capacity still need to be assessed.

International Non-Governmental Organisations

China-UK AIDS

The HIV/AIDS Prevention and Care Project funded by the UK Department for International Development has been designed to help China in its efforts to address the HIV epidemic. The project's purpose is to develop replicable models of HIV prevention, treatment and care in two pilot provinces for vulnerable groups in order to inform and develop the national policy framework.

Ford Foundation (US)

The Foundation has supported several projects/programmes related to sexual and reproductive health, HIV/AIDS prevention, and care of people who live with HIV/AIDS in China.

World Vision

The organisation has implemented projects in Guangxi on HIV/AIDS awareness and capacity-building, as well as health education programmes in cooperation with the Guangxi health department.

Marie Stopes International

The organisation has carried out AIDS prevention/education projects among migrants, construction workers and students. It also provides reproductive health service to unmarried people in cooperation with local family planning departments and supports the capacity development of PLWHA.

Save the Children (UK)

Its activity has been concentrated in Ruili, Yunnan, in the areas of school education and health promotion among women and youth.

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CHAPTER 4

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Sung Ho Ko[1]

4.1 Background and method

The population of the Democratic People's Republic of Korea (DPRK), popularly known as North Korea, is estimated to be about 23 million. Of these, about 59 per cent reside in urban areas. About two-thirds of the population lives on the west coast, the rest on the east coast. Only a small number of people live inland, along the Aprok and Tuman rivers that border China.

North Korea is one of the most closed nations in the world, and much of this self-imposed isolation can be traced to the ideology of self-reliance it practises called *Juche*[2]. All spheres of people's lives are regulated by the government. Food and other economic necessities are distributed through official mechanisms, and the population lives a highly organised and regulated life. Travels both into and out of the country have been largely limited.

The situation changed dramatically in the mid-1990s as a result of a severe economic crisis. The distribution of food and daily necessities slowed down and was then abandoned altogether. Since the 1995 there has been virtually no distribution. As the distribution system began to disintegrate, the highly regulated lifestyle of the people also changed. Mobility increased, with North Koreans travelling both into and out of the country in search of livelihoods and a means of survival. .

Given North Korea's isolation all these years, there has been no satisfactory study on the extent of North Koreans' vulnerability to HIV. In fact, there is no information available on this. Firstly, the North Korean government lacked the human and financial resources to address the issue of HIV. Second, the government has been reluctant to work with international organisations on this issue.

It is extremely difficult to gather information on North Korea since the government has published very limited data for the country. Some data exists, but this is dated to the early 1960s. Most of this relates to power consumption, production of coal and grain, the level of urbanisation and so on. Most of the recent data presented in this report comes from Eberstadt and Banister's *The Population of North Korea (1992)*. Nicholas Eberstadt and his colleagues, who visited North Korea to help the country conduct a population census, were permitted to bring out raw data on the North Korean population, and they subsequently corrected and published these data.

The Population of North Korea contains basic data on the population. Most of the data presented in the book related to the period from the 1960s to 1987. Although Eberstadt and Banister extrapolated these data until 2020, these projections could be unreliable since North Korean society has changed dramatically since the mid-1990s. Some researchers maintain that they have obtained population census data for 1990, but it is uncertain whether this data is authentic.

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2 The *Juche* idea is North Korea's guiding principle. Late President Kim Il Sung conceptualised the idea of *Juche* to represent an era when the oppressed masses would become masters of their destiny. He took their struggle for chajusong (independence) onto a higher plane, widely acknowledged as a new era in the development of human history in North Korea.

As a result, this report relies on two sources: secondary sources such as books and newspaper clippings, and informal interviews with a number of people from North Korea living in China and South Korea, Korean Chinese people in China and government officials. The most difficult problem encountered doing this research was the lack of data and previous research in this field. Where data and reports from North Koreans living outside the country are available, the problem of accuracy persists.

4.2 HIV/AIDS Situation in North Korea

It is not known if there has been any incidence of HIV infection in North Korea. Until the early 1990s, there was no report of any people living with HIV/AIDS (PLWHA). Travel was regulated, sex work was outlawed, and bars and brothels were forbidden.

However, since the mid-1990s, when the country was forced to open up to the world, the likelihood of North Koreans becoming vulnerable to HIV has been increasing. Mobility of populations has increased dramatically and travel conditions have deteriorated. Most travellers do not live in decent shelters. The state-run medical system has virtually collapsed, and when people fall ill, hospitals are ill-equipped or otherwise unable to provide treatment. Condoms are not easily available: there is a shortage in state-run shops, and the high price of condoms sold in the black market puts them out of the reach of most North Koreans. It is likely that large sections of the population are vulnerable to sexually transmitted infection (STI) owing to unsafe sex practices.

4.3 Internal Migrants

Numbers

Since North Korea is a highly regimented society, migration is also strictly regulated. According to Eberstadt and Banister (1992), only 5 per cent of North Koreans changed their residence over the *dong*[3] line. (A comparison with South Korea, where the migration rate over the county line is on an average 22 per cent a year, is illustrative.) North Koreans had limited opportunities to move within or outside the country. To move over the county line, whether on a short-term or long-term basis, an official permit had to be obtained. Thus, the number of internal and external migrants was rather low (Ministry of Unification, 2000).

Internal mobility was of two kinds: official travel and private travel. Official travel is undertaken by government officials and public sector workers, primarily for public purposes. Private travel is undertaken by ordinary citizens - for sightseeing, family visit, peddling and the like. In the past, very few personal trips were permitted. Only few travel permits to move beyond the county line were known to have been issued for personal purposes.

The situation changed dramatically in the mid-1990s when a famine struck North Korea and food distribution stopped. The government, which could not provide daily necessities, including food, relaxed regulation on travel and mobility; more and more people started to move in search of livelihood. The number of North Koreans moving both within and out of the counties for private purposes has increased significantly in recent years. It is easier today to obtain travel permits through formal or informal channels (Good Friends, 2000).

The increase in mobility in recent times is largely related to food-collecting and peddling. Food collectors may visit their relatives who live in rural areas to buy food, including grains, if they can afford it. If not, they beg or 'borrow'. They also pick wild greens from the countryside, farms and the mountains. Interviews with mobile populations from North Korean living in South Korea reveal that food collectors move as far as 60 km on foot with a rucksack on their back.

Peddlers also move around dealing in food items and daily necessities such as clothing, shoes, toothpaste and so on. Some of them go to the port, buy seafood and sell it in the markets in

3 *Dong* is a sub-administrative area of the county.

remote rural areas. Some go to China to buy grains and industrial goods and sell them in the North Korean markets. Besides the black market where peddlers trade their goods, the only existing markets are the "farmers' markets", which are supposed to be open in one place in each county every 10 days. There is no official trade in industrial goods. Since the mid-1990s, therefore, North Korean peddlers are on the constant move to trade their merchandise in black markets.

Source areas and migration routes

There appear to be two major migration streams in North Korea. One takes place between large cities and the immediate surroundings: urban residents may go to the countryside to collect foodgrains and vegetables and return home. Many of these movements are daily trips. The other migration stream takes place between the western and eastern regions: people in the western region, which is relatively urbanised, visit eastern regions. This journey may take a few days and a few nights.

There appear to be two major reasons for an eastward migration stream. The first is that the eastern region is less densely populated. There are more farms and open countryside, making it easier to find food. The second reason is socio-geographic. Since the eastern region shares a border with the Yanbian district of Jilin Province, China, where the Korean Chinese population is concentrated, people from the western parts of North Korea have a greater chance of obtaining farm products and industrial goods coming from China.

Living and working conditions

Since the movement of North Koreans was until recently entirely pre-arranged, living and working conditions were relatively favourable. Both housing and work were publicly provided. Even for short-term travel, hotels were officially reserved.

Since the mid-1990s, however, most of these trips have become irregular and travel conditions have deteriorated (Good Friends, 2000; Hwang, 2002). Trains no longer stick to publicly announced schedules, and there is great uncertainty about when they will run - and whether they will run at all. Some people possess travel permits; others board trains without a permit. Trains are almost always so crowded that some people ride on top of the wagons. Those without a permit keep moving so as not to be discovered; else, they bribe the attendant. Buses seldom run outside cities; in most cases, people wait hitch a ride from passing vehicles after negotiating a fare.

Travellers waiting for trains and buses - which may take anything from several hours to several days - stay in 'waiting shelters', which are private houses that provide room and board. Houses are so small that they have only one or two bedrooms and a living room. Travellers interact socially with their hosts and may sleep with the woman and/or her dependent children in the same room. One of the informants said that an increasing number of North Korean women may appear to be making a living by running such 'waiting shelters', but that most of them are really self-employed sex workers. Travellers who cannot afford to pay room and board sleep in railway stations, bus depots and public parks.

Health risks

North Korea has periodically been affected by epidemics such as cholera. Before the economic crisis overran North Korea, a very efficient healthcare system was in place. Before the mid-1990s, North Korean migrants had few sexually transmitted diseases, including HIV infection. Firstly, housing and food were provided free of charge and their travel was officially arranged. Secondly, there were few, if any, private restaurants, hotels, bars and places for sex work to take place.

In recent years, however, North Korean migrants have become rather more vulnerable to STI and HIV. Irregular movements through informal mechanisms have increased sharply as a large number of people are moving around in search of food or goods to trade. They may have sexual relationships with others who are mobile, with women running 'waiting shelters' or with sex workers. The limited availability of condoms

means that few people follow safe sex practices. The migrants' spouses who stayed behind are also vulnerable to infection if the migrants return with an STI, including HIV. Also, separation from their spouses for extended periods of time may lead to sexual relationships with others in the source community.

North Koreans may have little knowledge about the risks of unprotected sexual intercourse, including HIV/AIDS. Even if they have learned about 'safe sex' practices and sexually transmitted diseases in the past, priorities have shifted in recent years and little or no such information is available any more.

Even if people are aware that they have contracted an STD, access to adequate treatment is difficult (Good Friends, 2000). Even large hospitals are ill-equipped and don't always have the necessary medication. North Korean migrants say the only reliable source of pharmaceutical drugs is the black market.

Vulnerability to HIV/AIDS

In recent years, North Koreans have become more vulnerable to HIV infection than ever before. From an analysis of the recent changes in North Korea, a number of vulnerable mobile populations can be identified. In terms of mobility type, private travellers are more vulnerable to HIV infection. They are relatively less educated and more likely to have unprotected sexual intercourse. They may sleep in places that are not regulated and frequently change their sexual partners. Female travellers too are particularly vulnerable. They may have to exchange sexual services with a man in order to save the room charge, facilitate travel permits or be freed when arrested for unregulated migration.

Young migrants are also more vulnerable to HIV infection[4]. They are the most mobile and sexually active, and are usually not accompanied by their partners: even married men tend to move without their spouses from region to region.

In terms of occupational category, peddlers and truck drivers are among the mobile populations that are most vulnerable to HIV infection. Women running 'waiting shelters' and sex workers in the black market who might be migrants themselves are also vulnerable. Peddlers may have sex with other peddlers, women running waiting shelters and sex workers in the black market. Truck drivers are more likely to ask for sexual favours in return for giving rides to women peddlers who may be unable to pay transportation fares; they may also visit sex workers.

Strikingly, injecting drug use (IDU), which is one of the known sources of HIV infection, does not appear to be a serious problem in North Korea. Most North Koreans cannot afford to buy drugs; besides, the strong value they attach to the family is also a deterrent. For instance, young populations follow a strict and austere lifestyle so as not to embarrass their parents. But perhaps the biggest deterrent is the rule of law: drug use can invite capital punishment, carried out in public. However, with the break-up of civil society and a weakening of official regulatory mechanisms, drug use could become a matter of concern in North Korea. This needs to be explored further.

4.4 International Migration

International travel was also limited until the mid-1990s. Only those who attended official meetings and universities, and government-sponsored workers, were allowed to cross the border. Moreover, such travels were mainly to neighbouring countries such as Russia and China, which shared North Korea's communist ideology. Private travels, such as family visits, were permitted only to a small extent. There were not many instances of irregular and undocumented border-crossings because crossing the border without an official permit would have had severe consequences.

The situation changed in the mid-1990s, when

4 There is no reliable age profile of North Korean migrants. Statistics relating to North Korea-China border-crossers may provide an indication. According to a survey on 2,479 communities in three northeastern Provinces of China, 2.8 per cent of border-crossers were less than 20 years old, 29.6 per cent in their 20s, 31.7 per cent in their 30s, 24.2 per cent in their 40s, 9.1 per cent in their 50s, and 2.6 per cent were aged 60 or more (Good Friends, 1999).

severe economic problems and food shortages triggered an exodus of people from the country. Large numbers began to cross the border for China, Russia and elsewhere. Today, there are varying estimates of the number of North Koreans living outside the country. The Chinese government makes a rather conservative estimate: 10,000 people. However, international aid groups reckon that 150,000 to 300,000 North Koreans might be living in North East China, Russia and Mongolia or elsewhere outside the country (Good Friends, 1999; Korean Sharing Movement International, 1999; Commission to Help North Korean Refugees, 2000). These numbers vary in part because different definitions are used (Ko *et al*., 2002)[5]. Some of the migrants may be border-crossers who may return home when their economic needs are met. Others may wish to stay rather longer outside their home country. Still others may not want to return to North Korea at all and may choose to relocate.

By June 2003, an estimated 3,700 North Koreans had entered South Korea. Of these, 616 came prior to 1990, the rest after 1991. In 2002, more than 1,000 North Koreans came to the South; an equal number was expected to migrate in 2003 (Association of Supporters for Defecting North Korean Residents, 2003).

Origins and migration routes

The cross-border movement of North Koreans can be divided into two categories depending upon the travel destination. One destination is Siberia, where North Korean contract workers are engaged in cutting down trees (Suh, 1995). North Korea and Russia have signed a series of contracts on wood-cutting in Siberia; the details of the contracts are unknown, but thousands of North Korean workers have been working in the Siberian woods since the mid-1970s. Timber-cutting is carried out in cold weather in order to ensure the quality of the timber. Workers receive few daily necessities, including food, and need to do additional work on farms in the warm weather, to earn additional income. Their work destinations may be located nearby or as far away as Uzbekistan, or they may move from place to place.

North Korean migrants who move directly from their home country may enter either China or Russia; the preferred destination appears to be China. There are two major reasons for this. The first is geographical (Ko et al., 2002): North Korea shares about 90 per cent of its inland border with China and the remaining 10 per cent with Russia. Moreover, there are several places on the North Korea-China border where the river runs so shallow that people can swim across - and even walk across in winter. North Korea also shares a border with South Korea, but it is heavily fortified on both sides. In fact, South Korea is one of the most difficult countries for North Koreans to enter.

The second reason why North Korean migrants prefer China over Russia is the socio-cultural ties with the Korean Chinese, who are concentrated in Yanbian district of Jilin Province, just across the Tuman river. Given their cultural similarities and ties, it is easier for North Korean migrants to get by in this region. The major route is found along the Tuman river, with Moosan city as a major stepping stone.

Once they arrive in China, migrants may stay in the Yanbian area or move farther into remote areas. Until 2000, North Korean migrants tended to stay around Yanbian, but after that they began to move to other areas as the Chinese police intensified their search for undocumented migrants. The Chinese government tolerated the unregulated migration from North Korea until 1999, but since then it has intensified border area control (U.S. Committee for Refugees, 2001).

Interviews with local Korean Chinese conducted for this study established that they seldom encounter North Korean migrants in that area now. Previously, Yanbian residents say they frequently saw North Koreans (distinguishable by their appearance) begging for food and money and looking for work, but they appear to have

5 The term 'North Korean defector' has been widely used with no clear definition. In certain cases, it means a refugee under the international convention. In other cases, it means North Koreans who have moved out of North Korea without an official permit. The latter definition, which is adopted in this report, may include irregular North Korean migrants.

'disappeared' in recent years.

One interviewee said that undocumented migrants went only to those who they believed would not report them to the police. Those who are willing to help may be Korean businessmen and members of civil society. The prevailing view is that North Korean irregular migrants are now moving further into China, to both cities and the countryside. They may go to big cities such as Shanghai, where they can move around more freely, or to distant farms in search of work and protection. This recent trend suggests that North Korean migrants are no longer concentrated in one or two places and they go to many destinations in search of security. This is a reflection of the heightened tension in recent years.

Many North Korean migrants wish to enter South Korea as a final destination using a variety of unconventional ways. There are largely three ways: visiting South Korean agencies in China; taking advantage of smuggling boats, and via 'third' countries (Ko et al., 2002). In recent times, a small number of North Koreans have been making rather extensive use of the consulates and other agencies in China. For instance, in 2001-02 seven migrants stormed into a United Nations office, and demanded passage to South Korea; others took shelter in German, Japanese and Spanish embassies and a German school. All of them succeeded in entering South Korea. However, the number of migrants taking this route is small (Iredale and Coghlan, 2004).

In June 2001, Chinese foreign ministry spokesperson Zhang Qiyue said his country refused to recognise North Koreans on its soil as refugees; according to Amnesty International, China again cracked down, this time in August 2001, and began returning more North Korean asylum seekers. It remains unclear whether Beijing accords the office of the United Nations High Commission for Refugees (UNHCR) the diplomatic immunity that foreign missions are entitled to. Apart from putting Beijing in a quandary, the incidents highlight the plight of thousands of North Koreans fleeing repression and famine in their country and crossing the border into China to seek food and refuge.

The second route for North Korean persons to enter South Korea is to sneak in, on smuggling boats. There are many smugglers afloat on the West Sea (the Yellow Sea), transporting goods and workers between South Korea and China. Of course, there are many problems with boarding these vessels. For most North Koreans, the fees are exceedingly high and only those who possess lots of money or whose South Korean relatives have guaranteed to pay for them can take this route.

The third route for North Koreans to enter South Korea is through 'third' countries such as Thailand, Vietnam, Laos and Myanmar. But the problem with this route is that migrants must cross nearly 5,000 km of Chinese territory. This may take months, or years; many migrants work on the way in order to earn money for food, shelter and travel expenses.

Living and working conditions

North Koreans experience great hardship, both in moving out of their country and at the destinations (Ko et al., 2002). Whether they are simply border-crossers, economic refugees or political refugees, they have to find food and shelter. They may have to beg on the streets, knock on the doors of local Korean Chinese and sleep in makeshift houses in the mountains. In most cases, they work on farms such as cornfields, rice paddies and orchards. If they are lucky, they may receive help from Korean businessmen or non-government organisations.

Women migrants have been known to marry local Chinese in order to avoid arrest and make a living. Three respondents interviewed in Yanbian in September 2003 said they had heard of North Korean women being 'sold' to the local Chinese. The Chinese husbands treat them not as wives, but as labourers and sexual partners. In this way, North Korean women may be sold and resold over and over until they are handed over to local bars or brothels.

Economic exploitation is a serious reality for North Koreans migrants. They are paid much less (say, 30 yuan per day) than the average local Chinese worker (who may be paid 50 yuan a day) for the same work.

Some North Koreans work full-time without any payment, just food and shelter facilities. In some instances, their employers refuse to pay them and threaten to report them for illegal residence.

Another challenge that North Korean migrants face relates to their physical protection. Those who go to Russia no longer have to run for their life from the police but the situation is different in China, where they have to be alert if they are not to be detected and arrested by the police. If they are arrested and deported to North Korea, they and their families may be tortured or even put to death. Consequently, they do whatever it takes to avoid being noticed and arrested. In fact, many North Koreans are known to live in makeshift camps and 'mud caverns' near the tops of mountains so they can be forewarned if the police come from below and run away. Another tactic is, as mentioned already, to move farther from the Yanbian area.

Apart from the problems of economic and physical security, North Korean migrants also suffer from various psychological problems. First, they live in constant fear of arrest and deportation. Irregular migrants of other nationalities too live in fear of being forced out, but in the case of North Koreans, the situation is worse: they risk death if they are deported. Back home, they will be seen as national "traitors" and could be subjected to humiliation, torture, imprisonment or even execution in public.

North Korean migrants, particularly women, frequently encounter prejudice and discrimination from local residents, who treat them like beggars. The local Chinese reckon North Korean women are easily available for sex, willing to 'throw their bodies for a night for a bowl of rice' (Good Friends, 1999).

Health risks in China

Most North Korean migrants in China appear to live in a constant state of physical and psychological exhaustion. This renders them much more vulnerable to illnesses. First, healthcare of any kind is a 'luxury', given that they are rather more preoccupied with feeding and protecting themselves and their families. Second, they are more likely to enter into casual relationships. Many of them may not have enduring sexual partners, since they are on the move a lot. This suggests an increased vulnerability to HIV, in the absence of access to health services.

The North Koreans' heightened vulnerability may also arise from their status as "defectors". Even if they suspected they were infected with HIV, they would be reluctant to report to health authorities. Although the Chinese healthcare system is well-developed, most North Korean migrants would not be able to afford the hospital fees. More importantly, they could be afraid of being reported by the hospital staff. In fact, North Koreans say they never go to hospital. Instead, they go to the local pharmacy and ask for medication they believe to be effective. This is especially true in the Yanbian area, where the police actively search for irregular North Korean arrivals.

Young migrant women keep changing their residences. This increases the chances of having casual relationships. Even marriage to a local Chinese does not provide stability in sexual partnerships. They are not treated as wives, but as sexual objects and may be sold repeatedly. An increasing number of North Korean women are working at bars and brothels. Many North Korean women who defected to South Korea via China are known to suffer from gynaecological diseases; the extent of HIV infection among them has so far gone unreported.

Vulnerability to HIV/AIDS

The incidence of HIV infection among North Koreans in China is unknown. Based upon the circumstances of their lives, however, vulnerable groups may be identified. First, young populations appear to be highly vulnerable: most of them have no stable partners, have little knowledge about the seriousness of HIV and accord low priority to safe sex practices.

Young women may be at the highest risk of being infected. They may move around with other North Korean men for physical protection as well as emotional support, which increases the chances of their having casual sexual relationships. Then again, they may be treated as sexual objects by Chinese

'husbands' and sold and resold to other Chinese men. They may be forced to work at bars and provide sex services for money. The situation could potentially become worse in the future as they move to far-flung areas where access to health services may be very limited.

4.5 HIV Infection Prevention Among Migrants: A Review of Existing Programmes, Policies and Initiatives

General services in North Korea

There are no known health programmes targeted at combating HIV in North Korea, and authorities will perhaps deny that anyone in the country is infected. Moreover, given the severity of the famine and an economy in poor health, healthcare is not a major area of official concern. Hospitals are not adequately equipped with diagnostic systems, and drugs and condoms are in short supply. This does not mean, however, that authorities are unconcerned about HIV. Some migrants say that the North Korean government is, in fact, serious about checking the possible spread of HIV into the country: migrants are questioned about their health status, particularly HIV infection, on their return. But given the shortage of resources, the officials are, however, unable to enforce any guidelines.

General services in China

There also appears to be no systematic HIV infection prevention programme for North Koreans in China. The Chinese government looks for irregular and undocumented North Koreans and deports them when found. Such migrants do not benefit from the HIV prevention programmes that China runs. They may be able to buy condoms at pharmacies, but few can afford to buy them. Even when they suspect they are infected, they may not visit the hospital for fear of deportation. In short, they are a 'blind spot' as far as the host government is concerned.

General services in South Korea

Once North Koreans enter South Korea, their identity, background, motives and routes of travel are rigorously investigated. This may take anything from a few weeks to a couple of months. After the investigation, they undergo two months' 'adaptation education' - a general orientation programme to acquaint them with life in South Korea and its people. Then they are provided with a resident registration card (South Korean identity card), after which they can start their life as ordinary citizens. This process is the same regardless of how they enter South Korea. Once they are granted citizenship, they are no longer considered migrants; consequently, they can access healthcare, including HIV infection prevention programmes, just like any South Korean.

4.6 Policy Gaps and Recommendations

Policy gaps

Whether they live in North Korea or in other countries, North Koreans remain in a 'blind spot': even general data on North Korea are difficult to obtain. Therefore, further detailed investigations are needed to understand their situation and their vulnerability to HIV/AIDS. North Koreans in North East Asia and South Korea can be a useful source of information. International organisations could be influential in conducting research, as they may be able to persuade North Korean authorities about the vulnerability of North Koreans to HIV infection and the seriousness of the issue.

The North Korean situation suggests that HIV infection prevention is still largely a personal matter: people must know about the importance of safe sex practices and act accordingly. If they are diagnosed as infected, they may be isolated from the general public.

Opportunities for international organisations also need to be expanded. The activities of NGOs may be constrained by human resources limitations, and the extent of co-operation that North Korean authorities provide. For instance, Médecins Sans Frontières (MSF) or 'doctors without borders' withdrew its services citing lack of co-operation from North Korean authorities. The

doctors were not allowed to freely meet people, visit areas or provide services openly. North Korean authorities were highly suspicious of the doctors who were providing voluntary services. MSF felt frustrated and pulled out.

South Korea may be another source of help; in the past, it has provided rice, chemical fertilizer, medical equipment and drugs to North Korea (Ministry of Unification, 1999). So far, however, North Korea has not asked for condoms and HIV drugs. Although some South Korean NGOs routinely send drugs, HIV-related medication does not appear to be on their list. In fact, North Korea's needs are far more basic, and authorities there do not think of HIV prevention as a priority issue.

Recommendations for North Korea

As the North Korean population's vulnerability to HIV infection increases, it is important to draw the authorities' attention to the HIV vulnerabilities and the need for prevention as well as caring for people living with HIV. The uniqueness of the context in North Korea calls for modified responses; even so, capacity-building, reaching-out and education programmes about safe sex practices need to be undertaken.

■ *Address issues of marginalisation*

North Korea classifies people according to their family background[6]. Such a classification system may drive a particular group of people deeper into poverty, irregular mobility and vulnerability to particular kinds of disease. Instead, equal opportunities should be provided for men and women, and a social and political environment where women are equally respected should be promoted. Otherwise, mounting inequality may lead to a greater marginalisation of women and itinerants.

■ *Strengthen knowledge and capacity*

It is difficult at present for foreigners to secure the authorities' co-operation to work inside North Korea. The withdrawal of MSF suggests that volunteer groups are unable to operate effectively in the country. It is desirable that international agencies such as UNAIDS, UNDP, WFO and WHO are involved as neutral agencies. North Korean authorities must be persuaded about the need for HIV prevention programmes. When volunteer groups wish to work, they should set up an umbrella organisation.

■ *Provide affordable services through international community*

The co-operation of North Korean authorities is needed to distribute condoms to encourage safe sex practices. The distribution should be such that it reaches vulnerable populations such as young peddlers (especially border traders), truck drivers and women in the service sector. Pricing is critical: they should be affordable to ordinary people. When the need for treatment drugs arises, these should be procurable through the UN-administered Global Fund for AIDS, Tuberculosis and Malaria (GFATM).

■ *Conduct public education campaigns on HIV and safe sex*

There is a compelling need for a public education campaign on HIV and safe sex practices. The involvement of international agencies in providing information and producing and disseminating leaflets on HIV would make such a campaign more effective.

Policy gaps in China

The data and research about North Koreans in China is only marginally better than in North Korea. That there has been little systematic research reflects a serious knowledge gap, given that there have been up to 300,000 North Korean migrants in North East China. Currently, the only sources of information are anecdotal reports, such as newspaper and TV reports, circulated among interested people. The knowledge gap arises in part because the Chinese government is reluctant to address this sensitive issue in public. If the Chinese authorities are persuaded about the vulnerability and seriousness of HIV to their own population, they may cooperate.

The situation of North Koreans in China suggests

6 North Korea is known to have classified its people into three classes, based upon their family background: core class, waiving class and hostile class. Accessibility to education, job placement, food provision, and the like is determined according to this classification (Ko, 1999).

an official policy that holds that HIV infection is a personal matter: people have to decide whether to use condoms, maintain stable relationships or abstain from unprotected sexual intercourse; treatment of the infection will be on a case-to-case basis; it is up to the people whether they buy drugs or go to hospital, as hospital treatment comes with the risk of arrest and deportation. That this situation is untenable in the face of an HIV/AIDS pandemic is obvious.

Many international organisations are active in providing rescue services, but as one interviewed person said, "NGO workers may not have HIV specifically on their activity list." First, their financial and human resources are stretched in trying to feed and protect the North Koreans in China. Second, the Chinese government sees the involvement of foreign agencies as "intervention" in its domestic matters. This is especially so in respect of North Koreans; NGO activities targeted as North Koreans are particularly unacceptable to the Chinese government.

Recommendations for China

The extreme delicacy of the situation of North Koreans in China makes an open and effective response extremely difficult. Responses need to be carefully calibrated and enmeshed within the networks that operate among the North Koreans and civil society organisations that work among them.

■ *Target HIV prevention activities at North Koreans*

Since the resources of NGOs are stretched, there is a dire need to boost their funding levels so that they can be active in promoting HIV awareness and knowledge about safe sex. Leaflets on HIV awareness and safe sex practices could be disseminated among the North Koreans in their own language. Condoms must be distributed free of charge or made available at an affordable price at pharmacies. Given the North Koreans' inhibition about appearing in public, peer leaders or religious groups could be involved. For more effective distribution, the co-operation of local governments should be sought.

■ *Initiate dialogue with local-level authorities*

Local-level administrators are often open to programmes that will improve the situation in their region. The government of the Yanbian district, in particular, should be approached as the Yanbian district is a transit point for North Koreans coming into and travelling throughout China.

■ *Provide confidential counseling and testing services and access to treatment*

To reach out specifically to North Koreans and yet not single them out, a HIV Anonymous network (like Alcoholics Anonymous) could be operated, especially in areas where there are larger concentrations of North Koreans. To enable this, co-operation from local governments would be crucial. Yanbian and other cities in Jilin Province would be a good place to start. For the programme to succeed, it is important to win the trust of the North Koreans: they should know that their safety and privacy will be guaranteed.

■ *Conduct further research about North Koreans in North East China*

Field study on issues of concern for North Korean migrants in China and an assessment of their vulnerabilities would be helpful in designing informed projects to address these concerns. This could be undertaken by an international research team, including scholars possibly from China and South Korea and others concerned about North Koreans in China. To conduct such a research, it is important to establish a partnership with the authorities in charge. It may be desirable to first contact local governments, such as those in Jilin Province and/or Yanbian district, and agree on the terms for conducting the research.

Policy gaps in South Korea

There are no specific anti-HIV programmes for North Koreans apart from those that target the general public in South Korea. Such programmes are not included in the orientation process either. Since South Korean authorities are equally concerned about the North Korean migrants' health, they must put in place a system to carry out medical tests, including blood tests, when North Koreans enter South Korea. Government authorities claim that no case of HIV infection has

been detected so far among the North Koreans.

Recommendations for South Korea

- South Korean Authorities should acquire a heightened sensitivity to the fact that North Koreans are highly vulnerable to infection. First, they have had no access in North Korea to information on safe sex practices; second, they had at best limited access to health services; and third, they are likely to have faced harassment, including sexual exploitation, in transit.
- *Enhance North Koreans' HIV awareness*

North Koreans should be made aware of the seriousness of HIV and the need to practice safe sex. This can be done as part of the 'adaptation education' process. Along with the awareness programme on safe sex and HIV (which must be imparted in the North Koreans' language), access must be provided to condoms as well.

- *Expand community outreach services*

Branding North Koreans who cross the borders as defectors will only drive them underground. Instead, it is important to address the problems they face in South Korea. Clusters where North Koreans live together could be identified for community-based outreach programmes; some North Koreans could be involved in this effort as peer support persons.

Table 4.1: Summary of Vulnerable Groups, Responses and Recommendations

Vulnerable Groups	Current Situation	Responses	Recommendations
Internal migrants in North Korea (peddlers, travellers, truck drivers)	Increased mobility through informal mechanisms Increased chance of casual relationships Little knowledge of risks of unprotected sexual intercourse	Deteriorating healthcare system Non-availability of drugs HIV not a priority for the government MSF withdrew services due to lack of co-operation from government	Health-related, particularly HIV-related, personnel should be allowed to work in North Korea International community should ship condoms and medications immediately North Korean authorities should conduct public education on HIV, safe sex
Migrants in China, especially young men and women, engaging in casual sex CSWs: young women employed in bars/brothels Girls and women who have been trafficked to Chinese men	Increasing dispersal of migrants in N.E. China or elsewhere to avoid detection Young people very vulnerable (high mobility plus increased chance of casual relationship) Very vulnerable as they have little knowledge and no protection from HIV/AIDS Women 'sold' to Chinese husbands, arranged through traffickers; they may be resold or used for sex work which makes them more vulnerable	Little access to healthcare Political position limits IO/NGO involvement	International agencies and NGOs could engage in HIV infection prevention programmes among North Korean migrants International agencies should contact Chinese government officials Safe sex practices need to be encouraged Opportunities should be provided for people living with HIV to be treated in hospital

4.7 List of readings and resources

This list is obviously very limited due to the nature of the circumstances in both North Korea and China. No NGOs are known to exist in North Korea and those that do work in China do not wish to be identified, for obvious reasons. This means that future research and/or programmes would need to be conducted sensitively and discretely.

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CHAPTER 5

INDIA

Swati Ghosh[1]

5.1 Background and Method

India's population surpassed one billion in 2001; 67.2 per cent of the population lives in rural areas, and 32.8 per cent in cities. The proportion of the population living in urban areas has steadily increased from 17.3 per cent in 1951. Of the total workforce, 73.3 per cent remain in rural areas; 58 per cent remain dependent on agriculture.

In a country as vast and as populous as India, predictably, a great deal of migration is evident. Migration is a complex process, and different forms of mobility manifest themselves simultaneously. At one end of the spectrum, people move away permanently from their place of birth, and maintain little or no contact with their place of origin; at the other end, people residing in one place travel a long way to their workplace and return the same day, covering a large distance daily. In between are many other forms of mobility, with differences in the duration of stay, regularity of movement and nature of the links maintained between the origin and the destination. Accordingly, migrants can be classified as semi-permanent, temporary, seasonal or circular migrants. Although there may be a bit of an overlap in the definition of each of the categories, they denote a variegated range of differences as well.

This paper draws principally from secondary sources of information. The data on internal migration have been obtained from various Census reports and the different rounds of the National Sample Survey (NSS). Data from international development agencies such as UNDP, USAID, UNAIDS, ILO, WHO have been used extensively. Various other studies undertaken by individual scholars, research institutes and non-governmental organisations (NGOs) provided information on migration, health and the socio-economic profile of different target groups. A number of government reports from different ministries - such as the Labour Ministry, Health Ministry and the External Affairs Ministry - provided relevant information. The state labour and health departments also shared documented information regarding migration and health issues. Other important sources of information were individual scholars and activists involved in the effort to combat the AIDS epidemic. Trade union leaders, NGO personnel and coordinators of various programmes implementing policies contributed a great deal. Interviews and in-depth discussions with them[2] provided insights that served to enrich the qualitative aspect of the analysis.

5.2 HIV/AIDS Situation in India

India has one of the largest populations of people living with HIV/AIDS, second only to South Africa (UNAIDS, 2003). An estimated 5.1 million individuals currently live with the HIV infection,

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2 In particular, Dr Sasi Kumar of the V.V. Giri National Labour Institute; Dr Ravi Srivastava of the Jawaharlal Nehru University; Dr Shalini Bharat of the Tata Institute of Social Sciences, Mumbai; Dr S.M. Afsar, National Program Coordinator, ILO; Dr S.Raju of the Mahatma Gandhi University of Kerala; Dr Prabhu Mahapatra of the University of Delhi; Dr Ritu Priya of the Jawaharlal Nehru University; Dr Rajashri Basu of the Rabindra Bharati University; Rajeev Sadanandan, former health secretary, Kerala; Ramachandra Khuntia, Member of Parliament; and Gita Banerjee of *Sanlaap*.

across all the states. The HIV prevalence rate among the adult population is 0.8 per cent: that's low, but the absolute number of people living with HIV is very high and growing rapidly. In areas that have been affected the most severely, the epidemic is challenging the development achievements of recent years and is raising fundamental issues of human rights.

In Maharashtra, one of the most affected states, the HIV prevalence rates among population sub-groups tell a disturbing story: 60 per cent among Mumbai's sex workers, 14-60 per cent in sentinel STD clinics and over 2 per cent among women attending antenatal clinics. The past four years have seen the epidemic spread across the southern, western and northeastern states. The prevalence rates in Andhra Pradesh and Karnataka are the highest; these two states have overtaken Tamil Nadu in recent years. In other parts of the country, the overall number of people living with HIV infection is still low. However, high levels of STD (indicating high levels of unprotected sex), migration and gender bias all point to a significant vulnerability.

In India, the HIV/AIDS epidemic is characterised by heterogeneity; it seems to be following the Type 4 Pattern, where the epidemic shifts from the most vulnerable populations (including sex workers, injecting drug users, men who have sex with men) to bridge populations (clients of sex workers, STD patients, partners of drug users) and then to the general population. The shift usually occurs when the prevalence in the first group exceeds 5 per cent, with a time lag of two to three years between the shifts from one group to another. Some key characteristics:

- The epidemic continues to shift towards women and young people - 37 per cent of all HIV infections in India are now estimated to be among women - with an increase in vertical transmission and pediatric HIV;
- Migration both within and between states is a major source of transmission of HIV between urban and rural populations;
- Gender bias, unequal power in decision-making between men and women, and women's lack of ability to negotiate safer sex represent a major obstacle to prevention;
- A sharp increase in injecting drug use is under way, with drug users switching from inhaling to over-the-counter injecting drugs;
- There is little reliable data available on HIV among men who have sex with men (MSM), although informal estimates and small surveys suggest rapid increases may be taking place.

Important new elements are entering the picture. The burden of AIDS cases is beginning to be felt in states that were affected early by the epidemic. In Maharashtra (in particular, Mumbai) and Manipur, hospital bed occupancy rates from HIV-associated illnesses range from 24 per cent to 40 per cent in some referral hospitals. Home-based care is still in its infancy in most parts of the country. Greater visibility and awareness of HIV has triggered a mixed response. While there are individual examples of support and care, communities have generally discriminated against people living with HIV. Access to healthcare is emerging as a critical first point of contact with public and private services for HIV-positive individuals; it is also an area where they face blatant discrimination. Campaigns to increase awareness of HIV have more often triggered fear among the public.

5.3 Internal Migrants

Numbers

According to the 1999-2000[3] Census reports, migrants accounted for 26.6 per cent of the country's population. This represents a decline from 30.6 per cent in 1971 to 27.4 per cent in 1991. The absolute number of migrants, however, grew from 167.7 million in 1971 to 231.9 million in 1991. The number of women migrants has grown steadily in recent decades; according to some estimates, women today account for the majority of migrants.

3 Srivastava and Sasikumar, An Overview of Migration in India, Its Impact and Key Issues, 2003

However, these figures also include women who migrate or move as a result of marriage. Recent evidence based on NSS figures for 1992-93 (49th Round) and 1999-2000 (55th Round) suggest an increase in migration rates from 24.7 per cent to 26.6 per cent over this period. .

Additionally, the NSS reports that about 2.28 million persons migrated from other countries to various states in India. The states that received a high percentage of migrants from overseas are: West Bengal (44 per cent), Tamil Nadu (12 per cent), Kerala (10 per cent) and Uttar Pradesh (8 per cent)[4].

Source areas and migration routes

Estimates from NSS data show that there was an increase in urban-to-urban migration between 1992-93 and 1999-2000 (Srivastava and Bhattacharya, 2002). Urban areas are migration destinations for more men than women: 49 per cent of male migrants moved to urban destinations, against 29.5 per cent of women migrants. Among women, marriage was the most important migration-inducing factor; such migration was confined to short distances. Migration in India predominantly takes place over short distances: about 60 per cent of migrants change residences within the same district, and about 20 per cent within the same state. Inter-state migration is a feature of the relatively more developed states (with the exception of Madhya Pradesh); about 20 per cent of the country's population crossed state boundaries between 1981 and 1991. This includes internal migrants across states as well as overseas migrants from India.

Among the long-distance migrants, men moved between states mainly for economic reasons. Of the 27.4 per cent of those who had migrated in the period 1982-1991, 8.8 per cent moved for employment reasons and 2.3 per cent for business purposes. Men were more likely to move for economic reasons than women. The primary motive of employment also is an indication of how mobility is influenced by demand and supply within the national labour market.

A distinct regional variation was visible in this respect. In the northeastern states and the relatively more developed states of India, migrants were primarily employed in the tertiary and secondary sectors of the economy; in contrast, in the less developed states, a larger proportion of migrants were employed in the agricultural sector. In the western states, significant proportions of male migrants were engaged in industrial activity, but in the southern states they were mainly engaged in the tertiary or service sectors. Among women migrants, 40 per cent were involved in production-related work and a significant proportion in technical and professional activity (Srivastava and Sasikumar, 2003).

The 1991-2001 decade witnessed a sharp increase in urban male mobility, again largely for economic and employment-related reasons. Comparing activity status before and after migration, higher work participation rates are revealed for both urban and rural areas (Srivastava and Bhattacharya, 2002), which reaffirms that migration is an important livelihood strategy. The NSS (55th Round) showed a significant transition towards regular employment and self-employment among males and a small decline in the percentage of casual labour (even though there was an increase in the absolute numbers). In rural areas, there was an increase in all the three categories percentage-wise, with a significant shift towards self-employment. Women workers' participation increased in all the three categories. However, proportionally more women work as casual labour in the rural areas than in urban areas.

Many short-duration labour migrants who lack stable employment and sources of livelihood are engaged in agriculture, seasonal industries and the urban informal sector of the economy. They are either casual labour or self-employed and often move from one job to another from rural to urban, urban to rural and between rural areas or urban areas. It is impossible to isolate the 'push' factors from the 'pull' factors of migration in their case, and for this reason they are likely to be underreported in the data collection system.

4 Ibid.

In 1999-2000, there was an estimated 8.45 million short-duration out-migrants in rural areas, and 2.42 million in urban areas. The estimates of the National Commission of Rural Labour (NCRL) were marginally higher: in its estimation, short-duration migration accounted for around 10 million seasonal and circular migrants in rural areas alone. This included an estimated 4.5 million inter-state migrants. They were largely engaged in agriculture and plantations, brick kilns, quarries, construction sites and fish processing.

Informal estimates and micro-studies suggest that seasonal/short-term migrant workers are concentrated in specific pockets. A 1999-2000 study on the seasonal pattern of migration in the rice-producing belt of Bardhaman in West Bengal suggested that the number of migrants there exceeds 500,000. They belonged largely to Muslim and tribal communities and caste groups that are at the bottom of the caste hierarchy (Rogaly et al., 2002). The annual seasonal migration of tribal households from Dhule district of Maharashtra to the sugarcane fields of south Gujarat accounted for between 100,000 and 150,000 people (Teerink, 1995). Other studies in tribal areas of Madhya Pradesh, Rajasthan and Gujarat also indicated a high rate of out-migration - about 60-80 per cent of households (Mosse et al., 2002; Heberfeld et al., 1999; Rani and Shylendra, 2001). Significant numbers of indigenous communities from the drought-prone areas of Andhra Pradesh, Karnataka and Maharashtra also migrate in search of work in construction, brick kilns and crop-cutting in Maharashtra (Pandey, 1998). Every year, around 40,000 girls are believed to migrate from Kerala to other states to work in the fishery industry (Sarodamoni, 1995).

The landless poor, who mostly belong to backward castes and indigenous communities in economically backward regions, migrate for survival and constitute a significant proportion of the seasonal labour flow. At the other end of the spectrum, men migrating from urban to urban areas may not be from the poorest classes in the agricultural sector. They are relatively better placed, but migrate in order to improve their status further.

Living and working conditions

At their destination, migrants are vulnerable to two types of insecurities: economic and social (Ghosh, 2002). Economic insecurity manifests itself in many forms: irregularity of employment, the casual nature of jobs, low payment, difficult work conditions and the migrants' susceptibility to fall into debt traps. In addition, migrant workers face insecurity born of difficulties in the socio-cultural domain: these include health hazards, the sense of isolation that comes from being separated from family and community, alienation in a new workplace, strange and unfamiliar living arrangements, the shortage of space and language barriers. Since the two types of insecurities are related, they constitute a vicious circle, and the more a migrant wants to escape, the more entangled s/he finds her/himself.

Migrants are exposed to large uncertainties in the potential job market. They have little knowledge of the market and have to risk high job search costs. The further they are away from home, the higher the costs and risks. Migrants at the lower end of the market comprise mostly unskilled casual labourers and, often being locked into a debt-migration cycle, the earnings from their new jobs are used to repay debts incurred at home or at the destination on arrival. The contractors, sub-contractors or their agents recruit labour directly from the village, often by advancing money. Labourers pay this off by working for the employer. Recruitment is based on individual contracts with the employer and characterised by organised migration.

In the construction industry, migrants are recruited through contractors who also play a supervisory role, settling wages by retaining a part of the earnings. In the fish processing industry, women labourers are recruited through former women workers. In recent times, private agencies have begun recruiting labour through informal channels to provide certain services in demand among urban consumers. Employers prefer migrant workers to hiring local labour, as the former are

cheaper and do not/cannot develop social relationships at the place of destination or organise themselves. In the metropolitan labour market, the recruitment of migrant labour often takes place at railway stations such as in Punjab or bus-terminus and road crossings as in West Bengal.

Women migrant labourers fare the worst. They are generally paid less than male migrants, and even less than those below age 18. In the construction industry, they are employed as unskilled workers, with no scope for social mobility. Skill upgradation is also not possible for women because of social beliefs that forbid women from touching tools and equipment used for work. Women also face greater insecurity in terms of recruitment, work conditions and access to minimum facilities at the workplace. Sexual harassment is a common-enough threat for women wage-earners. Living conditions are also difficult for women migrant workers in the city slums and squatter settlements.

Urban and rural labour markets are linked through horizontal circulations of migrants from one to the other (Breman, 1996). Industrial production units in the cities have large labour catchments areas in different rural districts: for instance, the cotton textile mills of Ahmedabad absorb labour from rural Maharashtra, and the jute industry around Kolkata draws a large section of its industrial labour force from districts of Bihar and Uttar Pradesh (Haan, 1999). In spite of the linkages, the markets are segmented in various ways, and the locals and the migrants are kept apart as distinct groups, so as to exert effective control over the workers. Women migrants are concentrated mainly in the lower segments of the market in manufacturing, construction, personal services or household jobs. The markets are also split along ethnic and regional lines (Das, 1994).

In the urban informal sector, friends and relatives provide a safety net for migrants. Social networks provide initial income support, information, accommodation and access to jobs. In spite of the support from friends and relatives, the volume and nature of help is too meagre to fight the adverse situations in an altogether different environment.

Health risks

Labourers who work in harsh social conditions and live in unhygienic environments suffer from serious occupational and other health hazards. Those working in mines, quarries, construction sites and road repair works suffer largely from TB and lung diseases. As cost-conscious employers do not typically abide by safety measures, accidents are quite frequent. Migrants do not have access to free medical and health care programmes because of their temporary work and residency status. Regular preventive measures undertaken for diseases like malaria do not cover migrants. For women workers, there is no provision for maternity leave, and women continue to work immediately before and after childbirth so as to minimise the loss of working days. Those working in tile factories and brick kilns suffer from body ache, sunstroke and skin irritation (NCRL, 1991). As crèche facilities are non-existent, children often accompany their mothers to the workplace and suffer extensively.

Migrants live in deplorable conditions in urban slums. There is often no provision for safe drinking water or sanitation. Most of them have to live in open spaces or makeshift arrangements, although the Contract Labour Act stipulates that the contractor or employer should provide suitable accommodation (NCRL, 1991; Rani and Shylendra, 2001). Workers who migrate to the cities also live in open spaces such as parks or on pavements, since they cannot afford to rent a room in the city slums. Squatter settlements sheltering a large proportion of the migrants have inadequate space, no supply of potable water and bad drainage and sewerage systems. Staple food also costs more for migrants without ration cards, which entitles cardholders to subsidised foodgrains.

Apart from the stresses associated with adjusting to a new cultural, professional and social set-up, livelihood-related migration affects the mental health of migrant workers. Migrants are under additional pressure to earn enough to maintain a minimum standard of survival as well as remit

money to families back home, which - oblivious of the migrants' condition - expect regular remittances. In cases where safety nets for nurturing the physical and mental health of migrant workers are absent or inadequate, the economic, social and psychological condition of migrants is ranked bad. Competition and harassment from the local inhabitants who have better contacts and resources are also a constant source of pressure for a migrant. Additionally, migrants live in constant fear of being cheated and exploited by agents, contractors and employers - and the possibility of being entrapped in further debt situations.

Social and cultural factors play as much a part as economic factors in determining the working and living conditions of migrants. The migrants' inability to identify with the local lifestyle, the absence of provision for community counselling as in the villages and the lack of arrangements for recreation of any sort to ease their tensions and anxiety are serious problems. Cultural difference - summed up by the term 'ethnic distance' - marks a migrant as distinct from local workers (Tan, 1998). Language barriers, and caste or ethnic factors critically determine the extent of migrants' access to healthcare. Their poor health profile is linked to their low entitlements, and this is particularly true of newcomers. Exposure to a new cultural system, which is sometimes hostile to the migrants, often creates psychological problems arising from a sense of loneliness and isolation in a place far away from home.

Vulnerability to HIV/AIDS

Given the stress and lack of avenues for psychosocial support, migrant workers experience frustrations. Many of them turn to drugs for temporary relief or under peer pressure. Drug use stretches the migrant workers' already scarce resources and s/he is often caught in a cyclical state of anxiety and pressure. Injecting drug use is the most cost-effective way of taking to drugs. Sharing of needles is common, and this heightens their vulnerability to HIV infection. Unsafe sexual practices too contribute to their vulnerability. Most of the migrants are single young men. They do not travel with their families, and frequent visits to their homes may cost them their job. Male migrant workers in this situation are likely to visit brothels, or have sex with other men, including migrant colleagues, female migrants or local women. Unprotected sex increases their vulnerability to HIV/AIDS and other sexually transmitted diseases.

Women migrant workers in the informal sector are subjected to sexual harassment and physical abuse - sometimes as a condition for their being given a contract job such as in construction work. Single migrant women or women who have been deserted by their husbands and are under pressure to earn a living are particularly vulnerable to sexual harassment by contractors, agents and even other

> Because of faster economic development in certain regions of the country in the last few decades, there has been significant migration of population from rural to urban areas, both inter-State and intra-State. Migration of rural population in search of employment has also led to increase in the number of slums with poor public health infrastructure in urban and semi-urban areas. Migration is mostly single with the workers living alone in substandard living conditions. The separation from families for long periods also result in high-risk behaviour among these migrant workers. These workers, after they get infected with HIV, do also infect their unsuspecting housewives when they go home for vacation or for agricultural operations. The problem therefore has to be addressed both at the place of origin and the place of migration. The problem of these migrant workers needs special IEC and intervention programmes for provision of services like STDs clinics, condom distribution centres and access to health care. All these measures should be able to increase the awareness levels of the general population both in urban and rural areas to more than 90 per cent in the next five years.
>
> National AIDS Control Policy

male workers. In the absence of any mechanism that protects migrant workers' rights, such workers, and particularly women workers, are susceptible to commercial exploitation. Women workers' claims for equal wages, reasonable working hours or maternity leave are not even considered. Poverty and lack of resources might force them to trade sex for food and other necessary goods. Limited access to including information on HIV/AIDS and to condoms may further expose them to unprotected sex and STDs/ HIV/AIDS.

Thus, health as a 'state of physical, mental and social well-being and not merely absence of disease or infirmity' (WHO definition) is highly impaired, there is no equity in access to essential healthcare, and risks associated with health hazards are extremely high for migrants.

5.4 Trans-border Migrants

Apart from tourists, three types of labour migrations across national borders are observed to be taking place in India. These are relevant to this study:

a) People migrating from neighbouring countries in South Asia, primarily from Bangladesh and Nepal to India;

b) Return migration of less skilled Indian workers who migrated on temporary contracts to oil-exporting countries of West Asia;

c) Migration of highly skilled migrants.

a) (1) Nepali migrants in India

Numbers, routes, living and working conditions

Large numbers of Nepalese citizens have migrated to India to work as labourers. During colonial times, Nepalese were recruited in the Gurkha regiments of the Indian army, and that continues to this day. There are only rough estimates of the number of Nepalese migrant workers crossing the border into India (Gurung, 2001), and they vary between 1.8 million and 3 million people a year. Nepal and India share a common, open border and the nationals in both countries don't require a travel permit or a passport to cross the border. The informal migrant workers traveling to India are not required to register themselves or undergo medical tests, although a work permit system was introduced in the Kathmandu valley on an experimental basis in 1987.

Promotion of foreign employment opportunities is a major aspect of Nepal's 'economic diplomacy'. However, poor workers prefer to work in a country that is near their home, India is the de facto choice. There is a pattern of preferred destinations among migrants; they prefer certain cities and specific professions. This suggests there are well-established links between certain districts in Nepal and the more developed states and cities in India. The Nepalese workers from the districts of the Eastern Development Region are concentrated in the eastern Indian states and cities; those from the Western and Mid-western Development Regions are located in the northern, southern and western parts of India. A majority of Nepalese migrant workers are engaged in low-paying jobs as porters, guards or peons. A few hold clerical positions in India (Gurung, 2001:16). The ethnic pattern shows that migrants from the Eastern and Western Development Regions are mainly from the Gurung, Magar, Rai and Limbu communities, which were categorised by the British as 'martial races'.

The Indian army is a big employer of Nepalese migrant workers. Allied services include the Border Security Forces, the Assam Rifles and the Army's Pioneers, which build roads in the border areas. For over 180 years, the Nepalese have been an integral part of the then British Indian Army; typically, they are from better-off families of the Eastern and Western Development Regions. Nepalese enlisted in the Indian Army and allied services enjoy far better terms and conditions of work than those who work in the informal sector. The latter are poorly paid and live in miserable conditions. Unlike those enlisted in the armed forces, they do not have access to insurance or medical coverage or have pension or provident funds upon retirement.

Women make up a large proportion of the Nepalese labour force in India. They end up as

domestic help in rich Indian families or as sex workers in the red light districts in Mumbai, Kolkata, Delhi and Chennai.

Vulnerability to HIV/AIDS

Nepalese women migrants are highly vulnerable to commercial and sexual exploitation. Those who are engaged in commercial sex, live in unhygienic and inhuman conditions; even those who work as domestic help are at risk of being physically and sexually abused by their employers. They are vulnerable to the same sense of displacement and alienation that migrant workers - wherever they may be - face. The need for companionship and intimacy drives them to seek relationships with other Nepali migrant workers employed in the same household or in the same neighbourhood. However, given their isolation, these Nepalese migrants do not have access to information about HIV/AIDS or sexual health services; this renders them vulnerable to HIV/AIDS.

Nepalese sex workers work and live in demeaning and inhuman conditions in India. They are lured by pimps and traffickers with the promise of better jobs - and, in some cases, even marriage to Indians (Gurung, 2001). The majority of sex workers come from poor families, particularly from the backward districts of the Central Development Region. They often start out as migrant workers in search of domestic employment, but find themselves trafficked and sold to middlemen or brothel owners. As sex workers, they are particularly vulnerable to commercial exploitation, and are often chased out of the brothels if they test HIV-positive even if they have nowhere to go.

a) (2) Bangladeshi migrants in India

Numbers, routes, living and working conditions

The number of lawful or documented Bangladeshi migrants into India is far less than the undocumented numbers. Very few of these migrants are educated or skilled. Most of them are either permanent migrants seeking a better livelihood in India or are irregular temporary migrants. Being illiterate and unskilled migrant labourers from rural Bangladesh, they have little access to information regarding migration and employment opportunities in India.

The remittances of these migrant workers are an important source of foreign exchange earnings for Bangladesh. The Bangladesh government's policy on labour migration focusses on the promotion of employment and remittances but, as Chapter 2 establishes, there are little or no provisions to protect the welfare needs and human rights of migrants. Evidence from several micro-studies show that cross-border migration from Bangladesh to India bypasses all legal procedures and is characterised by malpractice of various sorts, on both sides of the border. The lack of legal channels for labour mobility from Bangladesh to India has led to large-scale trafficking of women. Certain geographical locations on the Indo-Bangladesh border are designated transit points for trafficking young women. The women belong to very poor families and are easily lured with promises of marriage or wage work across the border; many of them eventually end up as sex workers in India.

The undocumented migration of very poor, landless families from rural Bangladesh into India is arranged by agents. The migrants join the informal labour workforce as illiterate, unskilled labourers and are vulnerable to exploitation and fraud practices at every level. At their destination, the constant threat of eviction, deportation and joblessness forces them to accept very low wages and miserable work conditions. Where entire families migrate, the women and often the children of the family also take part in wage labour activity, along with domestic chores, to supplement the family income. The burden of having to manage the home front and help bring in additional income is particularly stressful for the women migrants.

Vulnerability to HIV/AIDS

The chapter on Bangladesh details the risk situations that both men and women from Bangladesh face in India. The relatively well-to-do Bangladeshi migrants and the regularly employed

Nepalese migrants in India are, by comparison, less vulnerable than those who are undocumented and in informal jobs. Since Bangladeshi and Nepalese migrants share a common experience - characterised by hardship and economic exploitation - they draw social and emotional support to an extent, but the close ties also heighten peer pressure. The Nepalese migrants in India are, like the Bangladeshis, undocumented; yet, unlike the Bangladeshis, they are not considered illegal migrants. This gives them a sense of security. Searching for jobs is much more difficult for an undocumented Bangladeshi migrant than for a Nepalese migrant worker. The Bangladesh government does not recognise the migration since it was in violation of migration laws, and the migrants are largely unwelcome in India. In that sense, the Bangladeshi migrants are at the bottom of the migration hierarchy in all respects, including housing, access to health and social services (including access to information about HIV), salaries and conditions in the labour market. All this can be traced to their undocumented status and their limited skills.

b) International less-skilled labour migrants

Numbers and routes

Migration of semi-skilled and unskilled labour to West Asia and the OECD countries started in the mid-1970s; the growth in demand for foreign labour was triggered by the oil price boom. The continuing escalation in oil revenues, the high rate of investment in domestic industry and infrastructure of the oil-rich states and the shortage of domestic labour only fuelled this demand further (see Table 1.1 in the Introduction). The migration boom to West Asia was accompanied by the emergence of a large number of recruiting agents, many of whom were illegal and who were exploitative. The Gulf crisis in 1990 triggered a reverse migration process. Even so, from 1990 to 2001, nearly 360,000 labourers migrated from India to the Gulf countries. Saudi Arabia and UAE were the principal destinations for Indian migrants during the past two decades (Table 5.1); in 2000, they accounted for almost 72 per cent of India's total emigration to West Asia (Srivastava and Sasikumar, 2003).

The state-wise distribution of emigration clearances granted during the period 1993-2001 shows that 16 states contributed to the process of emigration to the OECD countries. Three states - Kerala, Tamil Nadu and Andhra Pradesh - together accounted for 60 per cent of those who obtained emigration clearance (Table 5.2). A steady decline in Kerala's share has been accompanied by a rise in

Table 5.1 Distribution of Indian Migrant Workers in West Asia, 1979-2000 (%)

Country	1979	1983	1987	1991	2000
Bahrain	5.19	3.28	7.03	6.64	4.23
Iraq	3.99	5.46	3.19	-	-
Kuwait	12.97	12.55	9.12	5.85	9.12
Libya	2.00	4.37	2.28	0.80	-
Oman	11.98	10.92	16.79	14.62	11.07
Qatar	5.99	4.37	4.56	4.98	3.91
Saudi Arabia	19.96	29.48	34.67	39.87	39.09
UAE	30.34	27.29	20.53	26.58	32.57
Others	7.58	2.29	1.82	0.66	-
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Source: Based on data of Ministry of External Affairs, GOI (Srivastava and Sasikumar, 2003).

the corresponding numbers for Tamil Nadu and Andhra Pradesh. This could also mean that those who are migrating from Kerala are now engaged in skilled and professional work, and that there has been a larger outflow of unskilled labour from other states.

However, this data source (furnished by the Ministry of Labour, Government of India) tells only a part of the emigration story: it relates only to those who demanded and obtained emigration clearance while migrating. The volume of irregular migration - which takes place by manipulating tourist or business visas - is not reflected in these statistics. Those who travel for non-employment purposes and later stay on and find employment in the destination country miss out on the advantage of legal clearance (suspension of ECR) and remain outside the data bank.

Since the mid-1980s, there has been a reverse migration from West Asian countries to India. With labour supply in excess of employment opportunities, this has become an inevitable aspect of temporary or contract migration. But in spite of the continuous labour flow in both directions, there is a paucity of data to gauge the magnitude of the return flow. Zachariah et al. (2002) estimate that nearly 147,000 persons returned to Kerala alone from 1988 to 1992, and 400,000 persons from 1993 to 1997. The Kerala State Planning Board estimated a total of 1.6 million Keralites to be working in West Asia (State Planning Board, 1998). The current number of return migrants in the state would be around 750,000.

Living and working conditions

In 1983, new legislation was introduced to promote labour migration and protect migrants by regulating private recruitment agencies through a

Table 5.2 State-wise Distribution of Emigration Clearances Granted (%)

State	1993	1994	1995	1996	1997	1998	1999	2000	2001
Andhra Pradesh	8.12	8.11	7.29	7.24	9.19	8.62	9.58	12.47	13.64
Bihar	1.72	1.60	1.41	1.40	1.53	4.10	2.96	2.80	3.55
Gujarat	3.14	3.01	2.93	2.89	3.07	2.40	2.00	2.38	3.99
Goa	0.39	0.04	0.23	0.23	0.25	0.27	0.27	0.55	0.82
Haryana	0.19	0.18	0.19	0.22	0.22	0.48	0.15	0.02	0.06
Karnataka	7.84	7.58	8.06	8.15	9.70	3.25	2.67	4.54	3.69
Kerala	35.41	36.30	15.80	40.40	37.49	25.82	30.52	28.95	22.48
M.P.	1.49	1.37	1.02	1.00	0.94	1.81	0.46	0.71	1.84
Maharashtra	8.04	7.56	6.34	6.09	6.04	6.94	4.98	5.55	8.30
Orissa	0.80	0.85	0.89	0.83	0.84	0.58	0.28	0.24	1.10
Punjab	3.24	2.93	2.85	2.84	2.98	7.57	7.66	4.17	4.54
Rajasthan	5.76	6.45	6.83	4.40	6.78	5.58	4.95	4.23	5.48
Tamil Nadu	16.04	16.58	15.83	15.69	15.29	19.65	23.93	26.56	22.52
U.P.	5.73	5.36	4.56	4.58	4.26	9.50	5.95	3.81	5.08
West Bengal	0.64	0.47	0.55	0.57	0.54	1.06	0.79	0.81	1.76
Delhi	0.99	0.90	0.79	0.70	0.60	1.56	1.80	1.32	1.16
Others	0.46	0.72	24.42	2.77	0.27	0.81	1.05	0.90	0.00
Total	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Source: Based on data of Ministry of Labour, GOI (Srivastava and Sasikumar, 2003).

licensing system and establishing public sector recruiting agencies (Appleyard, 1988: 114). To date, however, labour market development and marketing has largely hinged on the personal efforts of job seekers, kinship/personal links and the efforts of some state governments. For example, in 1977, the Kerala government established the Overseas Development and Employment Promotion Consultants. Currently, nine such organisations exist in various states: Kerala, Tamil Nadu, Andhra Pradesh, Uttar Pradesh, Karnataka, Himachal Pradesh, Punjab and the Union Territory of Delhi. However, there has been no coordinated national activity. 'Mostly recruiting agencies search out the new areas and avenues for deployment of Indian workers abroad' (Indian Ministry of Labour, 2003).

Little or no official effort is directed at protecting migrant workers' rights both at the time of recruitment and during the period of employment. According to Watkins and Nurick (2002: 65), official Indian policy with regard to migration is best characterised as being laissez faire. Its policies have removed restrictions to emigration, but they do relatively little to support and protect migrants once they leave the country. There is currently a proposal to set up a Central Manpower Export Council to promote employment opportunities in various countries, establish and operate a data bank of workers seeking employment overseas, lay down standards and guidelines for recruitment for overseas employment and advise Central and state governments and training institutes on redesigning their training programmes to keep pace with technological developments and current-day requirements (Indian Ministry of Labour, 2003).

In the absence of adequate protective mechanisms and given the severity of problems experienced by women migrants in West Asia, the National Commission of Women has called on the Labour Ministry to increase the minimum age for female migrant workers to West Asia. This proposal has been accepted by the Protector of Emigrants, and the government is considering prohibiting women under 35 from working in West Asia (Mistra, 2003). However, the government has not proposed any programmes that address the socio-economic needs of women migrants.

There is, for instance, no government intervention in the area of remittances, in spite of the significant contribution of remittances to foreign exchange earnings (around 10 per cent); likewise, there are no programmes that address the reintegration needs of returning migrants. There is no official information about the occupational patterns and investment decisions of returnees; the few initiatives in this space have been spearheaded by NGOs. It is often difficult for returnees to give an honest account of their negative experiences, if any, for fear of being marginalised by their community (D'Sami, 2000: 1).

Health risks

Migrants do not have access to any countrywide pre-migration training or awareness programmes. At best, some technical skills are provided to construction workers - either through NGO networks or through sponsoring agencies in the receiving county. Likewise, there is no welfare fund for workers abroad; there is, however, a proposal from the Ministry of Labour for the constitution of such a fund to be utilised to meet eventualities such as:

- repatriation of stranded workers;
- granting of lumpsum assistance to the families of workers who die while working with foreign employers;
- granting of lumpsum assistance to workers who become permanently disabled while working with foreign employers.

The health risks facing Indian contract labour migrants are similar to or worse than those facing Bangladeshi and Sri Lankan workers, which have been dealt with in other chapters. Given that the Indian government plays a limited part in protecting and supporting its offshore workers, the situation may perhaps be rather more extreme.

Vulnerability to HIV/AIDS

A returning migrant is often unaware of whether he has been infected with HIV, and the potential risk

of infection that his spouse and unborn children face. Even those returning because of illness, due to infections, may be unaware if their poor health is a consequence of HIV infection. Even those who know that they have been infected with HIV or other STD do not disclose this or protect their partner for fear of being stigmatised, discriminated against and denied access to treatment.

c) Highly skilled migrants

People with technical skill and professional expertise also migrate to countries such as the US, the UK, Canada and Australia as permanent migrants; there is an increasing trend of return, often temporary migration. Migration trends show that the US received the largest number of Indian emigrants between 1951 and 1990. A striking feature of migration flow in the 1990s, was the growing importance of newer destination countries such as Australia, Germany, Japan and Malaysia. Although this report focusses largely on less skilled internal and cross-border migrants, highly skilled Indian migrants overseas too are vulnerable on many counts, despite their education and access to services. For instance, they are not immune to the sense of displacement, loneliness that comes from being far away from familiar social nets and traditional norms.

5.5 Identification of Groups Vulnerable to HIV

Migrants find themselves in a vulnerable position in terms of access to health services in the destination countries owing to several factors. Some of these are the language barrier they are likely to encounter, the differences in the understood concepts of health and disease, the absence of migrant-friendly services, and ethnic problems that may exist in the society they have settled into. In addition, undocumented migrants, who do not have a legal status, are more vulnerable due to social pressure and fear of police raids, apart from the fact that they have to live in deplorable situations. Most migrants do not have the financial resources to buy health services or are unable to access local health services due to their status as irregular migrants. Many take on several jobs and work long and odd hours.

The concerns of different groups of migrants must be addressed separately as the vulnerability of each group is distinct. More than a country-wise classification of migrants, their categorisation in terms of their vulnerability to HIV/AIDS is more meaningful. That's because documented and undocumented migrants, poor and not so poor migrants and men and women migrants are vulnerable in different ways. Listing groups of migrants in terms of their vulnerability to HIV infection establishes this "hierarchy" in descending order of vulnerability:

- **Single women migrants working in or trafficked into brothel-based sex work across national borders or internally between states and districts in India**
- **Single women migrants in informal activity (inter-district and intra-state)**
- **Single, undocumented male migrants (across national borders; in particular, Bangladeshi migrants)**
- **Single male migrants working in the informal sector (inter-district and intra-state)**
- **Families of poor migrant workers without 'legal' entry (across national borders)**
- **The single male returnee migrant's spouse and sexual partners in source areas (across national borders)**

In addition, there are a number of other categories of mobile populations that are vulnerable to HIV infection, which must also be considered when designing a response. These include:

- **Highly mobile working men.** Single/married men who travel on work, such as truckers, are highly vulnerable. They regularly engage in extra-familial sexual relations with sex workers. As multi-partner clients of sex workers who do not always practise safe sex, they are vulnerable to HIV infection, and unknowingly infect their spouse. This group is highly vulnerable to infection as a result of

unsafe practises related to injecting drug use (IDU) or unprotected sex with men.

■ **Students migrating inter-state and intra-state.** Male students migrating to cities are vulnerable to HIV infection. Typically, they belong to a younger age group and, most often, live with other men in hostels. They tend to seek the company of sex workers or other women and are vulnerable to HIV infection. The sexual vulnerability of these men arises from unsafe practices related to IDU or from having unprotected sex with men.

A ranking of various migrant groups based on the degree of their vulnerability to infection also helps establish the common aspects of vulnerability. Cross-border migrants are often more vulnerable than inter-state migrants. The stress of remaining undocumented in the host country and of not being acknowledged as an emigrant in their place of origin is doubly enormous. The threat of deportation constantly haunts irregular migrants in transit and at the destination area. They also live in fear of being cheated and exploited by agents, contractors and employers, and of being entrapped deeper in debt. If they are permanent migrants, the option of visiting home is lost forever; assimilating and fitting into the new place is a difficult process. Language barrier and the ethnic distance impose economic pressure and, consequently, affect the general well-being of the migrants. They also have to deal with the hostility of the local community with whom they compete for scarce livelihood options; in addition, exploitation, violence, abuse and limited recreational options are everyday realities for migrant workers. Separation from family, partners and friends often triggers an emotional crisis. Psychological pressure, heightened aspirations and disappointments also result in depression and create vulnerability. Many migrant workers are driven to desperate coping strategies such as taking to drug use or commercial sex. Even if they are aware of safe sex practices and have access to condoms, many of them don't use them because of prevailing myths that condoms interfere with sexual gratification. Local communities are also highly vulnerable to infection because migrant men may have sex with men or women from the local communities - either regularly or in one-time encounters.

Vulnerability in transit is high owing to the lack of support systems to fall back upon. This is particularly accentuated by the lack of information both in transit and at the destination areas. Migrant women who start out looking for jobs may find themselves trafficked along the way. On return, these workers come back to the same unsafe condition under which migration took place, and others close to them are also vulnerable to similar risks.

The absence of official channels to document the migration of women at the source or destination areas enhances the vulnerability of those who seek employment; on most occasions, illegal transfer leads to trafficking.

5.6 Prevention of HIV Infection Among Migrants: A Review of Existing Programmes, Services and Interventions

General services and policies

The nature of the official response to HIV infection has varied critically over time. In the first phase of the HIV/AIDS epidemic in 1986-92, the response was characterised by denial and indifference from most quarters. Surveillance activities were launched in 55 sites in three states alone, and these efforts remained fragmented.

By 1992, the response accelerated, with support from the World Health Organisation (WHO) and the World Bank. The establishment of the National AIDS Control Organisation (NACO) marked the start of the first phase of the National AIDS Control Programme (1992-1999). Among its notable achievements were a general and widespread raising of HIV/AIDS awareness, the establishment of state-level structures to implement these programmes and a marked improvement in blood safety measures. Even so, the approach still remained primarily medical; HIV was seen largely as a health issue.

The second phase of the National AIDS Control Programme, which was initiated in 1999 and will

wind down in 2004, made targeted interventions at groups that were highly vulnerable to infection; this phase was also characterised by a decentralisation of programmes at the state-level, and increased emphasis on the need to look beyond a medical response by adopting a multi-sectoral approach. The formation of new partnership with NGOs and Community-Based Organisation (CBOs) opened up the possibility of launching innovative approaches to provide the scale and variety of technical resources needed for the programme. Surveillance was expanded and strengthened and 12 Technical Resource Groups were set up to provide technical support. Five crucial areas were marked for effective implementation:

- **Strengthening capacities within states rapidly.** This envisaged new models of partnership between governments and NGOs/CBOs, massive training and capacity-building efforts and provision of technical resources, together with the development of support systems for implementation in all the states, whether they were in an early or advanced stage of the epidemic.
- **Ensuring targeted interventions for effective impact.** The focus was on groups that were highly vulnerable, without in the process marginalising them. The aim was to provide information, services and support with high-level coverage and attain saturation. The idea was to create an 'enabling' environment so as to empower the marginalised groups.
- **Inducing behaviour change beyond the vulnerable groups.** This entailed moving beyond awareness creation to ensure behavioral change, and full coverage of the vulnerable population. The size and heterogeneity of the group posed a challenge. The social mobilisation effort involved youths and grassroots-level workers down to the village level.
- **Tackling discrimination and stigma.** Innovative interventions were devised at the state level to prevent stigmatisation; this effort involved civil society debates on public health and human rights.
- Addressing the urgency of care and support. The need for care and support services through non-institutional, home-based care models was recognised. A scaling up of the existing programmes was designed to take advantage of the huge investments already made on health services.

Services and policies specific to migrants

There are no specific services for migrants at this stage. However, the National AIDS Control Policy explicitly acknowledges that "labour migration and mobility in search of employment from economically backward to more advanced regions" is an attributable factor for the rapid spread of the epidemic across the country.

5.7 Policy Gaps and Recommendations

Policy gaps

India is in the process of formulating the third phase of its National AIDS Control Programme. Against this background, it is critical to identify gaps in the policy formulations so as to facilitate

> While addressing the problem of HIV/AIDS among the economically productive and sexually active sections of population, specific emphasis needs to be given not only to high risk groups like commercial sex workers and injecting drug users, but also to specific groups in general population like students, youth, migrant workers in urban and rural areas, women and children. Migration of economically productive sections of population from rural to urban areas in search of employment is a common phenomenon all over the country. Most of the migrant labourers are in the disorganized sector, are highly mobile and live in unhygienic conditions in urban slums. Long working hours, relative isolation from the family and geographical social mobility may foster casual sexual relationships and make them highly vulnerable to STDs/HIV/AIDS. All these aspects provide an unusual challenge of spread of HIV infection through various routes which comes with its long period of invisibility and subsequent manifestation through opportunistic infections.
>
> National AIDS Control Policy, Government of India

the inclusion of appropriate responses to address the vulnerabilities of migrant populations. Some of these gaps are:

- The inadequate attention given to the risk of stigma that could arise from attributing the spread of the epidemic to the movement of migrant workers and the failure to acknowledge that it is the circumstances of migration that make migrant workers vulnerable.
- The absence of focussed efforts to provide services including prevention, voluntary counseling and treatment (VCT), STD and treatment, care and support to migrant workers and their families
- The lack of initiatives to reduce the vulnerability of spouses, in particular women left behind in source areas of migration
- The inadequacy of systems to reach out to HIV-positive migrants and facilitate treatment adherence
- Insufficient attention to the so-called low prevalence states - Bihar, Uttar Pradesh, Madhya Pradesh, Orissa, Chattisgarh - which are the key source states for migration

The focus on rapid and effective implementation of programmes has promoted technological and managerial solutions, but has tended to overlook social and culturally rooted development dimensions. Some examples:

- The promotion of condom use, VCT and STD management are useful service, but these should have gone along with efforts to address gender inequity, which gives women, including spouses of migrant workers, very little control over their sexual life, including protection against HIV/AIDS;
- Programmes aimed at prevention of mother-to-child HIV transmission (PMTCT) has not been accompanied by efforts to protect women who often have been infected by their migrant husbands but are blamed by the families for the HIV infection
- The emphasis is largely on inducing behavioural change; not enough has been done to address the structural causes of vulnerability to HIV - such as the sexual needs of young migrant workers separated from their spouses, who visit sex workers who in turn have no power to negotiate condom use.

The control of HIV transmission can only be envisaged in an enabling environment that empowers everyone who is vulnerable. The focus on targeted interventions for vulnerable groups and bridge populations has promoted a false sense of security in the general population. Broader responses that include both rural and urban communities (to which vulnerable populations, such as migrant workers, belong) must be developed to mobilise a societal response to the epidemic rather than isolated interventions. Such responses would address the gender bias against women and promote gender equity as one of the key elements for effective implementation.

So far, prevention efforts have looked at the developmental dimensions of HIV only to a limited extent. These programmes have not directly addressed macro-level phenomena such as economic development, migration and mobility, poverty, illiteracy and gender equality, even though all these issues have been acknowledged in the National Policy as key underlying factors in the spread of the epidemic.

Recommendations

Some recommendations in respect of migrants are quite similar to those for the communities at large. These seek to address the migrant-related issues that India has to grapple with. The country has both in-migrants and returnee migrants. Since migrants, in their many forms, make up such a significant component of the population, the general recommendations will be posed first. Many immigrants within India's borders are currently highly vulnerable to HIV/AIDS and they and their families and communities need attention, as do the returning out-migrants.

Define a new paradigm for public discourse

In order to change the norms and practices that increase the vulnerability of mobile and migrant populations, there is a need for a whole new paradigm for public discourse, one that envisages close partnerships between the state and civil society, and programmes that are planned

sensitively and comprehensively. The following elements could be considered:

- Recasting the awareness and sensitisation programmes so that the most disadvantaged sections (in terms of illiteracy) can easily get access to HIV-related information, condoms and services;
- Strengthening the role of men in family planning by promoting condom use as a mode of preventing both unwanted pregnancies and HIV/AIDS, and practising a more responsible sexuality that is sensitive to the safety of their sex partners, whether they are spouses, sex workers or other women and men;
- Breaking taboos and generating open discussion on sex and sexuality among all segments of society, but with emphasis on women and illiterate men.

Partnerships with panchayats[5]

Panchayats could be involved in influencing the relatively less educated rural populations about unsafe migration and the associated health risks. They can also help strengthen the system of the palayan register, under which people could register at the time of migration. This would be especially helpful in checking trafficking and exploitation of migrants. However, it is critical that the registration be a voluntary effort. Panchayats could also play an important role in pre-departure orientation or preparedness programmes for migrants. This would ensure that migrants make more informed choices regarding their migration; it would also build up a data bank of information about people's movements.

Following the general guideline framework mentioned above, strategies for the effective prevention of HIV/AIDS among migrants could aim to evolve into becoming a composite plan at the local level. Migration is a process that affects two or more communities; priority must be given to improving the access to healthcare of the migrating populations as well as the communities they form a part of. Another element of such a strategy would be to reduce discrimination against undocumented migrants in destination areas through concerted efforts involving civil society, private sector and government bodies.

HIV mainstreaming within reproductive rights of men and women

A complementary approach could be developed to broaden out family planning initiatives so as to ensure the right to reproductive health for all people. This would require linking up the inexpensive treatment of STD with sexual transmission of HIV to make it even more cost-effective (UNAIDS, 2001).

Inventory of information

Building an inventory of information for different migrant groups and mobile individuals through various stages has the potential to strengthen the responses by:

1. Helping to understand the pattern of migration;
2. Linking the reasons for migration with nature of movement;
3. Identifying the source communities, transit points and destination areas of migration.

This could take the form of a Behavioural Surveillance Survey (BSS) among different segments of migrant and mobile populations.

Advocacy for improved living and working conditions for overseas migrant workers

The Indian government could intensify efforts to establish bilateral agreements between countries that send and receive labour, with a focus on protecting migrant workers' needs and interest. The 1990 UN Convention on Migrant Workers and Their Families could provide a template for establishing an international framework that seeks to protect the interests of workers offshore. The establishment of a Central Manpower Export Promotion Council, as proposed, to promote overseas employment, provide technical support and disseminate information could also help reduce the vulnerability of migrant workers to exploitation and HIV/AIDS.

Systems that offer migrant-friendly services

The services currently available to the communities at large may not be useful or

5 Rural self-governance institutions

accessible to migrant workers for various reasons. Services and information must be made available in the migrant workers' own language, at a time when most of them are able to access them (including night-time services), and from various sources, including both workplaces and communities. While many migrant workers are accessible at their workplaces, a large number of them do sundry jobs and do not have one particular workplace. They can be better reached at the community level.

5.8 List of Resources

Various resources exist and provide support to programmes related to HIV/AIDS. Institutions directly involved in providing support and infrastructure, law and policy-framing bodies with a positive outlook, non-government and voluntary agencies as representatives of civil society and the media - all of them provide various kinds of resources to fight the epidemic. The active involvement of the Ministries of Home Affairs, Labour and Women and Children is important - since they are either major employers of mobile workers or have a stake in migration and human trafficking. If these resources are utilised in a planned manner, they can generate a synergy that will impact the spread of the HIV/AIDS epidemic.

NACO and state counterparts

The first initiative that the Indian government has taken is to assume leadership for the fight against AIDS through the National AIDS Control Organisation. NACO has supported the establishment of State AIDS Control Societies at the state level and provided technical and financial support for their work at a decentralised level. States are being encouraged to generate political and administrative will to overcome the lack of inertia in the area of public health and indifference towards ensuring civil society participation. The Tamil Nadu State AIDS Control Society (TNSACS) and the All India Institute of Hygiene and Public Health (AIIHPH) are two pioneering bodies that have achieved success to a large extent. The emphasis has been in three areas: organisational reform, media involvement and state-NGO partnership.

Non-governmental organisations

Partnerships between the state and NGOs are developing gradually; NGOs working with HIV and migration issues, which have been identified and recognised by NACO, have been listed (See Appendix 1). Some of these NGOs are working to promote social development to ensure a better living for people, and have now taken on the HIV/AIDS agenda. Other NGOs are working directly on HIV/AIDS issues, but are starting to include mobile and migrant populations and communities through focussed responses. Co-operation between the state and civil society is strengthening, with the government having recognised the advantages that CBOs and NGOs bring in terms of outreach to the most vulnerable segments of society.

Legal and policy framework

Law and policy measures can be the cornerstones in cementing a rights-based approach and providing an enabling environment to combat the HIV/AIDS epidemic. They also highlight the areas for critical intervention and the nature of co-operation that can be extended towards different vulnerable groups.

The overseas employment policy regime in India, mainly addresses temporary and contract migration. The most important policy instrument is the Emigration Act, 1983, which deals with emigration of Indian workers for overseas employment on a contractual basis and seeks to safeguard their interest and ensure their welfare.

Section 10 of the Act lays down qualifying norms for recruiting agents - they must be registered and be financially sound - and lays down the fees that they may charge. (Authorised agents can charge fees ranging from Rs 2,000 for unskilled migrants, Rs 3,000 for semi-skilled, Rs 5,000 for skilled and Rs 10,000 for professionals.) These provisions seek to protect migrant workers from

economic exploitation, which is of course important; but this could be expanded to address issues related to HIV/AIDS and health and social concerns as well.

There is a compelling need to draw up a policy that addresses the specific concerns of migrants. Since social behaviour and sexual practices are critical determinants of how rapidly the epidemic spreads, every effort must be made to enlist civil society participation in the efforts to combat it. Research by NGOs, institutes and scholars form an important resource base for this task. Innovative policy and sensitive surveillance methods could follow from the attempt to incorporate recent understandings regarding better health and secure treatment. Only then can the available range of resources be utilised optimally for an effective and comprehensive response to the epidemic.

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Appendix 1: List of NGOs in India Involved in Migrant Workers and HIV/AIDS

NGO	STATE	GROUP
Organisation for Tribal Development, Bathu Basti, Glenchamme.	Andaman and Nicobar Island	Migrant Labour
Arunachal Pradesh Welfare Society, Itanagar	Arunachal Pradesh	Migrant Labour
NESPYM	Assam	Transport Workers
Rural Multimedia Publicity and Promotion	Assam	Migrant Labour
Association for Socio-cultural & Environmental Development	Assam	Migrant Labour
Jan Shikshan Sansthan SCO 313	Chandigarh	Migrant Population
Family Planning Association of India, Mohali	Chandigarh	CSW, Transport Workers, Migrants
DISHA, New Delhi	Delhi	Migrant Labour
Society for Services to Voluntary Agencies, Hari Nagar Ashram	Delhi	Migrant Labour
Child Survival in India	Delhi	Migrant Labour
Jan Uqahi	Goa	Migrant Labour
Sarvodaya Mahila Udhyog Mandal, Jamnagar	Gujarat	Migrant Workers
Shroff Foundation, Vadodara	Gujarat	Migrant Workers
Bhavnagar Blood Bank, Bhavnagar	Gujarat	Migrant Workers
Deepak Charitable Trust, Vadodara	Gujarat	Migrant Workers
SAHAS, Surat	Gujarat	Migrant Workers
Trust for Reaching the Unreached	Gujarat	Migrant Workers
SNS Foundation, Gurgaon	Haryana	Migrant Workers
Surya Foundation, Chandigarh	Haryana	Migrant Workers
SAWERA, New Delhi	Haryana	Migrant Workers
Dhauladhar Public Education Society, Kangra.	Himachal Pradesh	Migrant Mine Workers
DEEDS, Bangalore	Karnataka	Migrant Labour
SURAKSHA, Bangalore	Karnataka	Migrant Labour
Citizen Alliance for Rural Development & Training Society, Bangalore	Karnataka	Migrant Population
Gram Swaraj Samsthe, Bangalore	Karnataka	Migrant Workers
Pranja councelling Centre, Mangalore	Karnataka	Migrant Workers
HILDA, Wayanad	Kerala	Tribal people, TW, Migrants
Institute of Applied Dermatology, Kasargode	Kerala	Sex Workers, Migrant Workers, Slum Dwellers
Solidarity Movement of India, Idduki	Kerala	Tribal people, Migrant Workers, Slum Dwellers

Source: National AIDS Control Organisation, http://naco.nic.in/vsnaco/nacp/activity.htm (Srivastava and Sasikumar, 2002).

NGO	STATE	GROUP
Kerala Association for Social and Women's Welfare, Kollam	Kerala	Slum Dwellers, Migrant Workers
Naranganam Rural Development Society	Kerala	CSW, Migrant Workers
RANBAXY	Madhya Pradesh	Migrant Workers, Truckers
CLEAR, Bilaspur	Madhya Pradesh	Mine Workers, Migrant Labour
Padki Education Society, Ichalkarangi	Maharashtra	Migrants
Nandkishore Education Society, Nasik	Maharashtra	Migrants
CASP, PEN Raigarh	Maharashtra	Migrants
Jagruti Kendra, Mumbai	Maharashtra	Migrant Labour
Nagar Seva Probodhini, Mumbai	Maharashtra	Migrant Labour
AIDS Prevention Society, Shillong	Meghalaya	Migrant Labour
South Orissa Voluntary Association, Koraput	Orissa	Migrant Labour
Indo-National Socio-Economic Foundation, Bhubhaneswar	Orissa	Migrant Labour
National Institute of Applied Human Research and Development, Cuttack	Orissa	Migrant Labour
Orissa Institute of Medical Research and Health Services, Cuttack	Orissa	Migrant Labour
Society for Services to Voluntary Agencies	Punjab	Migrant Labour
GDC Rural Research Foundation, Jaipur	Rajasthan	Migrant Labour
Family Planning Association of India, Jaipur	Rajasthan	In Migrants
Rajasthan Medical Society and Research Centre	Rajasthan	Out Migrants
Himali Club, Sikkim	Sikkim	Migrants, Industrial Labour
Tamil Nadu Rural Environment Development Organisation, Madurai	Tamil Nadu	Migrant Labour
GRAMODAYA, Tiruchi	Tamil Nadu	Migrants, Sex Workers
Society for Social Education and Development, Chennai	Tamil Nadu	Migrant Workers
Krithialaya, Korattur, Chennai	Tamil Nadu	Migrants in Slums
Human Uplift Trust, Tiruchi	Tamil Nadu	Migrant Labour, CSW
Durga Women's Organisation, Thanjavur	Tamil Nadu	Migrant Workers
Dhanam Trust, Theni	Tamil Nadu	Migrant Workers
Society Organised for Promotion of Rural, Tribal and Downtrodden, Tiruchi	Tamil Nadu	Migrant Workers
Lion's Club, Agartala	Tripura	Migrant Workers
Udiyaman Sangha, Agartala	Tripura	Migrant Workers
Krishak sangha, Dhalai	Tripura	Migrant Workers
ACTION, Abhoynagar	Tripura	Migrant Workers
Organisation for Rural Services, Belonia	Tripura	Migrant Workers

Source: National AIDS Control Organisation, http://naco.nic.in/vsnaco/nacp/activity.htm (Srivastava and Sasikumar, 2002).

NGO	STATE	GROUP
The Calcutta Samaritan	West Bengal	CSW, Drug Users, Migrant Workers
Bhoruka Public Welfare Trust, Kolkata	West Bengal	Truckers, Migrant Workers
Matri-o-Shishu Bikash Kendra	West Bengal	Women and Children
Alakendu Bodth Niketan, Kolkata	West Bengal	Challenged Workers
Durbar Mahila Sammannaya	West Bengal	CSW
SANLAAP	West Bengal	CSW, Women
JABALA	West Bengal	CSW, Street Children
CINI (ASHA)	West Bengal	Women, Children, grant Workers

Source: National AIDS Control Organisation, http://naco.nic.in/vsnaco/nacp/activity.htm (Srivastava and Sasikumar, 2002).

CHAPTER 6

PEOPLE'S REPUBLIC OF MONGOLIA

Zheng Zhenzhen[1] and Ren Qiang[2]

6.1 Background and Method

Mongolia is a landlocked country of 1,564,560 sq. km. It is larger than Western Europe, but has a population of only 2.5 million; in fact, it is one of the most sparsely populated countries in the world. Mongolia has four major geographic zones: the Gobi Desert in the south; the grasslands in the east, which are mainly used for nomadic pastoralism; the Hangai mountainous region in the north central region, and the Altai Mountain Range in the west.

In 1990, the People's Republic embraced democracy and an open market economy. This dramatic shift resulted in enormous social and economic changes that continue to unfold today. Increasing privatisation and incorporation into the global economy have led to a decline in traditional pastoral activities and a rise in secondary and tertiary sector activities. The growth of the capital, Ulaanbaatar, has been part of this process. Internal rural-urban mobility has increased; additionally, large numbers of mobile populations are now crossing borders and entering into neighbouring countries.

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The health situation of people in Mongolia has been severely affected by the transition to a market economy. The transition has eroded health advances made in the past - in the areas of providing infrastructure, training and hygiene - and there is a shortage of medicine and equipment (McMurray and Smith, 2001). The breakdown of the socialist system of health services and economy has resulted in:

- a decline in food production;
- a reversal in mortality decline: male adult mortality rose during the 1990s;
- an increase in maternal mortality in the 1990s due to a deterioration in maternal services and an increase in unsafe abortions;
- an increase in morbidity rates: the incidence of communicable diseases (CDs), such as TB, hepatitis, skin diseases and sexually transmitted infection (STIs), and non-CDs is on the increase.

Table 6.1 shows the most recent population variables of Mongolia produced by the Population Reference Bureau of the US. Another important information source is the Mongolia National Census of 2000, which gives the precise number of residents in Mongolia: 2,373,493. Almost one-third of this population lives in Ulaanbaatar, which has the highest population density: 161.7 persons per sq. km (the national average population density is 1.5). The average annual rate of population growth was 1.4 per cent during the years between the two censuses, 1989 and 2000. The male:female sex ratio declined from 99.7 in 1989 to 98.5 in 2000. The Mongolia National Statistical Office suggested two possible causes for the decline: improved life

expectancy for women relative to men, and higher out-migration of men.

Compared to previous censuses, the proportion of population in the 15-64 age group has gone up in Census 2000. The proportion of children under 14 years of age as well as people aged 65 and above has declined. Taken together, these statistics reflect an increase in the proportion of the population in the working age.

By the age of 50, only about 3 per cent of the population has never been married. However, there is a discernible tendency to delay the age of marriage; also, Census 2000 shows up an increase in the number of divorces and separations.

Mongolia has a relatively high literacy rate: 97.8 per cent of the population aged 15 or above is literate. While there is little to distinguish between male and female literacy rates, the difference between rural and urban dwellers is significant. The rural illiteracy rate is three times higher than the urban rate, but more urban people receive secondary or higher education than rural people (74.1 per cent for urban; 52.0 per cent for rural).

Of the 944,083 persons in the labour force, 82.5 per cent are employed. The occupational break-up is: agriculturalists (46.2 per cent),

Table 6.1 Mongolia Population Data, 2003

Demographic Variable	Data
Population in mid-2003	2,500,000
Birth Rate (annual number of births per 1,000 total population)	18
Death Rate (annual number of deaths per 1,000 total population)	8
Rate of Natural Incr. (birth rate minus death rate, expressed as a %)	1.1
Infant Mortality Rate (infant deaths per 1,000 live births)	30
Total Fertility Rate (avg. no. of children born to a woman during her lifetime)	2.7
Population Under Age 15 (%)	36
Population Over Age 65 (%)	5
Life Expectancy at Birth, Both Sexes (years)	65
Life Expectancy at Birth, Men (years)	63
Life Expectancy at Birth, Women (years)	68
Urban Population (%)	57
Population Ages 15-49 Living with HIV/AIDS at End of 2001 (%)	<0.05
Contraceptive Use Among Married Women 15-49, All Methods (%)	60
Contraceptive Use Among Married Women 15-49, Modern Methods (%)	46
Births Attended by Skilled Personnel (%)	93
Maternal Deaths per 100,000 Live Births	65
Women Among Population 15-49 Living with HIV/AIDS (%)	-
Labour Force Participation (ages 15-64), 1980, Women (%)	76
Labour Force Participation (ages 15-64), 2000, Women (%)	77
Labour Force Participation (ages 15-64), 2000, Men (%)	86
Source of Supply of Modern Contraceptive Methods, Public (%)	75.8
Source of Supply of Modern Methods, Private Medical (%)	19.5
Source of Supply of Modern Methods, Other Private (%)	4.8

Source: Population Reference Bureau, 2003 World Population Data Sheet (http://www.prb.org).

professionals (9.6 per cent), service/shop/market sales workers (8.9) and craft and related workers (8.3 per cent). More women than men work in the education and health sectors, hotels/restaurants and financial services, as well as in traditional manufacturing and trade sectors. There are more unemployed men than women in urban areas: 67,900 men (26.0 per cent of those aged 15 or above); 49,900 women (22.4 per cent).

Census 2000 listed 8,128 foreign citizens, mainly from Russia (41.5 per cent) and China (24.8 per cent); 56 per cent of the foreign citizens lived in Ulaanbaatar, and about 27 per cent in the other two large urban centres. Compared to local residents, more foreign citizens were aged 35 or above.

The information sources for this report were very scanty: limited literature in English or Chinese, tabulations from the Mongolian National Census and Reproductive Health Survey, information from websites, and interviews with Mongolian officials and academia. Large knowledge gaps are evident, making it difficult to provide a precise picture. Further research is necessary to inform any HIV prevention programme design that addresses migration.

6.2 HIV/AIDS Situation in Mongolia

A study conducted between 1987 and the mid-1990s found that of 176,000 HIV tests carried out, there was only one reported case of HIV infection. However, the incidence of STIs is on the rise; the majority of these cases are in the 15-44 age group. The incidence of syphilis in the 15-24 age group is much higher - by 150-300 per cent - than for any other age group (Purevdawa et al., 1997). Migrant workers usually belong to these age groups.

A reproductive health survey carried out among 7,461 women in the childbearing age (15-49 years) in late 1998 also collected information on their knowledge and attitudes relating to HIV/AIDS. Some 96 per cent of the respondents had heard about HIV/AIDS - mostly from television, radio and newspapers. Most respondents also knew about HIV/AIDS prevention: the most common responses being to restrict sex to one partner and/or to use condoms. However, many women were ill-formed about the risks of HIV infection. For example, one-third of the women said they felt that a healthy-looking person could not be HIV-infected. Women with a lower standard of education were rather less aware of HIV/AIDS.

Mongolia has only four officially reported cases of HIV/AIDS; however, the vulnerability of the country's population to the epidemic is recognised. In the 2001 annual report of the National AIDS Foundation (NAF)[3] of Mongolia, the following challenges to the HIV prevention effort were highlighted:

- There is a large adolescent population: 50 per cent of the population is below 21 years of age, and the pattern of sexual activity among young people is changing;
- The prevalence of sexually transmitted infection is high and condom use is low;
- Recreational drug use is becoming widespread and there is early evidence of injecting drug use (IDU) (NAF, 2001b);
- Widespread poverty (36 per cent in the LSM survey of 1998) is resulting in deteriorating standards of public health, homeless children and adults, school dropouts and an increasing number of sex workers;
- The HIV epidemic is spreading rapidly in the region: areas on Mongolia's northern border are in its grip, and the other borders too are susceptible;
- Internal migration is increasing, since the rural areas have poor amenities and infrastructure: the rural population in half the country is bracing itself for a third consecutive year of disaster caused by abnormal winter weather (NAF, 2001a)

6.3 Internal Migration

Numbers and migration routes

The 2000 Census records lifetime ('permanent')

3 NAF's mission is to contribute to a concerted national response to STI/HIV/AIDS by supporting civil society efforts to address community sexual health, STI/HIV prevention, care, support and the protection of human rights of people living with HIV/AIDS. For further information, see http://www.naf.org.mn/

migration during 1995-2000, and a year prior to the Census. Five-year and more recent mobility patterns are relevant for this report. Many of the short-term movements to China are not adequately captured by the Census.

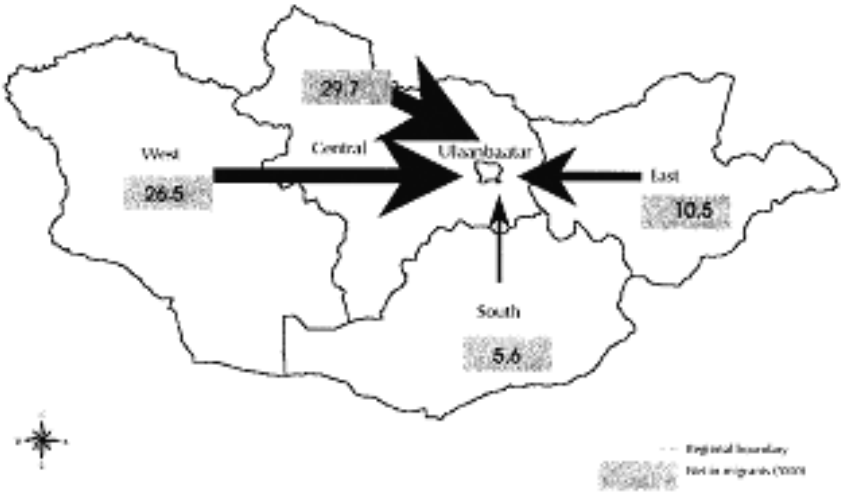
The largest outflow during 1995-2000 was from the western region to other regions, mainly to Ulaanbaatar and the central region, which received the most number of migrants. The south received the second largest number of people, perhaps as a consequence of the growth and development of Zamiin-Uud, the border town with China, in the southern region. More recent migration shows a similar pattern, mainly from other regions to Ulaanbaatar and the central region. In some rural areas, less than 5 per cent of the residents live in their place of registration.

were 95,435 five-year in-migrants to Ulaanbaatar, and 41,985 one-year in-migrants. Other smaller towns, such as Zamiin-Uud in the South near the China border and Darkhan-Uul in the North near the Russia border, also witnessed an increase in in-migration. The Mongolia railway network has expanded rapidly in recent years, and the pace of urbanisation is expected to further accelerate mobility after the cross-state (east to west) railway is constructed, since most towns will be near the railways.

Living and working conditions

There have been very few specific studies on migrants' working and living conditions in Mongolia. Information has to be collected either from the available research studies. The

Figure 6.1 Number (x1000) of Net In-migrants to Ulaanbaatar by Region, 1995-2000



Among the migrants, there are more men than women. For example, in 1999, there were 42,900 migrant men against 36,100 women. Most migrants were in the 15-25 age group; this was true of both men and women. However, it is not clear what proportion of migrants were travelling with their family.

Figure 6.1 shows the net in-migration to Ulaanbaatar during 1995-2000. The capital city recorded a population of 760,100 in 2000; there

information on housing obtained from the 2000 Census may help understand the living conditions of ordinary residents.

There were 541,149 private households in 2000, and 50.9 per cent of them lived in gers (traditional tent-like Mongolian housing); 28.3 per cent lived in urban areas and 78.3 per cent in rural areas. Among urban households, 94.6 per cent had electricity and 29.3 per cent had a telephone; among rural households, 34.1 per cent had

electricity and 2.1 per cent had a telephone. Of those living in gers, 48 per cent drew water from wells (that is, they had access to safe water), 42 per cent from rivers, lakes and springs, and 10 per cent from snow, rain and other sources.

Living conditions for families residing in houses, apartments and dormitories were relatively difficult. About 80.7 per cent lived in crowded conditions. About 73.7 per cent of the largest households - those with seven or more persons - lived in 1-2 rooms.

Health risks

Detailed information on health risks is unavailable, but there is evidence to establish that migrants face health risks. This may be related to the high incidence of STIs, the rapid spread of the HIV/AIDS epidemic in neighbouring Russia and China, the frequent movement of mobile populations such as traders, truck drivers and tourists across the borders, increasing incidence of casual sex, the increasing number of sex workers, low condom use in both casual sex and sex work, increasing incidence of domestic violence and alcohol abuse (which may impact the STI/HIV situation owing to a consequent loss of control of sexual behaviour), low level of HIV awareness in the general population and young people, the economic situation and the limited sources of income, and limited resources in rural health facilities to ensure safe blood, particularly in the border areas[4]. The latest findings of the National Centre for Health Development point to a rise in the number of reported cases of STI (gonorrhea and syphilis). In 2003, 43.3 per cent of all reported infectious diseases were related to STIs. Although the HIV/AIDS epidemic has not spread in Mongolia, the risk environment is increasing and sexually active adolescents are considered to be among the most vulnerable.

6.4 International Migration

According to the Census, the numbers of foreign residents in Mongolia and out-migrants from Mongolia are small (Table 6.2). However, these numbers are believed to be an underestimation since there is limited information about mobile populations.

The following extract, from the assessment report by the NAF (2001b), provides a better picture of cross-border activity:

Internal mobility is increasing in Mongolia. The railways carry 4 million passengers each year. Ulaanbaatar, Dornogobi, Selenge, Orkhon and Khovd are particularly vulnerable to drug use because these provinces lie along a major transnational transport route and have a very high

Table 6.2 Number of Migrants in/from Mongolia, 2000

Country	Out-migrants	In-migrants
Total	26,178	8,128
Russia	3,224	3,374
China	866	2,020
DPRK	8.631	338
Germany	2,478	61
Japan	1,204	150
US	2,324	303
UK	466	80

Source: Mongolia Population and Housing Census, 2000.

4 Internal review, UNFPA, 2004

rate of internal and international mobility. A review of findings indicates that the border towns of Zamiin-Uud in Mongolia and Erlian in China both function as major transit points. Erlian is also a market town where traders from Mongolia come to purchase goods and Chinese bring goods from all over the country to sell. The town offers a number of entertainment outlets to visitors, with commercial sex work involving Mongolian girls. This mobility allows for introduction to new substances into Mongolia and opportunities for networking among drug users in different areas. The trans-Mongolia railway also acts as a potential drug trafficking route; in other countries, drug use among local populations has been known to grow rapidly, accompanied by related HIV epidemics, along new drug trafficking routes.

An example of the increase in travel: 4 million passengers travel annually with the Mongolian railway. According to local data, in the year 2000, a total of 23,186 people travelled through the five temporary border points in Bulgan soum in Khovd aimag to China and Russia. The Assessment Team noted that when these temporary border points are open, the consumption of spirits increases, as does the incidence of STIs. It was also noted that Kazakhs form a part of the population of Khovd aimag. Since 1990, the movement of Kazakhs to Kazakhstan and Kyrgizstan has increased substantially. Of these, some have returned to Mongolia. The Assessment Team met with young people who had studied in Kazakhstan. It was reported that they had injected morphine into each other while studying in Kazakhstan. In 2000, 52.3 per cent of all of the Mongolian citizens who travelled abroad passed through the Buyant Ukhaa border crossing (Ulaanbaatar Airport), for the purpose of undertaking private business in China. The second most frequently used border crossing is that of Zamiin Uud, the border town in the Dornogobi province.

Most reported cross-border movement from Mongolia to China was for the purpose of trading. There is a trading zone near the border by the railway, with the cities of Erlianhaut and Zamiin-Uud on each side. Before 2000, more than 220,000 trips were made across the border each year from Mongolia to China (Aurenqi, 2000). By 2003, this figure increased to about 300,000 a year, including visitors from Mongolia, Russia and other former communist countries (Yang and Tumen, 2003).

As mentioned in Chapter 3, there are plans to build a free trading zone around Erlianhaut and Zamiin-Uud and a new Trading Mall in Erlianhaut. This will perhaps trigger an increase in cross-border activity between China and Mongolia.

Vulnerability to HIV/AIDS

The assessment report by NAF (2001b) had this to say of the groups vulnerable to drug use and HIV infection in Mongolia:

The vulnerability of the population to drug use and HIV infection is exacerbated by a number of factors including:

- *age (50 per cent of the population is under 21 years of age)*
- *high levels of poverty and unemployment*
- *widespread, heavy alcohol use*
- *an increase in sex work*
- *an increase in internal and international mobility*
- *a rapid increase in IDU and a high rate of HIV infection in neighbouring countries Russia, Kazakhstan and China*
- *a limited experience with drug use and associated problems leading to misperceptions, misinformation and inadequate responses to emerging problems*
- *a low level of awareness and understanding on drug use-related problem and its consequences among policymakers and the general public*
- *a lack of trained staff and facilities*
- *large numbers of injecting drug users and the absence of low-threshold, friendly public health services available to vulnerable communities, including drug users*
- *limited knowledge among young people about drugs and drug-related complications*
- *low level of condom use among vulnerable pop-*

ulation

- *limited supply of condoms in the countryside*
- *considerable stigma associated with drug use*
- *large tracts of the country are under cannabis plants*

Mongolia has yet to implement appropriate responses to the HIV epidemic associated with drug use; there is no specific policy that addresses the issue of HIV/AIDS prevention among drug users. The harm reduction approach is not officially reflected in national policy.

6.5 HIV Infection Prevention Among Migrants: A Review of Existing Programmes, Policies and Interventions

The annual report of the NAF (2001a) notes that community awareness programmes/projects and training have been conducted in Mongolia. It adds that in 2001-02 several programmes and projects were conducted among railway staff: workplace education programmes were conducted, as were 'training of trainers' projects and a KAP (Knowledge, Attitude and Practice) survey. Besides, voluntary and confidential STI check-ups were conducted for all railway employees. STI/HIV/AIDS prevention materials were distributed to over 100,000 foreign and domestic railway travellers. However, documentation of the details of these projects is extremely scanty.

A few other HIV/AIDS prevention services are worth mentioning, even though they are not specifically targeted at migrants. A newspaper for adolescents is being brought out, as is an 'AIDS Bulletin' journal; life skill training programmes, with emphasis on STI prevention, were organised in secondary schools; peer education projects were introduced in workplaces and tertiary education institutes; combined reproductive health and STI/HIV education sessions for youth were conducted in vulnerable regions; international and local organisations are working with homeless and disadvantaged children (UNGASS *Infosheet*).

A 1998 Memorandum of Understanding[5] between the government and UN agencies has catalysed many activities and led to the implementation of a National STI/HIV Strategic Plan. As reported by the UNGASS *Infosheet*, several activities targeted at young populations have been carried out since 2000. There are now more than 20 local organisations working on HIV prevention and sexual health, with the support of international organisations and the National AIDS Foundation. HIV/AIDS prevention programmes have been conducted among vulnerable children, young military recruits, mobile traders and truck drivers, sex workers, the MSM community and students. The range of prevention activities includes peer education, community education, condom promotion, and providing reproductive health and sexual health services for the most vulnerable children, adolescents and young people.

Technical services for STI/HIV prevention have been improving and a system of VCT (Voluntary Counselling and Testing) is being implemented. Legislation to initiate efforts to prevent the spread of AIDS was approved in 1995 in Mongolia, but to the authors' knowledge there is no specific policy or regulation related to migrants. The implementation of the first National STI/HIV Strategic Plan is nearing completion and a new Plan is now ready. A broad National STI/HIV Programme has been drafted. A National AIDS Committee was established in 1997 with all Vice-ministers as members and the Prime Minister as chair. The government is updating and revising policies, legislation and procedures.

According to the UNGASS *Infosheet*, a range of activities have been initiated in the area of information, education and communication (IEC):

- selectively targeted quality IEC material is being

5 In July 1998, in response to serious social and economic problems facing young populations in Mongolia, the United Nations Country Team Agencies signed a Memorandum of Understanding on Youth Issues (MOU) with the Mongolian government. The implementation of the MOU is currently being coordinated by the Ministry of Health and Social Welfare, Department of Women, Family and Youth Affairs together with the United Nations Youth Coordinator and the United Nations Youth Theme Group

produced;
- IEC materials, include a 'Love' newspaper for adolescents, an 'AIDS Bulletin' journal, a Reproductive Health Newsletter, posters and leaflets for annual campaigns. They are being produced regularly;
- UNFPA-supported Life Skills Education, including STI prevention, has been successfully piloted in a number of secondary schools; there are plans to widen this activity;
- peer education is being introduced in workplaces and tertiary education institutes;
- UNICEF and other international and local NGOs are working with homeless and disadvantaged children;
- GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit) is reaching out to young populations with combined reproductive health and STI/HIV education projects in the more vulnerable aimags (provinces);
- with the support of the NAF, local NGOs working to prevent STI/HIV are implementing community-based education projects;
- the government conducted a National STI/HIV Campaign targeted at young populations in May-June 2003.

6.6 Summary, Identification of Gaps in Knowledge, Policies and Services and Recommendations

The situation in Mongolia can be summarised as follows:
- there has been an increase in mobility, both internal and across borders;
- there is very limited information about vulnerable sub-populations, including migrants;
- projects/programmes on HIV awareness and intervention, which are mainly community-based and targeted at the workplace, are under way, but information about the impact of these projects/programmes is not readily available.

Systematic research is needed to better understand the mobile populations in Mongolia, their working and living conditions, their social support networks, their families and practices that may make them vulnerable to HIV infection. The *Infosheet* lists the following priorities for action:
- give top priority to promoting changes in behaviour that will result in safer sex practices, especially in the younger, sexually active age groups;
- promote, market and distribute the Mongolian condom ('Trust');
- improve sexual and reproductive health services, STI/HIV diagnostic services and the quality of blood products;
- target more prevention activities at mobile and vulnerable groups, including traders, sex workers and street children;
- strengthen and provide support for STI/HIV NGOs working in the community;
- enhance national capacity;
- improve health services and infrastructure, especially in the rural sector.

The inclusion of mobile people and traders, sex workers and street children in this list highlights the increasing awareness of the fact that these groups are vulnerable and need attention. But until their numbers, patterns of movement, living and working conditions and so on. are understood, it will be very hard to target appropriate policies and programmes. A study conducted by the Korea UNAIDS Information Support Center (KUISC)[6] among Mongolian migrants in South Korea reveals that prior to going to Korea, most of them had heard of AIDS, and that their perceptions of HIV/AIDS were more accurate than those of other migrant communities studied, such as Bangladeshi, Korean-Chinese or Han-Chinese. However the increase in the number of young people migrating in distress conditions and the relatively lower risk perception among them make them rather more vulnerable. More community-based research within Mongolia among these mobile groups is required.

6 "Migration and HIV : vulnerability assessment among foreign migrants in South Korea", a study conducted among Bangladeshi, Han Chinese, Korean Chinese and Mongolian migrants in Seoul, Gyunggi-Inchon region and Daegu-Gungbuk region, Korea UNAIDS Information Support Center (KUISC), June 2004.

6.7 List of Resources

A few of the relevant government departments are listed here: Ministry of Health and Social Welfare and the Mongolian Family Welfare Association. The National AIDS Foundation is one of the most active organisations.

UN organisations are also critical partners in formulating and implementing HIV/AIDS prevention responses. There are several ongoing projects of the UN system in several sectors: agriculture, education, employment, environment, general development issues, health and social development and HIV.

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CHAPTER 7

REPUBLIC OF KOREA (ROK)

Jungwhan Lee[1]

7.1 Background and Method

South Korea, with a land area of 98,753 sq. km, is comparable in size with Portugal or Jordan. With a population of 48 million (the male and female populations are almost equal in number), it has a population density of 485 persons per sq. km, which makes it one of the world's most densely populated countries. The average annual population growth rate has been steadily declining since 1975: it was 1.5 per cent from 1975 to 1985, 1.0 per cent from 1985 to 1995, and 0.9 per cent from 1995 to 2002. In 2002, the growth rate was 0.6 per cent. This decline can be attributed to a steadily declining fertility rate, from 3.3 in 1975 to 1.3 in 2001. More women are now educated and taking up employment; as a consequence, they are delaying marriage and are opting to not have children - or have them late.

The age profile of the population has also undergone a significant change since 1975: there is a marked decrease in the proportion of young people, and a corresponding increase in the proportion of older people. People under 15 years of age accounted for 38.5 per cent of the population in 1975, 30.2 per cent in 1985, 23.2 per cent in 1995 and 20.3 per cent in 2002. The proportion of people aged 65 or over was 3.5 per cent in 1975, 4.3 per cent in 1985, 5.5 per cent in 1995 and 7.9 per cent in 2002.

Very little study or research has been carried out on the relationship between migration and HIV/AIDS in the country; relevant data on this subject is, therefore, scarce. The key sources of information for this report were newspaper reports, government reports, records and files with NGOs, interviews with individual scholars, government officials in relevant departments, NGO personnel and migrant workers[2].

Moreover, given the sensitivity of the subject and the illegal status of irregular migrant workers and sex workers, it is difficult to access useful information. To that extent, this report is a step towards acquiring a comprehensive understanding of the relationship between migration and HIV/AIDS in South Korea.

7. 2 HIV/AIDS Situation in Korea

There has been a rapid increase in the number of people living with HIV/AIDS (PLWHA) since 2000 (Table 7.1); during the six-month period between January and June 2003, there were 251 PLWHA, which represents a 42.6 per cent increase compared with the corresponding period of the

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2 In particular, Anne-Isabelle Degryse-Blateau, Representative, UNDP Korea; Cha, Dongpil, Professor, Department of Advertisement and Public Relations, Chongju University, Seoul; Choi, Yunghyun, Deputy Director, Ministry of Health and Welfare, Seoul; Chun, Woo-sub, Reverend and Director, Tabitha Community; Chung, Kiseon, Researcher, Survey Research Center, Sungkyunkwan University, Seoul; Goh, Hyun-ung, Representative, IOM Korea Office, Seoul; Kim, Hae-sung, Reverend and Director, Migrant Workers' House & Korean Chinese House; Kim, Hun-soo, Representative, KUISC (Korea UNAIDS Information Support Center); Kim, Hyun-sook, Executive Director, Galilea (Migrant Workers' Pastoral Center); Lee, Ok-soon, Programme Manager, UNDP, Seoul; Lee, Sungyong, Professor, TFaculty of Liberal Arts, Kangnam University; Nalini Taneja, Programme Director, KUISC (Korea UNAIDS Information Support Center); Yu, Hae-geun, Reverend and Director, Seoul Migrant Mission Center, Seoul; and several migrant workers, who did not want their names to appear because of their 'illegal' status or because they were engaged in the sex industry.

previous year. The number of women living with HIV/AIDS is 17, or 6.8 per cent of the total PLWHA in 2003.

Of the 127 PLWHA whose infection routes are known, 98.4 per cent were infected through the sexual route. Up until mid-2003, there were 2,258 people who had tested positive for HIV; of these, 2,010 (or 89 per cent) were male and 248 (11 per cent) female. Of these, 1,802 PLWHA were still alive as of June 2003. AIDS specialists, however, estimate that the real number of PLWHA could be six or seven times higher than the government statistics. According to an unpublished government document, 260 foreigners had tested positive for HIV infection; 20 of them are now under government care. Usually, foreigners living with HIV/AIDS are deported within one month of their condition being diagnosed.

The sex industry is illegal in Korea, but it is a big, flourishing industry: some estimates put it at at least $2 billion (KIC, 2002). Sexually transmitted diseases (STDs) are known to be prevalent among sex workers. One survey reported that 71 per cent of sex workers are infected with herpes virus (Donga Daily News, 24 February 2003).

7.3 Internal Migration

When Korea underwent rapid industrialisation between the 1960s and the 1980s, there was a mass movement of people from the countryside to the cities, where jobs and money were more abundant. For example, the net migration rate (in-migration minus out-migration rate) of Seoul, the capital city, was 6.8 per cent between 1975 and 1980, and 3.2 per cent between 1980 and 1985. Seoul's population rose from 5.9 million in 1975 to 9.6 million in 1985. But now that Korea has arrived at the threshold of industrialised economies, the urbanisation process has stabilised since the early 1990s. The net migration rate of Seoul was -8.7 per cent for 1990-95 and -6.3 per cent for 1995-2000. Seoul's population was 10.6 million in 1990, 10.2 million in 1995 and 10 million in 2002.

The net migration to Seoul is now negative, which is a sign of a flow out to rural or other urban areas. Internal migrants within South Korea largely enjoy the same benefits and services as the other inhabitants and their vulnerability to HIV/AIDS is no more or less than for other Koreans.

7.4 International Mobility

Numbers and migration routes

In earlier times, Korea used to send its people overseas: to Hawaii in the early 1900s, to North East China between 1910 and 1945, to Germany and South Vietnam in the 1960s and early 1970s, and to West Asia in the 1970s and early 1980s. Then, as the Korean economy grew and the pace of industrialisation quickened, especially after 1988, a large number of migrant workers began to enter Korea.

The first to arrive were Korean Chinese from China, who shared cultural similarities and spoke the Korean language. Filipinos, Pakistanis,

Table 7.1 Number of People Living With HIV/AIDS, 1985-2003

	Total	1985-1993	1994-1996	1997-1999	2000	2001	2002	Jan-June 2003
No. of persons with HIV (No. of women)	2,258 (248)	320 (34)	302 (32)	439 (61)	219 (25)	328 (35)	399 (34)	251 (17)
No. of persons with AIDS	354	16	47	102	32	42	88	27
No. of dead persons (No. of persons with AIDS)	456 (322)	42 (14)	67 (48)	125 (101)	52 (32)	58 (42)	76 (58)	36 (27)

Source: National Institute of Health (2003).

Table 7.2 Number of Irregular Migrant Workers by Country, 1991-2003

Nationality	1991		1997		2003	
	No.	%	No.	%	No.	%
Chinese	n.a.	n.a.	n.a.	n.a.	146,803	51.1
(Korean Chinese)	19,592	46.8	57,722	39.0	77,045	26.8
Thai	137	0.3	8,200	5.5	20,026	7.0
Filipino	15,745	37.6	13,909	9.4	17,847	6.2
Bangladeshi	593	1.4	9,033	6.1	16,444	5.7
Vietnamese	0	0.0	6,389	4.3	14,495	5.0
Mongolian	0	0.0	7,644	5.4	13,139	4.6
Uzbekistani	0	0.0	n.a	n.a	7,506	2.6
Pakistani	239	0.6	5,935	4.0	6,264	2.2
Nepalese	1,851	4.4	1,059	0.7	n.a.	n.a.
Others	3,720	8.7	38,157	25.8	44,532	15.5
Total	**41,877**	**100.0**	**148,048**	**100.0**	**287,056**	**100.0**

Note: All figures as of December 31 for that year; for 2003, the figures are as of March 31
Source: Ministry of Justice (2003).

Bangladeshis and Nepalese and others followed (Table 7.2). The number of irregular migrant workers increased from a few hundred to 70,000 in just four years from 1988.

In 1991, the Korean government formulated policy to regularise the inflow of foreign workers: the 'industrial trainee' status[3] category was created and companies with branches and factories abroad were permitted to bring in such 'trainees'. In 1994 another opening was made through the Korea Federation of Small and Medium Business (KFSB). Since that time, the number of migrant workers has increased rapidly; it reached 250,000 by late 1997, just before Korea underwent a financial crisis. The number of migrant workers came down to 140,000 by mid-1998 but rose again as Korea recovered from the crisis. As of June 2003, the number of migrant workers was about 405,000 (Table 7.3).

There are two distinctive aspects of migrant workers in Korea. One is that there is a larger population of irregular workers[4] than documented ones (mostly industrial trainees), as shown in Table 7.3. Three elements contribute to this.

1. The wages of industrial trainees are lower than those of undocumented workers. According to a survey (Seok et al., 2003), industrial trainees' wages are only 85 per cent of the wages of migrant workers. Therefore, many industrial trainees leave their assigned workplace to take up jobs at a higher pay. Between 1993 and 1997, one out of three industrial trainees left their designated workplace or did not go back to their home country after a termination of contract (Lee et al., 1998). Legally, industrial trainees are not allowed to leave the designated or contracted workplace before their contracted term expires. If they do, their stay becomes 'illegal'.
2. The government's failure to enforce regulations

3 There have been several changes in the stay-duration and status of industrial trainees. When the industrial trainee system started in 1991, the Korean government allowed industrial trainees to stay only for a year with a status of trainee; in 1993 this was extended to two years, in 1996 for three years with trainee status; in 1998 for three years (two years with trainee status and one year as a worker); in April 2002, for three years (one year with trainee status and two years as worker). In July 2003, the Korean government decided to implement an employment permit programme parallel with the industrial trainee system.

4 Migrants who were smuggled in or who entered with a visitor or tourist visas but stayed on to take up employment or overstayed for a period.

Table 7.3 Number of Migrant Workers in Korea, 1991-2003

Year	Industrial Trainees		Irregular Migrant Workers		Total	
	No.	%	No.	%	No.	%
1991	599	1.4	41,877	98.6	42,476	100.0
1992	4,945	7.0	65,528	93.0	70,473	100.0
1994	28,328	37.0	48,231	63.0	76,559	100.0
1997	69,052	31.8	148,048	68.2	217100	100.0
1999	46,814	25.7	135,338	74.3	-	100.0
2003	118,725	29.3	287,056	70.7	405,781	100.0

Note: All figures as of December 31 for that year; for 2003, the figures are as of March 31
Source: Ministry of Justice (2003).

strictly also contributed to the increase in the number of undocumented migrant workers. For example, between November 1997 and January 2000, the government issued six decrees ordering migrant works to leave; but there was hardly any administrative follow-up action on those decrees.

3. Some migrant workers, especially from China, spend a lot of money on migration fees[5]. According to a study (Seok et al., 2003), in 1998, Chinese Korean migrant workers spent on an average $5,400 as migration fees, seven times the per-capita Chinese GDP that year. They had to save or borrow from relatives - and sometimes sell their houses - to pay that fee. As a consequence, many of them stayed on in Korea for as long as possible so that they could pay back their loans/fees and save some money. In 1998, research findings showed that foreign workers wanted to stay in Korea for about 40 months average (Lee and Seok, 2001).

The second significant aspect of the migration into Korea is that there are many more men than women (see Table 7.4). When the Korean government initiated the industrial trainee policy in 1991, the intention was to provide labour for the manufacturing sector, which was experiencing a severe labour shortage. The sector was made up mostly of small businesses and offered what were called '3D jobs' (or jobs that were difficult, dirty and dangerous, such as operating metal pressing and shearing machines, moving heavy materials and dealing with toxic chemicals under unhealthy working conditions). Male workers were preferred.

Living and working conditions

Under immigration laws, companies that employ industrial trainees must provide them with housing facilities. The type of accommodation provided depended on the size and type of the company and the migrant's legal status. Big companies usually provide dormitory accommodation with cooking facilities and a central climate control system. Such luxuries, however, are afforded to very few migrant workers. Most companies that hire migrant workers are relatively small, and they provide housing with very rudimentary sleeping and cooking facilities. Some migrants, who have stayed in Korea for long and saved some money, often reside in housing not provided by the company.

Most companies hire migrant workers principally to reduce production costs; they consider investing in working conditions for migrant workers something of an extravagance. Typically, migrant workers work longer hours and receive less money than their Korean colleagues. In addition, there are a significant number of incidents of verbal abuse, accidents, illness, seizure of passport and breach of employment contract at the workplace (Table 7.5).

5 Many Korean Chinese, who can speak Korean and easily find jobs in Korea, use irregular means to enter Korea: forging documents and passports and smuggling. Trafficking and smuggling networks usually do this work for a fee.

Table 7.4 Migrant Workers by Status and Gender in 2001

Industrial Trainees		Irregular Migrant Workers		Total	
Male	Female	Male	Female	Male	Female
20,666 (70.6%)	8,617 (29.4%)	163,623 (64.1%)	91,583 (35.9%)	184,289 (64.8%)	100,200 (35.2%)

Source: Korean Women's Development Institute (2002).

Table 7.5 Treatment of Migrant Labourers at Their Workplace, 2003 (%)

Nature of Ill Treatment	Yes	No	Total
Physical attack or punishment	11.6	88.4	100.0
Verbal abuse or violent language	50.0	50.0	100.0
Body search	10.2	89.8	100.0
Forbidden to leave the workplace	17.9	82.1	100.0
Sexual harassment or violence	2.3	97.7	100.0
Injury at work	28.3	71.7	100.0
Illness due to work	22.6	77.4	100.0
Seizure of passport	47.6	52.4	100.0
Breach of employment contract	44.3	55.7	100.0

Note: Sample size is 741
Source: Seok *et al*., 2003

Migrant workers' perceptions of their working conditions, however, are somewhat less harsh. According to a survey (Table 7.6), migrant workers tend to perceive most of their working conditions as moderate or relatively satisfactory, although they think some working conditions such as wages and entertainment facilities are less than satisfactory. These results are, however, not very different from their Korean co-workers' perceptions of their working conditions.

Health risks

Migrant workers, especially those from South East Asia, are prone to illnesses because the climate in Korea is vastly different from what they are used to. Long working hours, the burden of physical labour, and a bad working environment cause migrant workers to be more prone to muscle aches, respiratory disease, headaches, accidents, and psychological stress and anxiety. When they fall ill, they usually either get medicines from the company where they work, or buy medicine at a local drug store, or take medicine sent or brought from their home country. If the sickness is severe, they visit a local hospital. Industrial trainees pay only a small portion of their medical expenses because they have access to medical insurance. Irregular migrant workers, however, have to pay full expenses. This acts as a deterrent to accessing health services.

Vulnerability to HIV/AIDS

a) Single male migrant workers

Most migrants workers stay alone, far away from their families and spouses and find it challenging to maintain steady relationships in Korea. Several conditions contribute to this situation:

- Migrant workers cannot bring their families into

Table 7.6 Perceptions of Migrant and Korean Workers on Working Conditions

Factor	Industrial Trainees	Irregular Migrant Workers	Korean Co-workers
Working hours	3.2	3.0	3.0
Work load	3.0	3.0	3.1
Work	3.3	3.3	3.5
Period of employment	3.3	3.2	3.4
Working environment	3.2	3.0	3.0
Regulations	3.3	3.2	3.2
Wages	2.6	2.7	2.7
Collective bargaining	2.8	2.8	2.6
Response to complaints	2.9	2.7	2.6
Entertainment facilities	2.4	2.5	2.2
Management style	3.2	3.0	2.7
Medical services	2.9	3.0	3.6
Meals	3.0	3.0	3.2
Lodging	3.2	3.3	-

Notes: 1. Scale: 1 = poor, 2 = unsatisfactory, 3 = so-so, 4 = satisfactory, 5 = outstanding.
2. Sample size is 717.
Source: Seok et *al. (2003).*

Korea under current immigration laws; nearly all of them migrate alone;

- Given their low wages and the fact that they get very few holidays, it is very hard for migrant workers to visit their home country. Their irregular status makes it even more difficult;
- There are more male migrants than female;
- Male migrant workers in their 20s and 30s - the sexually active age groups - account for 70 per cent of the total migrant workers in Korea.

Very few, if any of these migrant workers are able to establish long-term relationships with local Koreans. Because of these factors, there is a tendency for migrants to visit brothels. There are two major centres of commercial sex work, Miari Texas-chon and Chungryangri 588, in Seoul area, which are frequented by migrant workers. However, many sex workers in these areas do not accept migrant workers as clients for fear that they might have sexually transmitted diseases, and because they do not speak or understand Korean well and are regarded as a poor minority group. The few sex workers who do take on migrants as customers tend to be relatively older women who have been engaged in sex work for long and are thus more vulnerable to HIV infection or other STDs. Some of these sex workers and their clients are unaware of the importance of safe sex practices and they seldom use condoms. In some cases, migrants do not like to use condoms, and sex workers do not insist on condom use for fear of losing their customers.

b) Undocumented migrant workers

A significant proportion (three-fourths) of migrant workers in Korea are irregular. These migrant workers do not have access to public medical care or services. They seldom go to hospitals or health centres for fear of being caught and deported. Although some irregular migrant workers do receive sex education and medical services arranged by NGOs and voluntary medical groups, the proportion of those who have access to such services is very small. According to one survey,

only about 5 per cent of migrant workers have visited or contacted a migrant NGO or religious group (Seok et al., 2003). Moreover, the range of information and services they get from these voluntary organisations may not be enough to protect them from HIV infection.

c) Female migrant workers in the sex industry

Among the female migrant workers, those from Russian, Filipino and Korean Chinese, a high proportion of whom are engaged in the sex industry, are more vulnerable to HIV infection Most of them also have very little knowledge of HIV/AIDS and STDs.

Russian women migrants

It is estimated that more than 1,000 Russian women are engaged in sex work in Korea. They usually enter on an E-6 visa, issued to dancers and singers (restricted to work in the entertainment business), or on a C-3 tourist visa. Russians now account for 60 per cent of E-6 visaholders. In either case, upon arrival in Korea, most of them are coerced into commercial sex by the owners and managers of the business and the brokers of the recruitment agency. Trafficking organisations and the Russian mafia are usually involved in bringing them in.

Filipino women migrants

Filipino women have been entering Korea on E-6 visas since 1994, when Korea began issuing them. The proportion of Filipino women among E-6 visaholders has decreased in recent years to 16.6 per cent, because more Russian women are coming in. Filipinos usually work in bars and discos, especially those near US military bases, and they are preferred because they speak English. Under pressure from the owners of the bars and discos, some of them perform strip dances and sell sex as well. Crime organisations, in the Philippines and in Korea, are involved in recruiting and employing them.

Korean Chinese women

Korean Chinese have a long history of immigration to Korea. They can speak Korean, have a better understanding of Korean society and can find jobs more easily in the service sectors. Some of them come to work in the sex industry to make quick money. Unlike Russians and Filipinos in the sex industry, Korean Chinese women tend to enter Korea with a tourist or visitor's visa or on forged passports and usually work in bars and karaoke facilities.

7.5 Prevention of HIV Infection: A Review of Existing Programmes, Policies and Interventions

Services

The Korean government has very few official services or policies directed at protecting migrant workers from HIV infection. Typically, what it does is to bar foreigners with HIV from entering Korea and deport HIV-positive migrants to their home country soonest. Under Korean health and immigration laws, HIV/AIDS is classified as a third-tier epidemic disease and industrial trainees have to undergo pre-departure and post-arrival tests. Since the late 1990s, some local health offices have subjected migrant workers to HIV tests on an irregular basis; HIV-positive persons are occasionally found among migrant workers, and the number of reported infections is growing. But migrant workers and NGOs resent the manner in which these tests are conducted: the test procedure does not protect the migrants' privacy and sometimes the test is done in inhumane fashion. For instance, health officials may visit a factory and ask the manager to gather all migrant workers together and then carry out HIV tests without securing migrant workers' permission or counselling them.

Some NGOs carry out irregular medical check-ups, including blood tests, with the help of voluntary medical groups, social welfare institutions and local health offices. They do not tell the migrant workers that the check-ups include testing for HIV infection because if they do, migrant workers may avoid the check-ups. This is more a

comment on their fear of stigmatisation and possible deportation if they are found to be HIV-positive. Their somewhat fatalistic view is that if they are found to be infected, they will die anyway since there is no known cure - and additionally they run the risk of being subjected to stigmatisation. Therefore, they prefer not to know and to go without testing for HIV.

If a migrant worker is found to be HIV-positive, the local health office informs the director or manager of an NGO, as well as the immigration office. Usually the NGO invites the migrant worker to come in, explains the situation and helps him/her to return home (by raising money for airfare, if necessary). But many HIV-positive migrants tend to go underground to evade deportation.

Several migrant support organisations offer a range of services to different ethnic communities. According to a study conducted by the Korea UNAIDS Information Support Center (KUISC)[6], AIDS service organisations appear to be the primary source of potential assistance. The services provided include information about workers' issues, basic healthcare services as well as support for food and shelter. HIV awareness still does not form a part of the services offered by most of the religious organisations. Additionally, they can also receive medical help in hospital/health centres and Korean social/religious organisations.

7.6 Policy Gaps and Recommendations

Policy Gaps

Very few studies and research have been carried out on migrant workers' sexual practices, their knowledge of HIV/AIDS and the real conditions of HIV/AIDS infection among migrant workers. The government and NGOs have very limited data and records on the HIV/AIDS situation among migrants. Even this data is not organised but scattered among various government agencies and NGOs. KUISC carried out a survey among four foreign migrant communities in early 2004 in order to gather preliminary information on the social and health issues that make migrant ethnic groups vulnerable to HIV/AIDS.

Korean and migrant workers within South Korea do not have an adequate knowledge or understanding of HIV infection. They are prey to some common myths - that only certain population groups are vulnerable and that the virus can be transmitted by shaking hands with or talking to a HIV-positive person.

Despite the growing numbers of migrants with HIV infection and those who visit brothels/bars, few programmes and policies have been drawn up to reduce the migrant workers' vulnerability to the infection. Providing sex education for migrant workers would perhaps address one key area of concern, but such programmes are few. Likewise, there are few services available for migrants living with HIV/AIDS. The only major initiative that the government has taken is to trace HIV-infected migrants and deport them as soon as possible.

Government programmes and implementing agencies tend to regard migrant workers' sex life as their "personal problem". But this overlooks one critical factor: that it is public policy that bars migrant workers from bringing their respective spouses to Korea. Migrant workers never have enough money to go back home. It is this that leads them to frequent commercial sex workers and engage in unsafe sex practices. In spite of these compelling links, government officials have not yet woken up to the problems that migrant workers face.

What's more, many Koreans erroneously perceive migrant workers as carriers of sexually transmitted diseases who infect the rest of the Korean society. This overlooks the fact the most migrant workers living with HIV/AIDS became infected during their stay in South Korea.

Recommendations

- *Carry out extensive surveys on migrant workers' sex life and their knowledge, and the conditions of STD and HIV/AIDS infection*

6 "Migration and HIV: Vulnerability assessment among foreign migrants in South Korea", a study conducted among Bangladeshi, Han Chinese, Korean Chinese and Mongolian migrants in Seoul, Gyunggi-Inchon region and Daegu-Gyungbuk region, KUISC, June 2004.

It is important to gather accurate data and information on migrant workers' sex behaviour and their knowledge and the conditions of STD and HIV/AIDS infection. The KUISC study attempted to do this, but only among four migrant communities: Han and Korean Chinese, Bangladeshi and Mongolian migrants. Similar studies must be undertaken among other language groups, including Thai, Vietnamese and Sri Lankan migrants. Effective policies and services can then be put in place to reduce migrants' vulnerability to HIV/AIDS.

■ *Raise awarness about HIV among migrant workers*

There is a need for pre-departure and continuous post-arrival education on HIV to increase migrant workers' awareness of prevention and care issues. One way of doing this is to include HIV information in the post-arrival training provided to all migrant workers. This will cover most of the documented migrants. To target undocumented migrants, similar services and information could be provided through migrant support organisations. It is also necessary to raise awareness about and advocate for HIV/AIDS education among relevant agencies and organisations and the general population in both source and destination countries.

■ *Offer HIV-related services for sex workers*

Those in the sex industry have little or no access to information and services. Organising orientation programmes and information sessions for them will help protect them and their clients, most of whom are migrant workers.

■ *Improve bilateral/ multilateral co-operation among source and destination countries*

Dialogues and co-operation between governments and civil society organisations from both source and destination countries must be facilitated to develop well-coordinated and comprehensive HIV-preventive care programmes for migrant workers at all stages of migration.

■ *Make available migrant-friendly HIV-related services*

There is need for dissemination of information in the languages of foreign workers . They must also be provided access to services such as counselling, treatment for opportunistic infections and condom use. Additionally, testing facilities must become more friendly and rights-sensitive. Pre- and post - testing counselling, as prescribed by WHO, should be made available so as to encourage more testing. This could also be made easier by providing affordable testing arrangements so that more migrant workers are willing to participate.

■ *Devise special strategies to reach out to undocumented migrants*

The government needs to work closely with NGOs to provide irregular migrant workers with more access to HIV/AIDS preventative education and materials.

■ *Provide a more supportive environment for migrant workers, irrespective of their status*

A review of existing policy to identify gaps that make foreign migrant workers in Korea vulnerable to HIV is the first step towards the creation of a pro-migrant policy environment. It is also important to acknowledge that undocumented migrants are - and will continue to be - a part of the migration situation and their contribution to the local economy is the same as, if not more than, those of regular migrants. There is also a need to review the existing policies that prevent migrant workers from inviting their families/ spouses into South Korea.

Table 7.7 Summary of Vulnerable Groups, Responses and Recommendations

Vulnerable Populations	Current Situation	Responses/Climate	Recommendations
Single male migrant workers Undocumen-ted migrant workers	Most migrant workers are male 70% of male migrant workers are in their 20s and 30s, the sexually active age groups Lack of family reunion Lack of knowledge and education on safe sex and HIV/AIDS Engaged in sex work with high risk of STD and HIV infection Three-quarters of migrant workers are undocumented and so do not have access to medical care and treatment	Some migrant NGOs, voluntary medical groups and local health offices arrange HIV testing for migrant workers Few responses from the government except for deporting HIV-positive migrants as soon as possible Migrant NGOs raise funds for HIV-positive migrants to return home	Carry out surveys on migrant workers' sexual life and their knowledge and conditions of STD and HIV/AIDS infection Strengthen sex education Improve working conditions for migrant workers More availability and easier access to HIV preventive materials and products Cooperation between source and destination countries to develop comprehensive HIV prevention programme Development of humane and migrant-friendly HIV testing Special strategies for 'irregular' migrants
Sex workers	Russian, Filipino, and Korean Chinese women engaged in sex industry More than 50% of sex workers are infected with some STD Lack of knowledge and education on safe sex and HIV/AIDS Both international and domestic criminal organisations are involved in trafficking and smuggling sex workers	Government plans to strengthen screening test for E-6 visa and supervise post-arrival activity Government checks on owners of sex businesses that hire female migrants for sex work Some NGOs distribute STD and HIV preventive materials to sex workers, provide shelters for sex workers who escape from brothels and raise funds to pay their debt; they want the government to abolish the E-6 visa	Strengthen sex education programmes Place limitations on issuing E-6 visa Carry on a public campaign against sex work for the general population and regulate illegally operating sex businesses Conduct more studies and research on the migration routes and real conditions of female migrant workers in sex industry Provide shelters and medical services for sex workers

7.7 List of Readings[7]

Donga Daily News, 24 February 2004.
Joint Committee for Migrant Workers in Korea (JCMK), 2002, *Report on Female Foreign Workers*, Seoul: JCMK.
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National Institute of Health (NIH), 2003, *Report on HIV Infected People*.
National Statistical Office (NSO), 2003, *Social Indicators in Korea*, Seoul.
Seok, H., Chung, K., Lee, J., Lee, H. and Sudol Kang, 2003, *Workplace and Life of Foreign Workers in Korea*, Seoul: Jisikmadang.

7 All readings are in Korean.

7.8 List of Resources (NGO Programmes and Services, Government Programmes) in Korea

Name	Type	Location	Phone Number
IOM (International Organization for Migration) Korea Office	IO	#714 Korea Business Center 390 Gangnam-daero Seocho-gu Seoul 137-860	(02) 523-7647
KNCU (Korean National Commission for UNESCO)	IO	50-14 Myong-dong 2-ga Jung-gu Seoul 100-810	(02) 755-1105
ROK Red Cross	IO	32 Namsan-dong 3-ga Jung-gu Seoul 100-043	(02) 3705-3705
UNDP Korea	IO	#105 Hannam Tower 730 Hannam-2-dong Yongsan-gu Seoul 140-212	(02) 790-9562
UNHCR Liaison Office in the ROK	IO	#402 Sunggonghoe-hoegwan 3-7 Jeong-dong Jung-gu Seoul 100-120	(02) 730-3440
The Office of the WHO Representative	IO	Room No. 306 2nd Government Unified Office Bldg. 1 Jungang-dong Gwachon Gyonggi-do 427-760	
WHO Western Pacific Region Office ROK Country Liaison Office	IO		(02) 503-7533, 7592
National Institute of Heath	GO	5 Nokbun-dong Eunpyung-gu Seoul 122-701	(02) 380-1435
Ansan Migrant Shelter	NGO	791-4 Wongok-dong Ansan-si Gyonggi-do 425-130	(031) 492-8785~6
Anyang Migrant Workers' Center	NGO	Jeon Jin Sang Social Welfare Center 676-136 Anyang 4-dong Manan-gu Anyang-si Gyonggi-do 430-832	(031) 444-2876
Durebang	NGO	116 Gosan-dong Euijungbu-si Gyonggi-do	(031) 841-2609
Galilea (Migrant Workers' Pastoral Center)	NGO	Da-201 Inse-yonllip 843 Wongok-dong Ansan-si Gyonggi-do 425-130	(031) 494-8411
Hansorihoe	NGO	5th Floor Gisayeon Bldg. 35 Chungjung-ro 2-ga Seodaemen-gu Seoul	(02) 3147-1505, 312-7245
Joint Committee for Migrant Workers in Korea	NGO	#302 Samwoo Bldg. 298-4 Hyoje-dong Jongro-gu Seoul	(02) 747-6830~1
Korean Anti-AIDS Federation	NGO	93 Myungryun-dong Jongro-gu Seoul 110-522	(02) 747-4071, 4073
KUISC (Korea UNAIDS Information Support Center)	NGO	#225 Myoungsan Bldg. 2F, 646 Itaewon-dong Yongsan-gu Seoul 140-861	(02) 792-2672

Name	Type	Location	Phone Number
Medical Mutual-Aid Union for Migrant Workers in Korea	NGO	#704 Sangji Bldg. 326 Eulji-ro 3-ga Jung-gu Seoul 100-846	(02) 2263-0516~7
Migrant Workers' House & Korean Chinese House	NGO	137-22 Garibong-1-dong Guro-gu Seoul 152-801	(02) 863-6622
Seoul Migrant Mission Center	NGO	Geumgang Bldg. 611 Gueui-dong Gwangjin-gu Seoul 143-201	(02) 458-2981
Seoul Migrant Workers' Center	NGO	130-102 Changsin 2-dong Jongro-gu Seoul	(02) 3672-9472
Tabitha Community	NGO	430-4 Bosan-dong Dongduchon-si Gyunggi-do 483-060	(031) 861-0505

CHAPTER 8

SRI LANKA

A. J. Weeramunda[1]

8.1 Background and Method

According to the 2001 Census, the population in 18 of the 23 districts in Sri Lanka was 16.8 million; the average annual growth rate was 1.2 per cent. A striking development is the decrease in the proportion of men to women in the overall population: for every 100 women, the number of men has dropped from 103.9 in 1981 to 97.9 in 2001. Analysts attribute the reduced male: female sex ratio to the countless male casualties as a consequence of the ethnic conflict from 1983 to 2001. The age profile of the population too has changed significantly: in 1981, the 18+ age group accounted for 58.4 per cent of the population; in 2001, its proportion increased to 67.1 per cent.

Migration patterns too changed over this period. According to the 1981 Census, population movement took place mostly within the country, with migration directed predominantly towards Colombo from outlying rural districts. In addition, significant transfers of the population had taken place from the districts in the central and southern provinces to those in the north central areas due to the opening up of settlement schemes in the agro-climatic area known as the 'Dry Zone' (Department of Census and Statistics, 1981). Since 1981, however, the pattern of migration has seen a radical shift due to two developments: first, civil unrest due to armed conflict between the government and Tamil separatists led to internal movement and the emigration of Tamils and their subsequent return; and second, contract labour migration to overseas destinations emerged as a major source of economic development.

Since the outbreak of the civil strife, several hundred thousand Tamil civilians have fled the island. As of late 1996, 63,068 of them were housed in refugee camps in southern India, an additional 30,000-40,000 lived outside the Indian camps and more than 200,000 had sought political asylum in the West. With the signing of the Peace Accord between the Sri Lankan government and the militants in 2001, the trend has been reversed, with people returning to their places of domicile.

The second major population movement is an outcome of the globalisation of the Sri Lankan labour force. Currently, according to the Central Bank of Sri Lanka, remittances account for 30 per cent of foreign revenue, displacing traditional income sources through agriculture such as tea, rubber and coconut cultivation. Furthermore, migrant workers account for about 30 per cent of the revenue accruing to the airport and airlines, with a total of about 200,000 departures in 2002 (compared with 300,000 tourists). There are also reported instances of smuggling from the shores of Sri Lanka to South East Asian and European countries (principally Italy and Greece) and to Australia. During the past year, about four such detections have been made and have involved, in each case, between 25 and 50 young men in search of employment abroad.

This study was carried out by collecting and analysing available secondary data, by scrutinising

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relevant publications and from interviews with key informants from two governmental agencies and personnel from 10 non-governmental organisations[2]. The absence of well-researched information on some aspects of the study was a challenge.

8.2 HIV/AIDS Situation in Sri Lanka

The first person with HIV in Sri Lanka was identified in 1987. According to information provided by the National AIDS/STD Control Programme (NACSP) of Sri Lanka, the number of people living with HIV increased to a total of 493 as of July 2003. Of these, 294 (or 59.6 per cent) are men; the remaining are women. Of these 494 people, 152 persons are living with AIDS; 110 of these (or 72.3 per cent) are men, and the remaining women. The number of cumulative deaths is 114. Although Sri Lanka is regarded as a 'low incidence' country, health authorities believe that the actual number of people living with HIV could be in excess of 5,000. The vulnerabilities arise largely from unprotected sex and intravenous drug use. Studies indicate that the vulnerable groups include sex workers (local and foreign), drug users, soldiers sent for duty in the war-affected areas of the North and East of the country, traders, businessmen, child sex workers and beach boys catering to the sexual demands of tourists and paedophiles, and garment factory workers in the country's Free Trade Zones.

In recent times, several new vulnerable groups have been seen to be emerging. They include immigrants returning from other countries, particularly India, under the resettlement programmes in the North of the country in the wake of the Peace Accord. Others in the vulnerable group are internally displaced persons returning to their domicile after nearly three decades of living in welfare centres or refugee camps with limited means of livelihood. A third group consists of labour migrants, who accounted for 50 per cent of the total of 264 persons who were identified as people living with HIV/AIDS as of 31 December 2002[3].

8.3 International Contract Labour Migration

Numbers

Over the years, there has been an increase in the number of labour migrants leaving Sri Lanka; in particular, in 1995 the process accelerated dramatically. Table 8.1 shows a 65.3 per cent increase from 60,168 departures in 1994 to 173,489 in 1995. The increase can be traced to the introduction of a system of compulsory registration of all labour migrants with the Sri Lankan Bureau of Foreign Employment (SLBFE), following an amendment of the relevant law. The pace of labour migration has remained unchanged since then; an estimated total of one million migrants (that is, approximately 1/16th of the total population) are currently working in other countries. Table 8.1 shows that the male:female migrant ratio is now 1:2. The majority of labour migrants belong to the 20-39 years age group.

Typically, women migrant workers come from the ranks of the rural poor, are married, have one or more children, have had a primary school education and have entered the foreign job market in order to supplement household incomes, particularly since their husbands are

2 In particular, Dr Nisha Arunatilleke, Fellow, Institute of Policy Studies; Dr Kulasiri Buddhakorala, National STD/AIDS Control Programme; Sr. Mary Immaculate De Alwis, Congregation of Holy Family Sisters; Swarna Fernando, Department of Demography, University of Colombo; Mallika Ganasinghe, Executive Director, Organization for Protection of Social Environment; Kalyani Herath, Manager/Research, Sri Lanka Foreign Employment Bureau; Savithri Hirimuthugoda, Information Officer, Center For Women's Research; Harsha Jayasinghe, Research Officer, Center for Women's Research; Viola Perera, Coordinator, Action Network for Migrant Workers; Sr. Shirani Perera, Provincial of the Council of the Sisters of Perpetual Help; Maj. Esslin Ranhoti, Salvation Army, Sri Lanka; R.K.K.M.P. Randeniya, Sociologist, Sri Lanka Foreign Employment Bureau; Sr. Mary Sushila, Program Manager, International Catholic Migration Commission; David Soysa, Director, Migrant Services Center, Dehiwala; Duminda Weeraratne, Deputy General Manager (Planning, Development, Research and Training), Sri Lanka Foreign Employment Bureau; Maj. Wedage, Salvation Army, Sri Lanka; Manori Witharana, Project Officer, American Center for International Labour Solidarity; Kanti Yapa, Project Officer, International Organization for Migration.

3 These figures may be as a consequence of the tendency to conduct more tests among migrant workers.

Table 8.1 Distribution of Total Departures of Migrant Workers by Sex, 1986-2001

Year	Total Departures	% Males	% Females
1986	16,456	67.0	33.0
1987	16,127	66.0	34.0
1988	18,428	45.0	55.0
1989	24,724	35.0	65.0
1990	42,625	36.0	64.0
1991	63,983	33.0	67.0
1992	44,652	35.0	65.0
1993	48,753	35.0	65.0
1994	60,168	27.0	73.0
1995	173,489	27.0	73.0
1996	162,576	26.5	73.5
1997	150,283	25.0	75.0
1998	159,816	33.7	67.3
1999	179,114	35.4	64.6
2000	181,370	33.0	67.0
2001	183,888	32.5	67.5

Source: Information Technology Division, SLBFE.

usually unemployed or underemployed (Dias and Weerakoon-Gunawardene, 1991).

Source areas and migration routes

The Sri Lankan government allows recruitment through both direct sources such as friends, relatives or sponsors acting on their own initiative or through registered employment agencies. The latter accounted for 67-76 per cent of departures between 1996 and 2001. Recruiters are linked up with recruitment firms in destination countries and together they agree on numbers, terms and conditions of contracts and other issues. Sri Lanka has about 550 registered recruiting companies that are required by law to obtain a licence from the SLBFE and renew it every year. According to SLBFE sources, there is an unspecified number of unregistered agents who collect passports from prospective migrants and find them employment. There are instances where people who are below the employable age of 18 years are issued passports that do not show their real age. Where such instances are detected, the SLBFE cancels the licence of the agent. A further control on illegal recruitment is the SLBFE's stipulation that all vacancies for employment should be approved by it.

The major destination countries are in West Asia, which accounted for 95 per cent of labour migrants from Sri Lanka in 2001. Table 8.2 shows that Saudi Arabia, Kuwait and United Arab Emirates receive the largest numbers of Sri Lankan workers. In terms of skill levels, women taking up employment as domestic help - who are considered 'semi-skilled' - comprised a little over half (55.91 per cent) of labour migrants in 1991, while others were unskilled workers (18.19 per cent), skilled workers (19.96 per cent), clerical and related (3.27 per cent), and professional and middle-level workers (3.89 per cent). By 1996, there was a drop in the proportion of women taking up employment as domestic workers, due to a slight increase in the numbers of skilled and unskilled workers. Recently, however, that number has risen again.

Table 8.2 Country of Destination of Migrant Workers, 2001

Region/Country	Number of Migrant Workers	%
West Asia	**175,064**	**95.21**
Saudi Arabia	66,644	36.24
UAE	28,284	15.40
Bahrain	3,740	2.03
Oman	3,669	2.00
Kuwait	35,093	19.08
Qatar	14,046	7.64
Jordan	8,028	4.36
Lebanon	15,430	8.40
Yemen	23	0.01
Israel	24	0.01
Syria	26	0.01
Egypt	57	0.03
South East Asia	**2,642**	**1.44**
Singapore	1,507	0.82
Others (in SE Asia)	1,135	0.62
South Asia	**2,418**	**1.31**
Maldives	2,392	1.30
Pakistan	26	0.01
African subcontinent	**297**	**0.15**
Western countries	**3,342**	**1.83**
Other (Seychelles)	**125**	**0.06**
Total	**183,888**	**100**

Source: Information Technology Division, SLBFE.

Although job agencies are technically responsible for the welfare of the recruited person from the point of departure from Sri Lanka to his/her return after completion of the contract (usually for a period of two years), there are many problems with this arrangement. Migrant workers do not sign a contract with prospective employers but enter into agreements with job agents. The worker is rarely aware of the conditions specified in the contract or the rights and privileges to which s/he is entitled, due to a lack of interest or education. Furthermore, according to the Director of the Migrant Services Center (MSC), employers usually tear up the contract when the migrant worker arrives; in any case, the contracts cannot be enforced as there are no bilateral agreements between Sri Lanka and the labour-receiving countries.

Living and working conditions

Living and working conditions depend on the country of work, the type of employer and the type of migrant worker. Speaking of the work conditions of women employed as domestic workers in general, the Director of MSC explained:

Some employers are civilised and treat the worker with respect. But in other homes where people are not educated or cultured, they may not get the same treatment. When the workers are sent indiscriminately without the agency finding out whether the home has patients with mental illness or sexual perverts or has a history of abuse, the treatment gets bad.

Women workers, rather more than men, tend to be at the receiving end of maltreatment by employers. Of the total of 7,927 complaints that

the SLBFE received in 2001, the bulk (81.9 per cent) were from women working in West Asia. Most complaints relate to violations of the job contract such as non-payment of wages (14.1 per cent), not being sent back after completion of contract (17.2 per cent), and breach of other terms of employment (18.2 per cent). A significant proportion (20.6 per cent) also complained of isolation, while another 15 per cent stated that they suffered some type of harassment (Table 8.3). It is important to note that the SLBFE does not differentiate between types of harassment such as sexual, physical or mental. Another vacuum in the data relates to the incidence of deaths: there were 156 reported 'natural deaths' for 2001, with similar numbers for preceding years as well. Precisely how there could be so many natural deaths in one year when migrants are subjected to rigid medical testing before and after departure is open to question. This is all the more important as international literature has classified Sri Lanka as a 'high-death sending country'. The SLBFE also has no record of the causes of these 'natural deaths' and it is possible that this may have a bearing on the extent of HIV infection among the workers.

For domestic workers, Jureidini (2002) identifies three subcategories, namely, 'live-ins', 'freelancers' and 'runaways'. A 'live-in' resides within the household of the employer, also called 'sponsor', usually for a period of two or three years. The sponsor is responsible for all the financial costs involved, such as the work permit, health

Table 8.3 Types of Complaints Received from Migrant Workers, 1999 to 2001

Type of Complaint	1999		2000		2001			
	Men	Women	Men	Women	Men		Women	
					No.	%	No.	%
Non-payment of agreed wages	483	1,785	342	1,437	81	7.2	1,042	92.8
Not sent back after completion of contract	239	471	51	300	96	7.1	1,265	92.9
Breach of other terms of employment	1,063	186	722	166	951	65.9	493	30.1
Isolation	166	1,661	70	1,596	29	1.8	1,608	98.2
Sickness	152	559	68	385	37	9.9	336	90.1
Harassment	144	1,661	70	1,325	29	2.4	1,164	97.6
Natural death	36	75	12	10	25	59.5	17	40.5
Accidental death	1	1	37	46	72	44.2	84	53.8
Murder	0	3	0	1	0	0.0	2	100.0
Suicide	0	0	0	2	1	9.1	10	90.9
Stranded upon arrival	8	57	0	29	2	3.8	51	96.2
Problems at home	1	15	7	103	11	5.0	209	95.0
Stranded without job	1	1	4	3	1	100.0	0	0.0
Other (domestic work)	25	618	9	356	6	3.2	180	96.8
Other (non-domestic work)	189	92	96	52	26	48.1	28	51.9
Not accounted for	36	146	24	0	137	100.0	0	0.0
Total	**2,508**	**7,331**	**1,542**	**5,811**	**1,438**	**18.1**	**6,489**	**81.9**

Source: Information Technology Division, SLBFE..

insurance, clothing and food as well as the return airfare upon completion of the employment. The worker cannot change employers unless the employer agrees and the employer can change domestic workers within the first three months of the contract. The avowed objective of the latter is to limit the worker's freedom of movement, a procedure that has received the sanction of the SLBFE .According to the Director, MSC, although the employer is expected to issue an iqama, a document that serves as an identity card in place of the passport that enables the person to move about, employers seldom do.

A 'freelancer's' living and working conditions are much less controlled. She lives on her own, either renting or staying in a room for a service rendered, and works on an hourly basis. To remain within the law, the freelancer must have a sponsor. 'Runaways' are former 'live-ins' who decided for various reasons, such as abuse and withholding of payments, to leave the house of the employer. They take refuge in embassies and with non-governmental organisations (NGOs), or sometimes share cheap accommodation with their compatriots. There are reported instances of embassies handing over such migrants to the official employer, who usually resorts to beating the migrant as a means of bringing the worker to a state of submission. According to one key informant, "if the migrant worker is at fault, she is taken by the agent to his office and abused (physically and even sexually) and sent to another home." When basic human rights and dignity are denied, the migrant workers have little choice but to run away and find temporary shelter in a "safe house" set up by their embassy.

Regular migrants are entitled to access resources and services provided by the Sri Lankan government through the embassies and welfare officers attached to them - although, according to some persons interviewed, this is "only on paper". Service provision through consulates is critical, particularly since the host countries have not signed any bilateral agreements with Sri Lanka and are not signatories to the UN Conventions relating to migrant labour.

Workers can access health services of the host country as long as their employers are compassionate enough to allow them this privilege. Sri Lankan embassies in three West Asian countries (Saudi Arabia, Kuwait and Lebanon) are known to have "safe houses", but the services provided are at a bare minimum. One Sri Lankan person who visited a safe house in Lebanon said:

The hostel provides accommodation for about 100 housemaids who are escapees. All sleep on the floor, some on mattresses but most on pieces of cardboard. Meals consist of rice and one vegetable or roti (a variety of 'nan') made of flour. They do not have medicines if they are ill. If a person gets very ill, a doctor is summoned. Inmates have to pay $10 dollars for treatment. (Excerpt from *Birinda* monthly journal, 7 January 2002)

According to some accounts, the victimisation of labour migrants from Sri Lanka is partly explained by the fact that they usually are less skilled, and perhaps less motivated when compared with other workers such as those from the Philippines. The Program Manager of the International Catholic Migration Commission (ICMC) commented:

Compared with Filipinos, our people do not work fast enough. Our people are also not creative. A Filipino assigned to clean a room will check the windows, change curtains, remove cobwebs, and even decorate it, whereas a person from Sri Lanka will just sweep the floor. I had domestic workers from Sri Lanka tell me that they pretend they don't know how to cook since they think that if they show their skills, they will be asked to do that as well or get exploited. I tell them: 'Don't fall into the mental state of a slave, doing only what you are asked to do.'

Those who are recruited to work in factories often experience difficult living and working conditions and are not free to join trade unions or get organised. The Program Officer of the American Center for International Labour Solidarity (ACILS) recounted:

Case Study of Bahrain

Despite the increasing importance and numbers of domestic workers, Article 2 of the Bahrain Labour Law for the Private Sector, 1976, exempts domestic servants from the purview of the law. This exemption is supposedly due to the private nature of housework and since workers are treated for legal purposes as a part of the family. Hence, the Ministry of Labour expects disputes to be settled internally or else 'the privacy of the household is desecrated'. In case of a dispute, a house worker can appeal to the police or to the court. The mandate of the Ministry of Labour and Social Affairs is limited. Domestic workers are largely unaware of the actions they can take to secure their rights. They do not even know the address or the telephone number of the Ministry of Labour. The majority of cases registered with the police are of runaway house workers. Most runaway cases occur after the lapse of the initial three-month period when the worker has completed the debt payment and the recruiting agent is no longer responsible for her. Running away from the employer is illegal. A police search is launched and the runaway worker's photograph is published in the local newspapers. Any person who hides or protects her is committing an offence. Only a small number of workers file complaints at the police stations. This low incidence is due to the fact that women house workers are unable to contact the police or they are afraid to go to the police, which could result in imprisonment and deportation. The largest number of cases involves Sri Lankans who are the majority of domestic workers in Bahrain.

(Excerpts from *Women Domestic Workers in Bahrain* by Sabika al-Najjar 2002)

The girls live in hostels that are situated in the factory premises. They cannot go out, and the factories are virtual sweatshops. In some instances, they are not paid on time and they can be fired at any time. Migrant workers from South and Southeast Asia face discriminatory treatment with regard to wages and other work conditions when compared with those who are recruited from the host country…

In most receiving countries, they are not allowed to unionise, although trade unions are allowed in Jordan and Kuwait; there are a few NGOs in Bahrain and Dubai that do social service work with migrant workers and some appear on their behalf in legal disputes.

Resources and services available to irregular migrants are extremely limited in Singapore. The Program Manager, ICMC, who had worked in Singapore for three years with labour migrants from Sri Lanka and other South Asian countries, recounts her impressions as follows:

Of the 25,000-odd Sri Lankans in that country, a very high proportion are 'illegal' and are mostly men. They come on tourist visas. The women get domestic work or work in nursing homes, while the men take up odd jobs. They wait around in the marketplaces to get a job. Most are unskilled. A few get together and rent a house and share the rent. If they are 'illegal' migrants, they live under fear of being detected by the police. As a consequence of that, they get no proper sleep and face severe mental pressure; some of them even lose their sanity. If the police raid the premises, some of them jump from high-rise apartment buildings and break their legs. They cannot get medical treatment since the law requires that they produce an IC (an identity card issued by immigration authorities) even to get medicines from a pharmacy. Some will produce another person's IC, but people are generally not willing to part with it. In case of such an injury, they will not have money even to buy crutches. The government (of Singapore) encourages employers to check the IC or passport of employees, and if they don't have it, they will get six months in jail. Conditions in jails are bad, since the government does not want to make jail an attractive place. Nor does the government encourage the public to give food or lodgings to 'illegal' migrants. They have no access to reproductive health facilities, and if they get pregnant, they will go in for an illegal abortion:

traditional Indian medicines to induce an abortion are available there.

The effect of such adverse living conditions on the mental health of all migrants, including the loss of self-esteem, and how this in turn could predispose them to engage in practices that make them vulnerable is noteworthy at this point. At the same time, young people migrating have a right and a need for a sex life and that has nothing to do with depression or boredom, but is a human need as much as love and caring.

Health risks

According to members of Migrant Worker Associations and other sources, conditions of work are harsh:

a) Most are given menial jobs or work that requires heavy physical labour such as cleaning, washing, ironing and transporting crates containing household goods brought from the market. The worker has to transport them usually through several flights of steps;

b) Work may be done for several families living in the same household so that the workload is sometime tripled or even quadrupled;

c) There is no limit to the number of hours of work; most have to work 12 hours a day or even more till they retire from sheer exhaustion;

d) Lapses are treated with verbal or physical abuse;

e) Workers rarely have access to medical care in the event of illness or accidents on the job such as a fall or a burn; some resort to self-treatment or simple use of pain relievers;

f) The actual numbers of complaints are under-reported simply because workers tolerate or endure all manners of hardship since their sole objective is to earn money.

The outcome of adverse work conditions is seen particularly in the large numbers of returnees who suffer from a variety of complaints such as heart disease, diabetes, arthritis, and back and limb pains. According to a Sri Lankan medical official who contributes to awareness raising programmes of the MSC, the lack of proper physical exercise or physical mobility and differences in diet in the host country may also account for their poor health situation.

Vulnerability to HIV/AIDS

The ratio of male:female HIV-positive labour migrants is 1:7 while the migration sex ratio is 1:2. This means that women are much more vulnerable to HIV infection. The Project Officer at the International Organization for Migration (IOM), an inter-governmental body that conducts programmes in Sri Lanka for capacity-building of the SLBFE, emphasises the importance of being cautious while establishing any connection between labour migration and HIV. Rushing to conclusions can stigmatise labour migrants who are mostly women from poor backgrounds and who are a marginalised category to begin with. In addition, HIV vulnerabilities may also exist in other types of population movements such as internal displacement due to ethnic conflict. Furthermore, the data that ostensibly establishes that migrant workers are especially vulnerable to HIV infection might be misleading: it might, for instance, be true that migrant workers are more likely to be tested than other segments of the population in Sri Lanka.

Within the sub-population of labour migrants, one can distinguish several subcategories on the basis of what may consider as predisposing factors that increase HIV vulnerability. These factors are: background of poverty; the harsh living and working conditions that deny them access to basic services and information available to other community members; sexual abuse; lack of availability of condoms, and knowledge about safe sex, and unprotected sexual relationships that are not abusive.

Pre-departure phase

Typically, labour migrants come from a background of poverty (Dias and Wijekoon, 1991) and go abroad for employment with the principal objective of earning money. Awareness creation on HIV/AIDS during pre-departure training programmes for migrants takes up only one of the 12 days of training (for those who go to Arab

countries). This is because HIV/AIDS awareness raising is, according to the SLBFE training staff, a 'peripheral activity'. More importance is given to other areas such as airport procedures, handling of appliances, and language learning. Most first-timers are brought for training from their homes in distant villages by the job agents, kept in boarding houses in Colombo, taken to training and after they complete the required training period they are taken to the airport. According to some informants, the participants are present there only physically, due to exhaustion from travel and dislocation. They are not required to pass a test upon completion of training nor do they get an opportunity to practice anything they have learned until they arrive at the doorstep of the foreign employer.

During stay in labour-receiving countries

There are two possible sources of HIV infection for women and men who migrate in unsafe conditions. First, it is the outcome of sexual abuse or rape and, second, it is a result of the migrant's need for sexual and emotional fulfillment. In the case of the latter, the knowledge and ability to practice safe sex becomes crucial. This is an area about which much more needs to be explored and understood.

There are instances of sexual abuse by employers, male children or male employees at the place of work. It is also reported that wives of West Asian employers encourage their husbands to have sex with the domestic worker as one way of preventing him from taking on another wife since that would result in dividing up his wealth. Some women (about 10-12 each year, according to the SLBFE's Manager/Research) return to Sri Lanka with unwanted pregnancies or with children born out of wedlock as a consequence of being sexually abused at the workplace. According to a warden of a Salvation Army "halfway house" in Colombo, the mothers usually hand over the children to children's homes or to foster parents or wait in a halfway house till the child is born in order to avoid shame and ridicule in their own community. Last year, there was a case of one child living in a children's home in a suburb of Colombo who was accidentally detected with HIV infection, although it is not known whether the child's mother was a migrant or not. As a consequence, the Salvation Army will, from now on, ask women seeking admission to their halfway house to submit a doctor's certificate although it does not force them to test for HIV.

Migrants may engage in sexual activities with other migrants, including those from other countries in the South Asian region, in their free time as a means of relieving boredom and mental depression resulting from isolation and harsh work conditions or to earn extra money. In Kuwait, Oman, UAE, Hong Kong, Singapore and European countries, workers are given a holiday once a week (usually on Sundays) when they can visit parks, which are the only places for recreation. According to the Executive Director of the Organization for Protection of Social Environment (OPSE), an NGO that works on child rights and migrants, when domestic workers are given free time on Fridays and Thursday afternoons in Abu Dhabi, many of them go to the local church and later visit the quarters of Sri Lankan men. Most of the men and women are married and have children in Sri Lanka. According to informants, some migrant workers have regular sexual partners, which may to some extent reduce the probability of infection.

It has been reported in Cyprus that women migrants who have husbands back home in Sri Lanka live with Sri Lankan teenagers who had gone for studies and dropped out of colleges due to the high costs of education in that country. Others choose sexual partners who are not from Sri Lanka as a measure of ensuring secrecy, but this may increase the risk of HIV infection since sexual partners may be from countries with a higher prevalence of HIV/AIDS.

It was also reported that when domestic workers escape from their official place of work in West Asia due to what they see as intolerable work conditions, men from Bangladesh or Pakistan accost them and provide them with a safe house that turns out later to be a house of commercial sex. This trend is reported to be very high in Lebanon, but there

underground networks for such activities are in the hands of powerful women migrants.

Some West Asian countries do not allow migrants to carry condoms as they believe it is against the tenets of Islam. Workers are stripped of such objects in addition to any medicines that they have in their possession when they disembark and go through customs. However, OPSE's Executive Director was skeptical about the ability of the ordinary migrant worker to use condoms even if they are available since, on the one hand, it would be impossible to do so in a situation when they are sexually abused or raped and in other situations too unless they have good negotiating skills, which they are usually not equipped with. On the other hand, most do not have skills in practising safe sex due to cultural and other obstacles. At the same time, there are cultural obstacles to discussion of safe sex during training and orientation programmes for migrant workers.

8.4 Other International Migrant Groups

Numbers, source areas and migration routes

OPSE's Executive Director emphasises the need to recognise that Sri Lanka is not merely a source country but is also a transit and host country for migrants, although the tendency is to focus only on the sending aspect.

We are a receiving country for sex workers from countries such as Russia and Thailand. They can be accessed at most of the big hotels in Colombo. We have also become a transit point for human smuggling of people from South Asian countries seeking entry to European or other destinations.

There are no reported instances of trafficking in the conventional sense of women or minors for sexual or other purposes, probably due to the fact that the country does not land borders with another country. However, there are reported instances of 'legalised trafficking' of women, including those who are under the legal age of employment, through a process that OPSE's Executive Director calls 'deception of work'.

Such persons are legal migrants but do not have a proper contract and are given work that was not mentioned in the original work agreement. In one instance, the person was recruited as a receptionist for a restaurant in Abu Dhabi, but was later asked by the employer to cater to the sexual needs of his clients.

In other instances, women from rural areas are recruited, purportedly as domestic workers by employment agencies, but are kept in safe houses in Colombo city and/or in certain West Asian countries for short periods and then found employment as domestic workers once they have done a stint as sex workers or are asked to continue as sex workers. This could be considered a modified version of trafficking.

Another strategy of job agents who work with international mafia is to change the destination of the prospective migrant from that given in the original agreement. According to the MSC Director, some agents recruit women to work as secretaries in a country in West Asia but the women end up as sex workers in Japan. The Director calls it 'smuggling people for imaginary jobs'. Women also are at a risk if they are recruited to work as garment factory workers since, if the factory is closed down, the agents will try to find them alternative employment as sex workers.

Apart from instances of smuggling from Sri Lanka to South East Asian countries, Europe and Australia, in recent months, there have also been two instances of human smuggling from India and Pakistan using major urban centres such as Colombo and Kandy as transit points. In these instances, about 112 Indian nationals and 254 Pakistanis were detected and are in the process of being deported after a judicial inquiry (Sunday Observer, 20 July 2003).

According to the MSC Director, this process has commenced with the relaxation of rules for issue of visas as a way of easing travel restrictions for tourists. Young men from India, Pakistan, and

Bangladesh come to Sri Lanka as tourists and are kept by local criminal elements in safe houses till they can board a multi-day fishing trawler that will take them to a ship lying at anchor in international sea-lanes. They are then taken to a convenient spot close to the country of destination and are left to their own devices once they have successfully swum ashore. After that, they will locate their friends and relatives and go underground. Some women are also found among groups that enter such countries through smuggling rings.

Vulnerability to HIV/AIDS

Casual migrants, including tourists (Sri Lankan and foreign), are very likely highly vulnerable to HIV infection. However, little secondary data exists about them to analyse their vulnerabilities.

8.5 Prevention of HIV Infection Among Migrants: A Review of Existing Programmes, Policies and Interventions

Services available

Current pre-departure training programmes provide rudimentary knowledge and raise awareness about HIV/AIDS, safe sex and sexual health, including the use of a visual aid showing potential risk situations while the migrants are in the host country. However, it was widely felt that the SLBFE's pre-departure training programmes are inadequate. As one respondent stated

Giving one or two lectures to prospective migrants, as is being done by the SLBFE during its 12-day training programme, is not enough. Tailormade lectures will not work. People who live with HIV should give the message. They should be able to relate their experiences. Secrecy and false fears of discrimination should be removed and the community should be strong to resist it.

Moreover, training programmes do not cater to male migrants. The official position is that men should be able to receive necessary information from awareness programmes targeting the general public, though some respondents pointed out that such programmes do not appear to have reached the public.

At present, mandatory pre-departure serological testing of labour migrants for HIV and other diseases is done through about 15 private laboratories. However, it was revealed by a source from the National STD/AIDS Control Programme (NSACP) that service personnel in one instance had returned the test results to a potential migrant with 'HIV POSITIVE' written in large, red lettering, causing much distress to the person and indicating lack of sensitivity to HIV-related issues among laboratory personnel. Labour migrants who have been identified as HIV-positive are directed to counselling and treatment to be obtained through district-level Medical Officers of Health.

Much emphasis has recently been given by the SLBFE to the reintegration of labour migrants after they return, through soft loan schemes for housing and self-employment projects, as a means of facilitating informed choices when considering repeat migration.

Relevant policies

The Sri Lankan government regulates labour migration through the SLBFE, which was set up by an act of Parliament in 1984. This was amended in 1995 to enable the SLBFE to stipulate that all labour migrants be registered with the agency by payment of a sum of money proportionate to the income they expect to earn from foreign employment (see List of Resources at the end of report). The Sri Lankan government also undertakes an aggressive policy of securing employment opportunities in other countries for its unemployed labour force.

The government undertakes mandatory testing of potential labour migrants for HIV/AIDS, STD, diabetes, high blood pressure and tuberculosis. The tests are a requirement imposed by the receiving countries, particularly those in West Asia. It also endorses testing of the migrant after he or she has started their employment. If the migrant is found

positive, s/he has to return home. At times, testing is done in secret and the migrant is not told the reason for deportation. The Sri Lankan government, however, has no mandatory testing for returning migrants or a method of monitoring their health status once they return.

A National AIDS Plan was endorsed by the Ministry Of Health (MOH) in 1994. The approach is multisectoral and the programme lays special attention on treatment of STDs as a key prevention strategy. The Ministries of Education, Planning, Tourism, Labour and Youth Affairs are partners in the National Programme. Social sector NGOs play an important role in the national response. However, involvement of the private sector is modest.

Two research centres specialising in HIV law and ethics, the Centre for Policy Research and Analysis (CEPRA) and the Human Rights Centre, based in Colombo University, also play a role in shaping the national responses.

8.6 Policy Gaps and Recommendations

The focus here is on overseas contract migrant workers as this group is seen as one of the most vulnerable at this time.

Policy gaps

- There are gaps in information that affect the possibility of corrective measures. These include
  - information about the sexual behaviour of migrants, including those who have been subjected to sexual abuse or rape. This could be due to cultural blocks or shyness or inability on the part of both the migrants as well the staff in various service organisations to broach the subject and openly dialogue. There could also be a lack of interest in this subject
  - knowledge of the successful methods of increasing awareness about the linkages between unsafe migration and HIV/AIDS among prospective migrants and those who have already migrated
  - Level of awareness about safe sex practices among migrants and their ability to practice or negotiate safe sex.
  - Details of critical events in the career of migrants that have a bearing on HIV transmission, including their family background, critical life events, contact with job agents, process of movement from village to city, details of time spent in the city, arrival in the host country, and post-arrival events including relations with employers.
  - Nature, size and behaviour of most vulnerable sub-populations among migrants, including freelancers and undocumented migrants.
  - Causes of so-called 'natural deaths' of labour migrants.
- There are no concrete policy guidelines for facilitating re-integration of returnee migrants; one of the issues is the marginalisation and stigmatisation by the local population and by governmental agencies when the returnees wish to access facilities and services.
- For a country where migration is one of the key livelihood strategies, the policy does not outline the steps that would be taken to minimise the stigma associated with labour migration and HIV/AIDS.

Recommendations

- *Adopt innovative Information, Education and Communication (IEC) methods*

The government has to go beyond the traditional approaches and strategies and focus on several specific interventions such as providing cheap drugs, care facilities, counselling, skills development and livelihoods for people living with HIV/AIDS.

- All categories of workers, regardless of gender, need to be reached, including those working in garment factories in the Free Trade Zones
- Use of native drugs for preventing and treating opportunistic infections that people will accept and are low-cost, as is being done in Thailand.
- Innovative IEC methods for migrants need to be adopted such as repeating messages about HIV prevention even after the formal training period, through the use of a video tape containing messages during flight, making available a cassette containing songs interspersed with

messages to every migrant worker, and using annual cultural events organised by welfare organisations in the host countries as a medium for such messages. NGOs and religious groups should also be engaged in more IEC activities than they are at present.

- SLBFE pre-departure training programmes need to increase the time devoted for HIV/AIDS awareness among migrants preparing to go abroad for employment.

■ *Frame a holistic approach for self-development and empowerment of migrant workers*

There is a need to make HIV prevention part of a larger effort to empower labour migrants psychologically and materially in the countries in which they are employed and to give them skills for self-employment activities after they return.

■ *Facilitate reintegration of returnees in the community*

Health authorities also need to pay more attention to the problems of returning migrants since some returnees are unable to fit into society upon their return and the dynamics of readjustment have a bearing on their future careers. Negative attitudes and the absence of support services can push women to migrate again or to engage in sex work.

■ *Create adequate monitoring systems in the host country as well as in Sri Lanka*

There is no proper mechanism to monitor the health status of returnees with regard to HIV/AIDS. The Sri Lankan government's airport procedures do not have a system for compiling a database on returning migrants. Currently, the procedures do not identify returnee migrants. However, the SLBFE has exhibited interest in developing such a mechanism in co-ordination with the Department of Immigration and Emigration. The latter has suggested the use of a box in the disembarkation card where the information could be entered, although not all returnees fill out the card. The viability of this should be assessed within the overall framework of the rights of migrant workers. Moreover, this information should be used for planning services for the returnees.

■ *Emphasise counselling for returnees and their families*

NGOs working in psychological counselling have the skills to interact with people, win their confidence and maintain confidentiality. Returnee migrants services should include counselling and, where applicable, access to treatment. Victims of sexual abuse would need specific counselling services.

■ *The government must take a proactive role in the implementation of rules and procedures relating to labour migration*

The plugging of gaps and weaknesses in the implementation of rules and procedures relating to labour migration could avert many untoward events, such as rape and sexual harassment, running away from employers, trafficking, commercial sex work, imprisonment and deportation.

■ *Formulate regional strategies*

Governments need to make HIV/AIDS prevention an inter-regional matter by involving regional organisations such as the South Asian Association for Regional Cooperation (SAARC) and the Association of South East Asian Nations (ASEAN). NGOs can be a critical partner along with governments and multilateral agencies in negotiating safe mobility for the migrant workers.

Table 8.3 Summary of Vulnerable Groups, Responses and Recommendations

Vulnerable Groups	Current Situation	Responses	Recommendations
Contract labour migrants; female domestic workers most vulnerable Casual immigrants and commercial sex workers (CSWs), both foreign and local Returning Tamils and internally displaced people (IDP) returning home from camps Drug users, army soldiers sent for duty in the war-affected areas of the North and East of the country, traders, businessmen, child sex workers, beach boys and garment factory workers in Free Trade Zones	Comprise 50% of total count of 264 HIV-positive people: 7 women to 1 male prevalence ratio but migration ratio is 3:1. Contracted by a) forced sex or b) voluntary sex No programmes No testing or programmes No testing or programmes	1-2 hours on HIV/ AIDS in 12-day pre-departure training for domestic workers; No specific training for men; Pre-departure HIV testing for people going to West Asia; No post-return testing or counselling	Develop more innovative pre-departure training methods Improve understanding of offshore behaviour that leads to HIV infection Find ways to destigmatise HIV/AIDS; Facilitate integration on return Find ways to identify returnees with HIV/AIDS Empower communities to develop holistic solutions Strengthen a small number of NGOs

8.7 List of Resources

Government Programmes

The Sri Lanka Bureau of Foreign Employment was set up by an Act of Parliament (Act No. 21 of 1985) and amended by Act No. 4 of 1994 and is a body established to regulate labour migration. In addition, over the last decade, it has expanded its activities to include training of women who take up employment as domestic workers through a network of 29 training centres established in different parts of the country and staffed by an officer. It also operates a halfway house near the international airport to provide temporary accommodation for returnees having problems, including those who were victims of abuse or have unwanted pregnancies or babies. All labour migrants hoping to work in any capacity on a contract basis are required to register with the SLBFE before they depart. Registration can be done either at the SLBFE headquarters in Colombo or at the airport. The fee for registering is scaled according to expected remuneration as follows: Rs 5,200 if monthly wages are up to Rs 10,000; Rs 7,200 if monthly wages are up to Rs 20,000; and Rs 10,200 if monthly wages are more than Rs 20,000. The registration is valid for two years and has to be renewed. Registration entitles the migrant to free life insurance cover of Rs 300,000 and to illness and accident cover up to Rs 200,000 in the event of permanent disablement. The registration is checked at the airport and is to be stamped on a separate page in the passport. All fresh migrants who expect to do domestic work have to undergo a course of training that is currently for a period of 12 consecutive days in Colombo and is given free of charge. In the event that the migrant is not a fresh recruit and has no document to prove previous training, s/he has to undergo compulsory orientation. The 12-day training includes a technical orientation (that is, how to work, operate household appliances), mental orientation, general and sexual health, reproductive health, processing of travel documents, airport procedures at arrival and departure, banking and money transfer. A basic knowledge of Arabic and English is also given. Address: No. 61, Isipathana Mawatha, Colombo 5. e-mail: develop@slbfe.lk or research@slbfe.lk

NGOs and IOs (in alphabetical order)

Action Network for Migrant Workers (ACTFORM), set up in 1999, began as a 'Women and Media Program' and grew into an umbrella organisation made up of several NGOs, including the Migrant Services Center, Welcome House, Women's Development Center, ACILS, and district-level Migrant Worker Associations. It organises events to raise public awareness about issues relating to migrants such as the introduction of the Convention on migrant labour on 1 July 2003, undertakes redress of grievances of individual migrants and their families, and is a part of international networks for migrants such as 'Migrant Forum for Asia' and the 'Asian Migrant Center'. It publishes a tri-monthly journal called Tharani in Sinhalese, English and Tamil languages with articles of relevance to migrants. Contact: Viola Perera, Coordinator. Address: 20/1, 8th Lane, Nawala. Tel: 2805127 or 2805579. e-mail: actform@sltnet.lk

American Center for International Labour Solidarity Its aim is to tackle the enormous challenges workers face in the global economy. The American Federation of Labour-Congress of Industrial Organizations (AFL-CIO), the national federation that represents more than 13 million working women and men in the United States, launched the American Center for International Labour Solidarity in 1997. The ACILS receives funding from both public and private non-profit sources. Funding sources include the U.S. Agency for International Development, the National Endowment for Democracy, the U.S. Department of State, the U.S. Department of Labour, the AFL-CIO, private foundations, and national and international labour organisations. Its recent activities include unionising migrant workers through the establishment of Migrant Worker Associations at the community level, holding workshops for job agents and sub-agents

to promote better business practices and give the latter legal recognition, and conduct studies about work conditions of migrant workers. Contact: Manori Witharana, Project Officer, ACILS, No. 09, Kinross Avenue, Colombo 04 Tel: 94 1 580080 / 94 1 74513497/ 94 1 599628. Fax: 94 1 593123.

International Organization for Migration (IOM) is an inter-governmental body and has carried out programmes in Sri Lanka for capacity-building of the SLBFE, strengthening its training programme with the focus on promoting learning of English by prospective migrants, strengthening legal aspects of the Sri Lankan government's Department of Immigration and Emigration with the objective of preventing illegal migration, and giving assistance for re-integration programmes. Under UNAIDS, it has prepared a concept for launching a voluntary counselling and testing programme for returnees. Contact: Kanti Yapa, Project Officer. Address: 31, Police Park Avenue, Colombo 5. Tel: 01-2581673. e-mail: kanti@sierra.lk

Migrant Services Center (MSC) was set up in 1994 on the initiative of David Soysa, who has been its director since its inception. It has set up a countrywide network of Migrant Worker Associations made up of returning and prospective migrant workers and members of their families. Members of these associations promote and financially assist self-employment activities to enable returnees to reintegrate with society and their work with banks, insurance companies, and research institutions and universities. It works with religious and other organisations, both local and foreign, and helps in advocacy campaigns, street campaigns and protest movements. Its main sponsors are CARAMASIA, a regional NGO based in Malaysia, and the World Solidarity Movement based in Belgium. It has initiated a research cum action programme for HIV prevention among migrant workers. It operates with an office staff of three persons and a field staff of 12 who are assigned to work in outstations. It also has a panel of experts in relevant fields such as law and health education. Contact: No. 10, Council Lane, Dehiwala. e-mail: migrant@sltnet.lk]

Organization for Protection of Social Environment (OPSE) is a small NGO established in 1998 to work on child rights and migrants. It is concerned with the relationship between HIV/AIDS and labour migration. Recently it carried out a study of a sample of 260-odd cases of sex workers who had been trafficked from rural areas of Sri Lanka to work in urban brothels. Its Executive Director is Mallika Ganasinghe. Contact: 17/12, Karlshrue Gardens, Colombo 8. Tel: 01-864926. e-mail: mallika@lanka.cccom.lk

Roman Catholic Church of Sri Lanka recently set up an International Catholic Migration Commission in reply to the worldwide phenomenon of both legal and illegal migrant workers. Sr. Mary Susila is its program manager. She began by counselling mothers who wanted to go abroad for employment not to do so and to make informed decisions about leaving the country. Her attitudes changed when she realised that women were the 'saviours of their families since most had to leave due to poverty and non-supportive husbands'. Contact: 16. Rodney Place, Colombo 8. e-mail: icmcslpr@sltnet.lk. Another congregation known as the 'Sisters of Perpetual Help' has initiated interventions in Cyprus in response to the Commission for 'Pastoral Care for Migrant Workers and Itinerants' and has three nuns working in Cyprus from April 2003. Contact: Sr. Shirani Perera, Provincial of the Council that manages the congregation in Sri Lanka. Tel: 031-38343. e-mail: perpetua@slt.lk

Salvation Army's Sri Lanka branch was set up in 1883 and maintains nine children's homes in different parts of Sri Lanka, including the North and East, six hostels for the elderly and for young male and female workers, 11 community centers, including two for HIV/AIDS education (in Hikkaduwa and Colombo), 12 childcare centres and 45 churches. One such facility is 'The Haven' located at 127, E.W. Perera Mawatha, Colombo 10, with 35 beds for women with unwanted pregnancies, including some who are labour migrants. Contact: Major Mary Ratnasingham and Major Esslin Ranhoti (Tel: 695275). Other staff are Sriyanthi Peiris, Community Services Director, and Gloria Iddamalgoda (Counsellor).

8.8 List of Readings

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UNDP is the UN's global development network, advocating for change and connecting countries, knowledge, experience and resources to help people build a better life. HIV/AIDS is one of its top organisational priorities, integrating it into its broader efforts to support effective governance and poverty reduction. UNDP has been one of the most outspoken advocates for a multi-sectoral response to HIV/AIDS since the late 1980s.

APMRN has been in operation since 1995 and encompasses 16 countries/economies in the Asia-Pacific region. It is a leading organisation involved in Asia and Pacific research. It incorporates top migration researchers from a variety of disciplines, and draws on a wide range of expertise. Its researchers often work closely with policymakers and NGOs, and have carried out research for international, national and local bodies.

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