

Migration and AIDS In a Permeable World

by Renata Rutman

The process of globalization has led to a new sense of interconnection among the world's regions and nations. Intensified integration of national economies into the world economy through the movement of capital and the removal of barriers to international trade has precipitated the rate at which exchanges between different countries take place. This process has allowed countries to import fruits and vegetables out of season, to pay less for products that would have cost more had they been produced domestically, and to provide goods to the rest of the world at lower prices. Yet as advantageous as some of these exchanges may appear, they do not come without a price. As this report will demonstrate, the free movement of goods, services, and persons, while being potentially beneficial, is not a risk-free venture. The interaction between the opening of state borders, the prevalence of HIV infection in developing countries, and the lack of a coordinated global response to this epidemic, reminds us that globalization is a potentially volatile phenomenon when it comes to human health.

The exacerbating preexisting push/pull factors, which arise from income inequalities within a given country, and in the different productivities of rich and poor countries, has been among the foremost consequences of globalization. Concentrating direct foreign investment in some countries and not others increases economic inequalities between communities. This generates pressure for labor to move both across national borders and within particular states; where globalization has resulted in an explosive growth of regional development, the migration of people from the surrounding areas in search of employment has risen sharply¹. Currently, some 150 million migrants live—and often work—outside their country of citizenship, hundreds of millions more migrate within their own countries, and between two and four billion people migrate permanently each year².

The process of urbanization has been so expansive that nearly half of all people are now living and working in urban centers³. Industrialization and the development and maintenance of transport routes both contribute to migration to and from urban centers. And it is not only the relatively skilled workers who are moving to developed economies; unskilled or semi-skilled workers are also moving, sometimes illegally, to neighboring countries whose growing economies are likely to offer higher wages for relatively low skills. Among the groups affected by this permeability of national borders are truck drivers, seafarers, transport workers, agricultural workers, mobile employees of large industries (e.g. mining, oil companies), and sex workers⁴. Members of these groups are among the most vulnerable to HIV infection.

How Disease Spreads

The spread of HIV resulting from transnational movement has been a major concern for many governments because, historically, migration has been a catalyst for the spread of disease. In many countries,

regions reporting higher seasonal and long-term mobility also have higher rates of HIV infection, and numerous studies have shown that communicable diseases usually spread farther and faster with the improvement of roads and transportation⁵. According to one study done by the World Health Organization, sexually transmitted infections (STIs) were found to be more prevalent in areas located along transport routes or surrounding major developing projects⁶. Supporting these findings, another study reveals how AIDS has spread along transportation routes from Zambia, Zimbabwe, Malawi, and Mozambique to South Africa⁷.

In the past, governments have tried to solve this problem by restricting immigration and instituting mandatory testing for various diseases prior to issuing visas. Besides ignoring the effects of internal migration on the spread of HIV within a country, this approach has provided a false sense of security by perpetuating the notion that HIV (and disease in general) is brought in by "foreigners." Unfortunately, such practices may have in fact encouraged illegal migration, increasing migrants' vulnerability to HIV/AIDS by driving them further underground and discouraging them from seeking prevention information, testing, counseling, and support⁸.

The particular vulnerability of migrants results from a complex interaction between pre-existing vulnerabilities—those derived from poverty in the country of origin—and new vulnerabilities stemming from social exclusion in the destination country⁹. Social stigma and the lack of traditional support networks make migrants more vulnerable to HIV infection because, without access to HIV prevention information, they frequently engage in casual, unprotected sex, or intravenous drug use¹⁰. Another factor that further complicates the migration/disease dynamic is the global push toward privatized health care and medical programs focused on treatment rather than prevention, due to the increased profitability of this approach. The privatization of medicine does little to address the migrant lifestyle, and to prevent the transmission of disease both within the migrants' current place of residence and in the country to which the laborer ultimately returns. For many migrant workers who work in another country to earn money to send back home, the cost of seeing a private health practitioner discourages them both from seeking information about their health and from obtaining treatment. Similarly, privatizing healthcare reduces the state's role in providing treatment to all who need it. By increasing the influence of private health corporations on public health policy, governments are compromising their capacity to intervene, even in the event of an emergency, by being unable or unwilling to break a patent.

Open and Closed Borders

In addressing an epidemic that has affected the entire world and transcends the boundaries of individual states, it is almost impossible to seek a solution within the confines of a nation-state. The global nature of the disease makes such a task problematic for several reasons—the most obvious being that the potential containment of HIV in one country or region would not prevent recurring problems in the future, especially if HIV prevalence is high in surrounding areas. An additional complication lies in the dormant nature of the virus, making an accurate estimate of current levels of infection difficult, if not impossible. As a report on international migration indicates, since HIV prevalence rates are now high in almost all African countries, concerns that migrants may bring the virus with them may no longer be of any practical relevance¹¹.

The nation-state framework hinders progress toward containment on a global level because it only tackles the regional manifestations of the disease and does not take into account the fact that, despite

restrictions, people continue to migrate illegally to places where better job opportunities are present. Thus, while the spread of HIV in the stable population may be restricted, the task of larger-scale containment remains, due to the constant flow of potentially infected persons.

Proponents of open borders believe that the process of globalization is beneficial to all sectors of the population because trade, direct investment, and emigrants who send money home can raise incomes in developing countries, thereby decreasing vulnerability to HIV through better economic standards. Such economic improvements, it is argued, will be accompanied by improved technology and broad-based innovation, such as more and better health services. David Dollar maintains that because innovation plays a key role in economic growth, integration into the global economy should be the first step in the economic agenda¹². Raising the income of the poor leads to improved nutrition, reduced child mortality, and improved education of females, all of which are significant factors in determining the health of a population. In this perspective, the link between globalization and health is through income¹³.

A study done by Timothy Hatton and Jeffrey Williamson shows that out-migration by unskilled workers raises wages for those who are left behind, and that in some African countries, the return flow of capital is of a significant value¹⁴. To the extent that global integration helps to reduce poverty, it will lead indirectly to the improvement of health through increased income. However, as those in favor of migration restrictions indicate, while global integration does increase the rate of migration, a positive correlation has been found between the presence of migrants in the population and the HIV prevalence rate¹⁵.

While it may be true that integration exposes communities to the various health risks mentioned above, it is also true that even without globalization, many of the health risks would still be present. Relatively closed developing countries tend to have high rates of migration across borders because many of these countries have few job opportunities as a result of low investment and production. People who migrate out of such countries in search of jobs are faced with the same factors that make other migrants vulnerable to HIV, and if they become infected, are likely to infect their partners when they return home. Burma and Zimbabwe—countries that are relatively closed to trade and foreign investment—nevertheless have severe AIDS problems¹⁶.

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Are the effects of migration on the spread of AIDS substantial enough to justify the isolation of particular states (and their economic resources) from the rest of the world? For proponents of globalization, the answer is no. A more realistic and effective approach may be to address the issue through such public health policies as direct intervention and condom distribution in areas where high-risk groups are present.

Advocates of globalization also argue that opening borders may be beneficial in addressing the spread of HIV/AIDS in migrant populations because the same forces that allow multinational corporations to operate in a way that disregards the existence of national boundaries, also allow NGOs, advocacy groups, labor organizers, and the like to operate on a global stage. Also, the spread of communication technology means that monitoring overseas activities of corporations and their proxies and communication among like-minded groups around the world will become easier¹⁷.

Those favoring global integration also point out that increased openness may help to change "traditional" practices, which increase vulnerability to HIV by inhibiting the use of preventive mechanisms like condoms. Due to traditional gender roles and customs, in many places where the prevalence of HIV is extremely high, women may not be in a position to initiate condom use even when such protective mechanisms are available. However ethically questionable this idea may be in terms of altering traditional views, as a result of an economy's effort to integrate itself into the world economy, the introduction of new norms and ideas may challenge previously held notions of gender relations for members of the population. To the extent that globalization may promote safer sex through innovative and culturally sensitive health services, it will be beneficial in containing the transmission of HIV, especially in high-risk mobile populations.

Who Has the Power?

While it may be true that globalization has empowered various advocacy groups, improved global ties between organizations, scholars, journalists, and academics, and has enabled them to effectively share information, it has done little to enable these groups to combat the AIDS epidemic. Aside from calling attention to the effects that this epidemic has had on different populations, establishing community programs to help their causes, and challenging powerful government and non-government entities to address the problem, individuals and NGOs alike still are powerless to craft new public health policies or to implement the health programs that they support. However, even if they had the power to do so, because these organizations cannot be held accountable to the people whom they claim to represent, to rely non-governmental groups to provide such public services would be highly problematic. Although shifts in power have been taking place on various levels with the gradual erosion of state sovereignty, in today's world, state governments ultimately remain the dominant agents in global affairs.

For migrant laborers who, more often than not, lack legal standing and are not protected by local labor legislations, this situation has particularly dire consequences. Since many states have been devoting less funds to public spending, partly as a result of privatization, repayment of debts, and IMF sponsored structural adjustments, the number of those who are vulnerable has increased sharply. To address this problem effectively, a partnership must be made between NGOs and governments in which NGOs work with and/or pressure states to affect change when the state falls short of fulfilling its responsibilities. In the case of Uganda, where increased HIV infection led the government to believe that the Ministry of Health alone could not deal with the growing problem, a multi-sectored approach was instituted in which government ministries, NGOs, and religious organizations united to consolidate care and prevention services. Community leaders took part in the mobilization and dissemination of health promotion services, and community groups used innovative means in music, dance, and drama to call attention to HIV and to bridge the knowledge gap between various communities¹⁸. As a result of the broad reach of this multifaceted partnership, HIV seroprevalence has been reduced from about 14% in the early 1990s to about 8% today, and in rural areas, HIV rates among teenage girls dropped to from 4.4% in 1990 to 1.4% by 1997¹⁹.

Despite their numerous victories and successes, and the fact that the diffusion of state power has bolstered their positions, NGOs are still unable to deliver a comprehensive public health policy. The creation and implementation of treatment and prevention programs, such as early treatment of TB and pneumonia, extensive AIDS education, and government-sponsored campaigns aimed at changing high-risk behavior are needed to prevent new infections. When governments do not create and develop such programs, as

witnessed in President Thabo Mbeki's position on AIDS in South Africa, as a result of improvements in communications NGO's are in a better position to challenge the government's stance.

The Global Approach

The global nature of the AIDS epidemic makes it such that it can be treated and contained more effectively if this task is approached on a global scale. However, to avoid dealing with a specific issue, government leaders contend that globalization has reduced state sovereignty and that states are not in a position to deal with the problem. This effect is evident in Mbeki's initial reluctance to pursue a lawsuit against the drug-companies, embodying a phenomenon of globalization put forth by Jessica Matthews:

National governments are not simply losing autonomy in a globalizing economy. They are sharing powers—including political, social, and security roles at the core of sovereignty—with businesses, with national organizations, and with a multitude of citizens groups, known as nongovernmental organizations (NGOs) .

In addition, by maintaining that the government cannot support expensive programs aimed at reducing the vulnerability of migrants—because its limited resources must be allocated to protect people at home or otherwise used to pay back its debt to the international lending agencies—governments can avoid taking responsibility for the health of those who are not full citizens. It is precisely this statelessness that increases migrants' vulnerability to becoming infected with HIV.

The possibility of a partnership between a state with a significant rate of migration across borders and a host state to provide prevention and treatment services is something that globalization has now made possible. This symbiotic relationship would better enable states to reduce the vulnerability of migrants by establishing programs that deal with this issue throughout the various stages of migration. States could set up parallel programs that address the issue of migrants' susceptibility to HIV prior to departure and establish prevention and treatment services along the popular migratory routes.

Presently, migrants are essentially stateless people without protection either from their place of origin or from host countries. Globalization has enabled states to relinquish responsibility not only because migrant laborers are outside of that state's borders but also because the role of the state has not changed significantly in the last twenty years. Even with more power being shifted to NGOs and other actors, it is still the state that dictates its health policy. Nonetheless, the global reach and impact of the AIDS virus has also enabled states to find new ways of dealing with the epidemic and to form partnerships with other states to reduce the rates of infection in affected areas. Once the implications of this interdependence have been fully recognized, such multinational partnerships will begin to realize their true potential.

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1. Irene Fernandez, "Migration and HIV/AIDS Vulnerability in South East Asia," http://www.gn.apc.org/caramasia/c_ifpaper.htm (1998), p.1.
2. Susan Martin, "An Era of International Migration," in *World Migration Report* (Geneva: International Organization for Migration, 2000), pp. 18-19.
3. United Nations, "World urbanization prospects: the 1999 revision," (United Nations Secretariat: New York, 2000).
4. UNAIDS, "Population Mobility and AIDS," UNAIDS Technical Update, Geneva: International Organization for Migration, 2001. Pg. 3. *Ibid.*, p. 5.
5. Rene Lowenson, "Globalization and occupational health: a perspective from southern Africa," *Bulletin of the World Health Organization* 79 (September 2001), p.865.
6. JHUCCP, "HIV/AIDS and Other STDs, Population Reports," November, 1996; available at http://www.jhuccp.org/pr/j45/j45chap3_1.stm.
7. UNAIDS, "Population Mobility and AIDS," p. 4.
8. Carlos del Rio and Silvia Panebianco-Labbé, "AIDS, Human Rights, and NAFTA: Challenges and Opportunities," *Canadian HIV/AIDS Policy and Law Newsletter*, October 1996, pp 2-3.
9. *Ibid.*, p. 2.
10. CICRED, "Migration and HIV/AIDS," *International Migration* (1998), p. 2.
11. David Dollar, "Is globalization good for your health?" *Bulletin of the World Health Organization* 79 (September 2001), p. 828.
12. *Ibid.*, p. 328.
13. Timothy Hatton and Jeffrey Williamson, "Demographic and economic pressure on emigration out of Africa," (Cambridge, Mass.: National Bureau of Economic Research, Cambridge, 2001).
14. Mead Over, "The effects of societal variables in urban rates of HIV infection in developing countries: an explanatory analysis," in M. Ainsworth, L. Fransen, and M. Over, eds., *Confronting AIDS: Evidence From the Developing World* (Washington, D.C.: The World Bank, 1998).
15. Dollar, "Is globalization good for your health?" p. 830.
16. Tim Francis-Wright, "The Flip Side of Globalization," April 8, 2001; available at www.bear-left.com/original/2001/0408glob.html
17. UNAIDS, "Partners in Prevention," available at www.unaids.org/publications/documents/responses/community/una98e29/css/una98%5F54.htm
18. *Ibid.*, p. 12.
19. Jessica Matthews, "Power Shift," *Foreign Affairs* (January/February 1997), p. 50.
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