# Women, Migration, Conflict and Risk for HIV

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## Introduction

Women now constitute the majority of those living with HIV/AIDS globally, even if only by a small margin (UNAIDS, 2007). While the lower status of women has been recognized as increasing their HIV risk, issues of migration and conflict combined with this lower status are believed to propel women's risk for infection further, particularly in high infection areas such as Sub-Saharan Africa. Recommendations to address women's risk for HIV in the context of migration and conflict are needed. However, such recommendations must be built upon our understanding of the global HIV epidemic among women as well as the needs of women facing conflict and migration. Thus, this chapter begins with an overview of HIV among women across world regions, considering how women's lower social status is increasing their HIV risk in nations characterized by high ($\geq$2%) and lower (<2%) HIV prevalence. Second, mechanisms by which migration can heighten women's risk for HIV are discussed, particularly focusing on forced migration, a common result of conflict. Although forced migration is not always linked to an increase in HIV incidence, it is commonly associated with behaviors and contexts that increase the likelihood of HIV infection among women migrating to higher HIV prevalence areas. Finally, taking into consideration the ways in which forced migration appears to increase women's HIV risk, recommendations are offered in the areas of reproductive and sexual health practice, policy, and research/surveillance.

## Overview of the Global HIV Epidemic Among Women: The Most Marginalized are at Greatest Risk

Current UNAIDS estimates indicate that approximately 33.2 million people in the world are living with HIV, with 7% of these individuals having become infected in

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the past year. Across regions and nations, rates of HIV, mechanisms of transmission, and populations most heavily affected vary; nonetheless, at a global level, women, particularly lower income and disenfranchised young women, disproportionately carry the burden of HIV. An overview of the HIV epidemic across international regions is presented to provide insight into how marginalization of women based on age, access to education and employment, social and economic reliance on male partners, and gender-based violence against women contribute to risk. Data presented are from the UNAIDS 2007 Report (UNAIDS, 2007); these data are offered in the order of regions with the greatest to the smallest numbers living with HIV.

## *Sub-Saharan Africa*

While the AIDS pandemic is now a global health concern affecting all continents, Sub-Saharan Africa remains disproportionately affected. Although Sub-Saharan Africa comprises 10% of the world population, the region accounts for 68% of the world's adult HIV cases and 90% of HIV cases in children. While HIV rates in Sub-Saharan Africa appear to have stabilized, with some nations (e.g., Kenya and Zimbabwe) actually reporting a decline in infection, these rates remain at a substantial level for most Sub-Saharan African countries, with adult (aged 15–49 years) HIV prevalence ranging from 5 to 32% across these nations; this is a notable contrast with the global adult HIV prevalence rate of 0.8%. While rates and populations affected in this region vary by nation, overall women, particularly young women, bear the brunt of the Sub-Saharan HIV epidemic. More than half (61%) of HIV/AIDS cases in the region are among women aged 15 years and older. Increased biological risk compared to males has been identified as a reason for increased risk for young women. However, compounding this biological risk are consequences of women's low status compared to men, which also contribute to women's increased risk for HIV. Women experience: (1) lower educational access and occupational opportunity increasing women's financial reliance on men, (2) patriarchal relationship dynamics which can include older and more sexually experienced male partners, (3) social acceptability and practice of sexual violence, and (4) masculine gender norms which support and reinforce men's promiscuity and non-monogamy in intimate and marital relationships.

## *East, South and Southeast Asia*

While Sub-Saharan Africa, particularly the Southern most nations of the region, remains at the heart of the HIV pandemic among women, the growing epidemic among women in Asia also warrants serious consideration. Current estimates indicate that an estimated 4.9 million people in Asia are living with HIV, with about half (51%) of these residing in India. This is in part attributable to the large population of the country; the proportion of adult Indians infected is about 0.36%. Proportions of the Asian population infected with HIV are greatest in Cambodia and Thailand, although rates of infection are declining in these nations. HIV prevalence is increasing in China, Indonesia and Vietnam, while other regions in Asia have

not yet hit epidemic proportions with HIV. Across Asia, the primary risks for HIV among women are attached to sex work (including sex trafficking and sex tourism), and being a partner to someone engaging in sex work or injection drug use (IDU). Additionally, there are signs that the epidemic could hit Bangladesh and Pakistan via injection drug use and sex trade involvement; currently Pakistan, in particular, has minimal prevention efforts in place to address the potential epidemic that could occur. For these emerging epidemics, again women's risk will predominantly be attached to sex work or their involvement with an "at risk" male partner. Hence, as with Africa, women's lower status, as demonstrated by educational and economic disenfranchisement as well as reliance on male partners, contributes to their risk for HIV.

## *Eastern Europe and Central Asia*

The AIDS Pandemic within Eastern Europe and Central Asia has been growing rapidly, experiencing a 150% increase within the past six years. The epidemic has historically been limited primarily to only two nations, the Ukraine, which continues to experience growth in its HIV rate, and the Russian Federation, which has the largest number of HIV/AIDS cases in all of Europe. However, Kazakhstan, Tajikistan, and Uzbekistan also now report epidemic levels of HIV. Historically, the region primarily saw transmission among young injection drug users (IDUs), a population often already on the margins of society. Young men in prisons, treatment centers, and homeless facilities dominate the epidemic; however, more recently, increased rates of HIV have been seen among those involved with sex work and those engaging in injection drug use, as well as those partnered with injection drug users. Again, young and lower income women are bearing the burden of the women's epidemic.

## *Oceania*

The HIV epidemic in Oceania is largely centered in Papua New Guinea, which accounts for 70% of the HIV cases in the region. Papua New Guinea is experiencing a notable HIV incidence rate of 1.3%, which continues to rise steadily. Pervasive negative attitudes toward women and women's right to sexual autonomy, as characterized by high rates of sexual violence and paid sex, have been linked to the disproportionate rates of HIV among young women in Papua. While much of the remaining 30% of HIV cases in the region are located in Australia, Australia's older HIV epidemic differs starkly from Papua's. The Australian epidemic is largely attached to men, specifically men who have sex with men (MSMs) and IDUs. Infected women are more typically IDUs or partners of IDUs. Notably, evidence also indicates that indigenous people are more likely than non-indigenous people to be infected; this disproportionate rate of infection may be tied to higher rates of IDU among indigenous peoples in Australia. While New Zealand has a substantially lower rate of HIV, the faces of the epidemic are similar to that seen in Australia.

## *The Caribbean*

Much of the Caribbean has been heavily affected by the HIV epidemic. AIDS is currently the leading cause of death among 25–44 year olds in the region. Adult HIV rates in Haiti are at 2% and rates have passed 1% in many other countries. Heterosexual infection is the primary means of infection in the region, and as seen in other regions of the world where the epidemic is centered on heterosexual transmission, younger women are at the highest risk of infection, being 2–6 times more likely to become infected than same age young men. Notably, the risk profiles of Caribbean females most likely to be infected are similar to the profiles seen in many Sub-Saharan African nations. In both regions, cultural norms related to relationships characterized by older men and young girls, with sexual exchange for favors and gifts, has been identified as a concern increasing risk for HIV among young women.

## *Latin America*

The largest Latin American nations are also those with the largest HIV epidemics. Brazil is home to one-third of the HIV cases in the region, though countries like Argentina and Uruguay are now experiencing high rates of HIV transmission as well. Within Central America, the proportion infected is greater for smaller and poorer countries, specifically Belize and Honduras; unfortunately, these nations also have few resources with which to address the epidemic, both in terms of prevention and treatment. Transmission in the region is largely due to injection drug use, but a reasonable proportion of MSMs are infected. The epidemic has only more recently begun to affect women; those most at risk are partners of men who use injection drugs or have sex with men. Taboos against MSM behavior result in many men leading "double lives", in which they have a steady relationship with women but on the side and without her knowledge have sex with other male partners. Higher rates of HIV among MSMs in the region are resulting in male infection and then transmission to female partners. However in more heavily affected nations in the region, such as Honduras where AIDS is the leading cause of death for women, sex work is also placing women at increased risk for HIV.

## *North America and Western Europe*

These nations, some of the wealthiest in the world, have relatively low HIV prevalence with which to contend, while simultaneously having greater resources with which to support HIV prevention and treatment efforts. The United States has the worst epidemic in these regions, with a 0.4% HIV prevalence rate nationally. As with many of the other nations in North America and Western Europe, the largest proportion of those infected are MSM. Although women are the minority of those infected, among women, those who are younger, racial/ethnic minority, and lower income are at disproportionate risk for contracting HIV. Studies from the region also

document that lower income and minority women, due to marginalization and lack of economic opportunity, may be more likely to use drugs and/or have partners who use drugs, are at greater risk to become involved with sex work, and are at increased risk for sexual victimization, all factors which contribute to risk for HIV/STI. Hence, these findings document that while there is overall low risk in the Western world, women at risk are those that are experiencing the greatest social vulnerabilities.

## *The Middle East and North Africa*

With the exception of the Sudan, HIV prevalence rates in these nations are less than .1%; the Sudan's HIV prevalence rate is 1.6%. The majority of those with HIV were infected via heterosexual activity. However, IDU-related HIV infection is a growing concern, particularly in The Islamic Republic of Iran and the Libyan Arab Jamahirya; these nations are also seeing high rates of HIV among their prisoners, many of whom are drug users. Information on potential risk for MSMs is minimal due to strong taboos against such behavior. Sex work has been an identified concern, as well, particularly in Algeria, Morocco and Sudan, which has identified high HIV rates among female sex workers. Overall, these findings indicate that primary risks for women in the region are attached to their male partner's risky activities; women's lack of control over sex and condom use, particularly in their marital relationships, combined with male partners' risky sexual behaviors exacerbate this risk.

## *Summary*

A review of the HIV epidemics across regions and nations documents that in high prevalence regions, women are more likely than men to be HIV infected, while in low prevalence regions men are more likely than women to be HIV infected. Patterns across global regions suggest that men's risk behaviors (e.g., injection drug use, same sex behavior), more than women's, escalate the epidemic in low HIV rate regions; this is attributable to the fact that shared needles and anal sex are more commonly reported by men and are riskier activities than penile-vaginal sex. However, penile-vaginal sex is a more pervasive activity; hence, in the presence of higher rates of HIV, penile-vaginal sex becomes the dominant means of transmission. In this context, rates for women increase because women are biologically more susceptible than men to HIV via penile-vaginal sex; this heightened biological risk is enhanced by the often lower social status of women which impedes women's access to HIV prevention education and inhibits their ability to request that their male partners use a condom.

Of note is the fact that, regardless of HIV risk levels, the most marginalized women are the first affected and remain at greatest risk for becoming infected as an epidemic escalates. Across regions, marginalized women are those who are lower income, less educated and younger; in wealthier nations, these also include racial/ethnic minority women (e.g., Blacks and Latinos in the US, indigenous peoples in Canada and Australia). Higher rates of drug use, sex trade involvement, and

victimization from gender-based violence are seen for these marginalized women and appear to be the primary reasons for their increased risk for HIV. Hence, while lower status of women contributes to HIV risk, those women most marginalized due to sociostructural factors (e.g., class, race, income) are also the most vulnerable to infection.

## Migration and Women's Risk for HIV

In the current climate of globalization and global industrialization, mass migration movements are further contributing to the marginalization of certain groups and their increased risk for HIV. Migration is simply the movement of persons or communities from one country or locale to another. Primarily, migration is occurring due to diminished economic opportunities in regions of origin, resulting in large rural to urban migration as well as migration from developing to industrialized nations. United Nations′ Educational, Scientific and Cultural Organization (UNESCO, 2002) reports that 1 out of every 35 individuals in the world is a migrant; in 2002, there were 175 million international migrants, which is approximately 3% of world's population. Migration has become increasingly feminized in the past decade, and women now comprise half of all migrants (UNESCO/UNAIDS, 2004).

Migration alone is not a risk factor for HIV, but the context in which migrants often live, i.e., poverty, discrimination, exploitation, and family/relationship/ community instability, does increase risk for HIV. According to UNESCO (2002), migration is linked to HIV in a number of ways: (1) Migrants are commonly denied health services and prevention education opportunities, as non-citizens in their places of residence; this may be particularly problematic for those HIV-positive migrants who migrated for access to HIV/AIDS care. (2) The legal restrictions typically placed on migrants, particularly undocumented migrants, result in their maintenance as a hidden and thus hard-to-reach population. And (3) migrants often are racial/ethnic or religious minorities in their places of residence, subjecting them to compounded discrimination; female migrants and those with HIV are further stigmatized and disenfranchised. Extensive evidence from Africa, the Caribbean, and Asia does indicate that migrants are at increased risk for HIV (e.g., Brewers et al., 1998; Foreit et al., 2001; Lurie et al., 2003; Poudel et al., 2006; UNDP, 2004; Zuma et al., 2003). However, some conflicting evidence also exists indicating that migrants are at no greater risk for HIV than natives (Mundandi et al., 2006; Singh et al., 2004). In some cases, returning migrants actually have had lower HIV incidence than the population that remained in the migrants' regions of origin (UNHCR, 2006). The differences in patterns of migration and the spread of the epidemic likely explain these differences in risk for migrants. Forced migration, a consequence of conflict, disaster, or development projects in a region, likely heighten risk in these contexts, as the option of returning home is often impossible for this group. Hence, there may be no way to avoid the diminished access to services, legal restrictions and discrimination these migrants, a predominantly female population, are forced to endure (UNHCR, 2006).

## Forced Migration and Marginalized Women

Forced Migration is defined by the International Association for the Study of Forced Migration (IASFM) as the displacement of people due to conflicts, natural or environmental disasters, chemical or nuclear disasters, famine, or development projects. Forced migration can result in relocation across international or regional lines, but it can mean internal displacement as well. Such migration occurs despite the migrants' lack of desire to leave their place of residence and involves destabilization and loss of resources in almost all cases. The most vulnerable to such destabilization and further loss are the marginalized – the young, the poor, the minority and the female – the same groups at increased risk for HIV.

According to Forced Migration On-Line (2006), a resource dedicated to understanding human displacement, there are three types of forced migration: 1. *Conflict-Induced Displacement*, which occurs when people are forced to leave their homes due to armed conflict including civil war, generalized community violence, or persecution related to their ancestry, race/ethnicity, religion, political opinion, or social group; 2. *Development-Induced Displacement*, which occurs when people are forced to relocate as a result of governmental policies and projects, such as large-scale infrastructure projects including dams and roads; urban clearance initiatives; mining and deforestation; and the introduction of conservation parks/reserves and biosphere projects; and 3. *Disaster-Induced Displacement* which occurs when people are displaced "as a result of natural disasters (floods, volcanoes, landslides, earthquakes), environmental change (deforestation, desertification, land degradation, global warming) and human-made disasters (industrial accidents, radioactivity)." These types of displacements result in millions of forced migrants globally each year, with 75–80% of these being women and children (UNHCR, 2006). Forced migrants can be refugees, asylum seekers, internally displaced persons (IDPs), development displacees, environmental and disaster displacees, smuggled persons, and trafficked persons; each of these groups is identified as a vulnerable populations and is predominantly female. While scholars have discussed how the context surrounding each of these types of forced migration can contribute to women's vulnerability to HIV infection, this chapter will primarily focus on HIV vulnerability in relation to conflict-induced displacement. Additionally, as these types of forced migration are not necessarily mutually exclusive, discussion will also include other types of forced migration where relevant and appropriate.

## Forced Migration and Higher Rates of HIV

Mass migration is commonly understood to be a key factor in the global spread of infectious diseases (Minas, 2001; Smith, 2002). While movement or exchange of individuals between high infection centers and low infection centers facilitates contact for communicable diseases to be transmitted to new populations, migration's primary effect on HIV rates occurs through increasing the rate of high risk sexual

behaviors (Coffee et al., 2007). Conflict, residential instability and poverty, the primary causes of forced migration, have also been linked to poor health outcomes including HIV (Murray et al., 2002; Richard et al., 1999; Noji, 1997; Connolly and Heymann, 2002; Levy and Sidel, 1997; Leaning et al., 1999; Spiegel et al., 2004a, b). However, more recent evidence suggests that increased HIV rates are not always the consequence of forced migration. Understanding when and why HIV risks increase in this context is vitally important to create programs to address these risks better. Unfortunately, inadequate data impede this process.

Epidemiological evidence linking forced migration and increased risk for HIV infection is minimal, and that which exists is largely subject to research biases (Hynes et al., 2002; Jacobsen and Landau, 2003; Salama and Dondero, 2001; Spiegel et al., 2004a, b, 2001). Such biases exist because it is difficult to capture accurate prevalence and incidence data in contexts of crisis. Roberts (2004) notes that rapid population movement affects both assessment of infection and determination of denominators; lack of baseline or comparable data also affect ability to compare numbers assessed from "norms." Hence, those migrants obtaining access to testing may be a select group and not necessarily indicative of the total refugee group in a region. Further HIV mortality data may not be identified as such, when opportunistic infections (e.g., TB or pneumonia) rather than HIV are identified as the cause of death. Also surveillance data even in optimal circumstances may simply not capture migrant or immigrant status or related factors, inhibiting our ability to assess infection rates (Roberts, 2004; Salama and Dondero, 2001; CDC, 2006). Thus making the data unreliable for epidemiologic surveillance purposes.

Nonetheless, despite these methodological concerns, existing data indicate that forced migrants within certain regions may be more vulnerable to HIV acquisition than both voluntary migrants and native residents, as reflected in one of the few pieces of work examining the link between forced migration, conflict, and HIV related vulnerability (Agadjanian, 2005). In this Angola-based work, forced migrants were found to be more likely to engage in casual sexual relationships than native residents (Agadjanian, 2005). Other work indicates that immigrants, migrants and refugees from certain regions have high rates of HIV or other STIs, and in some cases higher rates than those in their region of origin or those in the surrounding area. Studies of pregnant women and antenatal clinic attendees in Africa and Asia found that refugee women reported higher STD rates than that seen in their countries of origin (e.g., Cossa et al., 1994; King et al., 1990; IRC, 1999; Mayaud et al., 1997; Ministry of Health, Sudan, 1995). Studies of migrants and refugees from Africa and Haiti reported higher rates of HIV than those seen in their countries/regions of destination (Bouree et al., 1995; Nunn et al., 1995; Rey et al., 1995; Rey et al., 1996). Unfortunately, these studies did not have data to indicate whether infection was happening in refugee/relocation sites or had occurred prior to migration.

Historically, it was suspected that high conflict and forced migration, were linked to increased HIV infection at relocation, as a consequence of reduced capacity to screen blood and blood products, use of non-sterile medical equipment, reduced HIV/STI testing and treatment, and halting of HIV/AIDS prevention programs.

However, more recent evidence indicates that this is not always the case (Mock et al., 2004; Spiegel, 2002; Spiegel and Qassim, 2003; Spiegel and Nankoe, 2004). Increased isolation, high death rates, and low sexual activity due to sex segregation or depression/trauma may impede sexual practices that place people at risk for HIV (Mock et al., 2004). Additionally, when high conflict nations have lower HIV prevalence than surrounding nations, people with lower mobility remain within the lower prevalence high conflict regions. This may provide relatively lower HIV exposure to these low mobility groups. Such cases have been documented in the high conflict regions of Angola, Sierra Leone and Southern Sudan (De Jong and Spiegel, 2003; Kaiser et al., 2003; Van Rensburg et al., 1995). Of concern, however, is that the more mobile refugees from such regions will become infected upon relocation to the surrounding more stabilized nations characterized by higher rates of HIV (Spiegel and Qassim, 2003). As these HIV-infected displaced individuals return to their regions of origin and engage in sex with new partners, they take the epidemic with them. Higher rates of HIV in Rwanda and Angola have been attributed to rural Rwandan refugees in Tanzania and Zaire, as well as Angolan refugees residing in Zambia and Namibia, who brought the virus back to their countries of origin (Schreck, 2000; Spiegel and Qassim, 2003).

Further affecting risk in the conflict context is higher HIV rates surrounding war zones due to military presence. The military, a population with higher HIV/STI rates and riskier sex practices than the general population, may be heightening risk for infection among locally displaced women. There is evidence that refugee sites closer to war zones have higher HIV incidence than those farther from the war (Santos-Ferreira et al., 1990; McGinn et al., 2001); it is believed that the military presence in part explains the increased rates of HIV. Such patterns can result in the rapid increase of HIV prevalence among a population with previous low exposure, especially as those who became infected return to their low-prevalence nations of origin, post-conflict (McGinn et al., 2001).

## Forced Migration, Conflict, and Women's Risk for HIV

Despite global discussion regarding the importance of conflict, migration, and gender in shaping the global HIV/AIDS pandemic, very few studies have specifically examined how women's vulnerability to HIV may be exacerbated within the context of conflict-induced forced migration. Nonetheless, existing research does demonstrate that forced migration inevitably results in disenfranchisement regardless of what causes relocation (UNESCO/UNAIDS, 2006). There are always financial costs to relocation (e.g., paying to relocate, loss of resources such as land or housing in areas of origin), and there are often legal or linguistic barriers to social and employment opportunities upon relocation. Many forced migrants report taboos on sexuality, lack of condom use, and poor health care habits even in their countries of origin, exacerbating their risk for HIV after migration (UNESCO/UNAIDS, 2006),

and one recent study found that forced migrant women in Angola, relative to voluntary migrants in the region, felt at greater risk for HIV but less able to speak with partners or peers about this risk (Agadjanian et al., 2005). Forced migration often results in poverty, poor access to health care, poor nutrition, lack of education, and political, economic, and social discrimination, all factors that increase risk for HIV/AIDS (Roberts, 2004). Any society in which such drastic change has taken place will experience an erosion of civil expectations and social cohesion, resulting in increased high risk behaviors as well (Rhodes and Simic, 2005). The prejudice and stigma associated with HIV/AIDS can also become particularly virulent when combined with stigma directed at displaced persons (Salama and Dondero, 2001; Decossas et al., 1995).

Reviews conducted by Forced Migration On-Line (2006) and Humanitarian Practice Network (2002), in addition to the published literature, document the following reasons for increased infection attached to women's disenfranchisement and forced migration.

## *Lack of Health Infrastructure*

In situations of conflict, chaos, migration and resettlement, a stable health infrastructure is difficult to maintain. The ability to maintain blood supplies that have been screened for blood borne disease, including HIV, is more difficult, increasing the likelihood of infection via transfusions. Provision of HIV education and condoms is difficult, particularly if linguistic barriers prohibit any education from occurring. HIV counseling and testing may not be possible if testing kits and trained counselors are unavailable. All of these health infrastructure factors maintain increased risk in resettlement and migratory environments. Furthermore, medical facilities that serve forced migrants are also likely to suffer from shortcomings. For instance, work in conflict-affected Northern Uganda documented a shortage of HIV services, including prevention of maternal to child transmission (PMTCT), within districts containing camps for IDPs (Chamla et al., 2007). Furthermore, as refugee camps may be primarily staffed by male aid workers, forced migrant women may be less comfortable to discuss personal health needs, such as sexual health issues, thus leaving women vulnerable to HIV due to lack of knowledge, barrier-based protection, testing, and possibly treatment.

## *Use of Rape as a Weapon of War*

There has been extensive documentation of both military (including foreign militaries and paramilitary groups) and civilians using rape as a weapon in war (Donovan, 2002; Amnesty International, 2004; Roberts, 2004). In the context of high HIV rates, such sexual violence substantially increases the likelihood of women becoming infected. Sexual assault not only increases women's risk of

contracting HIV due to forced, unprotected sex, but such violent sex also confers HIV risk due to lacerations and other injuries within the female genital tract. Forced migrant women may be particularly vulnerable to being victimized by war-related rape and sexual assault. In multiple global settings that have grappled with widespread political turmoil (e.g. Darfur), women were often present in the villages during attacks while men were in neighboring towns as laborers. As women fled their villages to escape from the attacks, they were often chased and raped at security checkpoints, roadblocks, and elsewhere during their escape attempts (Amnesty International, 2004). Such experiences of sexual assault likely renders these women to face stigma from their communities, as they may be viewed as "tainted" by the enemies. Victimization from sexual assault, coupled with ostracization from their social circles likely bestows feelings of isolation among victims, leaving women and girls highly vulnerable to future sexual violence. Unfortunately, rape and sexual assault perpetrated against women have also been documented in refugee camps and settlements housing IDPs (Amnesty International, 2004; Kerimova et al., 2003). High and increasing HIV rates among women in refugee camps and regions plagued by war have been attributed to such assaults (Save the Children, 2001; Smith, 2002; Holmes, 2001; Roberts, 2004; Green, 2003).

## *Survival Sex and Sex Trafficking*

In the context of crisis and economic loss, circumstances common to forced migration, women may sell sex as a means of survival. This may be particularly true within the context of forced migration. In times of violent conflict, mortality disproportionately affects men (Murray et al., 2002), thus leaving women as single heads of household. With the sudden loss of income in an already depressed economic climate, women and girls may have very few alternatives, other than survival sex, to obtain money, food, and other necessities. Documentation of women turning to survival sex in the context of migration has been observed cross-nationally (Renaud, 2001; Lawday and Webb, 2002). In part, this can also be the context of smuggled or trafficked migrant women being forced into sex work. Like other forms of sexual violence (e.g. rape and sexual assault), sex trafficking, which is a form of gender-based forced migration in it of itself, is also believed to be rampant during times of conflict. While the documentation of HIV among sex trafficking victims is scarce, recent data from South Asia suggest that the prevalence of HIV among sex trafficked women and girls is as high as 38% (Silverman et al., 2007a). Likely mechanisms underlying such elevated rates include inability to demand condom use during forced, unprotected sex, and being forced to carry out sex work within a controlling environment characterized by debt bondage (Silverman et al., 2007a). The interplay of sex trafficking, forced migration, conflict, and gender are believed to create such a dire situation regarding HIV that sex trafficking has recently been specifically highlighted as an important factor in fuelling Nepal's dual epidemic of political conflict and HIV (Singh et al., 2005).

## *Social Norms and Regulations Related to Sex are Lost in Situations of Chaos*

Forced migration is highly destabilizing, as family and community members are lost or killed in the migration process. Such destabilization breaks down family, social, and/or cultural norms that regulate safe and healthy sexual activity. Normal development of sexual relationships and activity in such contexts is highly impeded. People in this context may turn to multiple others for sex as a means of obtaining comfort in a time of crisis, increasing risk for HIV exposure. Safe sex practices are also likely to be abandoned in such situations, especially involving women, as condom use is much more prevalent in MSMs than in heterosexual intercourse (UNHCR, 2006). In the context of violence, sexual violence may also feel "normal" to young men, again increasing HIV risk (Smith, 2002; Roberts, 2004). Finally, younger people may be exposed to sexual activity at too early of an age due to lack of sexual privacy and pervasiveness of sexual assaults; such early exposure may incite them to begin sexual activity at too young an age.

## *High Rates of Intimate Partner Violence in Conflict-Affected Settings*

Cross-national studies demonstrate that women experiencing violence from intimate partners are at increased risk for HIV due to abusive partners' higher likelihood of engaging in risky sexual behaviors, including multiple partnering and use of sex workers (Dunkle et al., 2007; Silverman et al., 2007b; Raj et al., 2006). As described above, the context of forced migration often results in greater availability of sex trade for men; it has also been hypothesized that men's victimization from political conflict, and their subsequent forced migration, increases male likelihood to perpetrate violence against their female intimate partners (Krug et al., 2002). Understanding and considering partner violence as an HIV risk factor for female forced migrants is clearly needed, but limited work has been undertaken to examine this issue.

Growing work documents a strong association between men's exposure to political conflict and their perpetration of both sexual and physical violence against female partners (Gupta et al., 2008). Consistent with these findings, extremely high rates of intimate partner violence have been documented in refugee camps and settings in multiple global contexts (HRW, 2003; Khawaja and Hammoury, 2008; Amnesty International, 2004). Such intimate partner violence perpetration among these men may be more likely due to stronger perceptions of the acceptability or normative nature of such violence, the negative mental health sequelae associated with these men's exposure to violent atrocities, and greater desire and entitlement to control female partners when these men become otherwise disempowered by society (Krug et al., 2002; Gupta et al., 2008). Policies that register refugee families using the male head of household's name are also likely to render forced migrant

women vulnerable to violence and dependency on male partners, as food and other goods are often distributed to family heads (HRW, 2003), thus fostering a situation of greater male power.

## *Military Members, Including Peace Keepers, Increase STI/HIV Risk*

Extensive evidence has documented heavy and high risk sexual activity among military members and their promotion of sexual activity, both consensual and non-consensual, with vulnerable local and refugee populations (McGinn et al., 2001 Van Landingham et al., 1993). Current indications are that HIV rates among the military are higher than those seen in the general population (McGinn et al., 2001; Elbe, 2003), in some cases 2–5 times higher (Webb, 2002), and condom use is not typical of many soldiers regardless of their HIV serostatus (Van Landingham et al., 1993; Roberts, 2004). Further, youth, lengthy periods away from steady partners, military values that promote risky behaviors, and better pay than local residents increases local demand for sex work (UNAIDS, 1998; McGinn et al., 2001; Zwi and Cabral, 1991); simultaneously, the vulnerability of displaced young women increase their turning to sex trade with the military as a means of survival. Reports have also documented the abduction of vulnerable women and girls by military groups; these women and girls are then used as sex slaves (Amnesty, 2004). Taken together, the military presence poses great risk to HIV for female refugees and forced migrants (Smallman-Raynor and Cliff, 1991; Hankins et al., 2002; Elbe, 2003).

## *Review Summary*

HIV is a global pandemic disproportionately affecting young, poor, women of color in regions and neighborhoods burdened by poverty and violence. While increased biological risk for HIV from penile-vaginal sex is in part an explanation of why these women are at increased risk, their reduced social status attached to gender, age, race/ethnicity, class, and place of origin further contribute to this risk. For many of these women, their vulnerability is further compounded by forced migration and loss of infrastructure in their places of origin. In this context, women's risk for HIV increases due to lack of health infrastructure in which to receive HIV education, condoms, testing or treatment; heightened risk for sexual assault from residents and the military; increased reliance on sex work as a means of survival and economic security; greater casual sex with multiple partners in a context of chaos and unstable family structures; heightened risk for intimate partner violence and related partner HIV risk attached to the political victimization and disempowerment these male partners have faced, and greater exposure to HIV due to military presence or relocation to higher epidemic regions. Research documenting higher rates of HIV among migrant, refugee and IDP women support these findings (e.g., Brewers et al., 1998;

Ministry of Health Sudan, 1995; UNDP, 2004; Zuma et al., 2003). These findings have implications for HIV program, policy, surveillance and research.

## Implications for Reproductive and Sexual Health Practice and Policy

In response to increasing concern regarding the sexual health of women and girls who are forced to undergo conflict-induced migration, several guidelines and manuals have been put forth by international agencies. These include the UNHCR publications entitled, "Reproductive Health in Refugee Situations: An Inter-Agency Field Manual" (1999) and "HIV/AIDS, Conflict, and Forced Migration" (Roberts, 2004), as well as the World Health Organization's Inter-Agency Standing Committee's Guidelines for HIV/AIDS Interventions in Emergency Settings (2003a), and the Reproductive Health Response in Conflict Consortium's Guidelines for the Care of Sexually Transmitted Infections in Conflict Affected Settings (2004). These resources provide important guidelines and recommendations for addressing HIV and other STIs in refugee populations. In this section, we have adapted these guidelines to integrate gendered aspects of conflict-induced forced migration (e.g. vulnerability to sexual assault) and their intersection with HIV risk.

### *Practice Implications*

A. Prior to undertaking new initiatives related to HIV prevention with forced migrants, a situational analysis must be conducted to help plan appropriate and comprehensive HIV prevention and treatment-related services. The situational analysis should assess: (1) the prevalence of STI and HIV in the host and home country (or region/area) and (2) the cultural and religious beliefs, attitudes, and practices concerning sexuality, reproductive health, STI/HIV prevention. Gendered considerations related to sexual assault, sex trade/survival, and family and marital relationships/dynamics (including child/forced marriage, partner violence) must be included, with an eye toward the differential gendered aspects of risk by age.

B. Any health care practice efforts undertaken or maintained must implement the practice of universal/standard precautions in health-care settings, to prevent transmission of HIV and other pathogens from patient-to-patient, health worker to patient, and patient to health worker. In stressful work settings, such as refugee camps, standard precautions may not be rigidly followed. For instance, within such crisis-oriented environments, health workers may be more likely to "cut corners" in sterilization techniques; they may also be more likely to experience work-related accidents such as needle-stick injuries. Thus, health care workers should all be trained on standard precautions. All patients must be informed of the precautions necessary for clinical setting and what currently is being undertaken in their care.

Communication surrounding the handling of body fluids can help reduce additional feelings of stigmatization within refugee camp settings, particularly for women.

C. High-quality condoms should be made accessible to both refugee communities as well as host populations, as contact is likely to occur between the two. In conjunction with distribution of condoms, promotional campaigns should target men, as men may be less likely to use condoms with female partners due to perceptions of diminished pleasure with sexual intercourse and/or attitudes favoring traditional masculine attitudes and norms. In times surrounding conflict, such attitudes may grow even more rigid than at baseline.

D. STI/HIV and reproductive health care must be delivered to women in a trauma sensitive and safe manner. Exposure to sexual violence and other trauma may result in heightened reluctance of women and girls to see male clinicians, particularly if a physical or gynecological exam is required. Simultaneously, such violence can result in increased risk for severe urogynecological injuries (Longombe et al., 2008), requiring greater need for gynecologic care. Female health providers must be made available and trained to support care of these women and girls with consideration of the often co-morbid mental health trauma that accompanies such assault-related injuries.

E. STI diagnosis and care are key to reducing vulnerability to HIV; hence, effective and proper STI case management is needed to ensure identified infections are handled appropriately. This involves the following: (1) training health care providers in diagnosis and follow-up, (2) providing guidelines for case management, (3) consistent availability of appropriate drugs and condoms, and (4) monitoring. For women and girls, it may also be necessary to ensure that adequate numbers of female health provider staff are available. Furthermore, due to limitations with clinical etiological diagnosis and feasibility constraints for using laboratory diagnosis in low resource settings, a *syndromic* approach to STI diagnosis is recommended. This approach was first put forth by WHO during the 1970s, and is currently considered the most feasible approach to STI management in conflict-affected areas. Syndromic diagnosis involves the identification of a consistent and easily recognizable group of symptoms and signs, followed by appropriate treatment and follow-up. (See WHO, 1999, 2003b for details.)

F. STI management must be sensitive to the vulnerabilities attached to partner disclosure and notification, among victims of sexual assault and other violence. While ideally, partner identification, notification and treatment are key to assisting in the management of STIs, such efforts must consider the vulnerabilities of women infected by abusive partners, sexual assault perpetrators, and those in positions of authority (e.g., police, military). Required partner notification may not be optimal in such circumstances. Broad testing and treatment should be considered in situations where such infections have been identified.

G. Comprehensive HIV/AIDS care and support services must be made available in sites known to have large proportions of migrant populations; these services must include HIV/STI prevention education; HIV and STI counseling, testing and quality drug treatment; and support and linkage to long-term care for those infected. For women and girls, these services should be integrated into comprehensive sexual

and reproductive health care, which should also include safe motherhood and emergency obstetric care services as well as family planning including provision of free condoms. This provision should occur in refugee and resettlement sites as well as migrant worksites and villages.

H. Comprehensive HIV/AIDS services must be created in ways that do not support the ostracizing and stigmatization of those infected with HIV nor those identified as victims of gender-based violence. To ensure the confidentiality of women and girls presenting for such care, the services must be integrated into more socially acceptable existing services, such as reproductive health care services, as described above. Similarly, health agents providing home-based care pertaining to HAART should also perform other health-related duties (e.g. general nutritional counseling) to minimize community members' association of certain personnel with HIV/AIDS.

I. Services must be broadened to address issues of gender-based violence including partner violence and sexual assault, these must include prevention/education as well as support services for victims. Additionally, educational services must be made available to potential perpetrators as well as potential victims; potential perpetrators can include but are not limited to site residents, local military including peace keepers, and health care providers. Given the substantial rates of violence experienced by forced migrant and refugee women, programs and services for victims must be maintained. These should include support, counseling and shelter; longer-term as well as short term shelter should be maintained when possible.

J. Programs for women involved or vulnerable to involvement with sex trade must also be maintained. These programs should include HIV prevention, testing, and education, as well as free condoms, to support women and girls involved with sex exchange. Simultaneously, primary and secondary education, as well as job skills training, should be provided to support women's economic empowerment. Many migrant women who have not had access to education or training may engage in sex trade in the absence of other job options, however, many become involved in sex work because of overall low economic opportunity for both men and women, regardless of skills and training. Improved identification of perpetrators of sexual exploitation must also be integrated, in order to prevent forced migrant women's further exposure to sexual assault and HIV/STIs.

## *Policy Implications*

All policies supporting migrant women must consider their special needs as migrants and their rights as humans. Existing international doctrines related to refugee rights, human rights and humanitarianism must guide government policies related to migrants. These existing doctrines include (a) the Convention on the Status of Refugees (1951) and its Protocol (1967), (b) the Universal Declaration of Human Rights (1948), and (c) the four Geneva Conventions (1949) and their two Additional Protocols (1977). While these international policy documents declare that migrants and those living with HIV have a right to health services on a par with nationals

and non-HIV infected individuals, national policies and practices do not always support these rights. National policies that are anti-migrant or anti-immigrant must be reviewed and reconsidered (e.g., limiting job opportunities or welfare access based on citizenship, birthplace, or linguistic fluency). Additionally, policies should be implemented to guarantee provision of health care and education for migrants, including documented and undocumented migrants, as well as trafficked and smuggled individuals; policies supporting family reunification among migrants should also be implemented as an important mechanism of potential HIV prevention.

Policies specific to the rights and health of those living with HIV are also needed. One easily observable indicator of high-level commitment within organizations is the existence of formal HIV/AIDS policy statements. The United Nations has taken a lead on such policies. In 1988, a memorandum was issued by the Office of the United Nations High Commissioner for Refugees (UNHCR), "Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS)." This memorandum stated that refugee and resettlement programs must provide care and support for those who are HIV-infected, regardless of when infection occurred. In June 2001, a statement of commitment was also adopted at the U.N. General Assembly Special Session on HIV/AIDS. This document specifically highlights HIV/AIDS in conflict-affected regions and pledges (a) to include HIV/AIDS education, care and treatment into programs or actions responding to emergency situations, (b) to train emergency personnel to deliver quality HIV education, care and treatment; and (c) to address the spread of HIV among military (including peacekeepers) by training them in HIV prevention, with special consideration of issues related to gender-based violence and sex trade. In 2006, the UN met again to discuss AIDS related topics, reaffirming the goals of the 2001 statement and adding a particular concern for gender inequality, resolving to focus on the increasing proportion of female AIDS sufferers (UN General Assembly/UNAIDS, 2006) Unfortunately, as with human rights policies, national governments do not always adhere to these international doctrines. Nonetheless, governments HIV/AIDS policy statements are increasingly more common, giving greater opportunity for advocates to push for development of more egalitarian and respectful HIV/AIDS policies across nations.

## Implications for Surveillance and Research

One of the greatest concerns related to increased risk for HIV among migrant women is the lack of data to guide and explain how risks are occurring. Many nations lack national surveillance efforts, and those that have them often lack questions on immigrant/migrant status, including time in current residence and location of origin. Inclusion of such data in national surveillance efforts will give important insight into differences between migrant and non-migrant communities within the nation; it will also serve as a comparison for local surveillance efforts with special populations, including forced migrants. Surveillance of migrant populations is

needed at refugee sites, resettlement locations, and migrant worksites and villages; such surveillance should include both HIV and STI assessments. Special efforts must be made to ensure that women and girls who are refugees or otherwise displaced from conflict-induced migration are included in such systems, both those within and outside of camps. Such surveillance should not only include biological outcomes, but also social contextual factors (e.g. violence, condom use, transactional sex, stigma). In addition to individual-level surveillance, efforts should also be made to capture program and risk indicators at the levels of health center and community level, as well as to capture demographic and migration patterns locally and regionally. With higher quality HIV/STI surveillance data mapped against community/health center indicators and global migration patterns, we will be better able to understand the complexity of how migration is linked with the HIV pandemic and what can be done better to reduce HIV transmission attached to migration. However, in addition to surveillance work, social and behavioral research is needed to identify risk factors linked to higher and lower rates of HIV and STIs among migrants compared with residents locally and in places of origin, with the goal of creating better programs to address the epidemic. Finally, with development and refinement of HIV programs and policies tailored to and targeting migrant women and girls, there will be a need to evaluate these programs and policies to determine and recommend best practices in future.

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