

**HIV/AIDS problem of migrants from Burma in Thailand**

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### **Abstract**

Over 50 years ago, the Constitution of WHO projected a vision of health as a state of physical, mental and social well-being - a definition that has important conceptual and practical implications. Recently, health professionals begin to recognize the importance of the protection and promotion of human rights as necessary precondition for individual and community health. It is now clear that regardless of the effectiveness of technologies, the underlying civil, cultural, economic, political and social conditions have to be addressed as well in the health care paradigm.

The continued violations of human rights, arbitrary arrests, torture and summary executions, continued use of forced labor projects, forced portorage for the military and economic hardships in Burma have led to migration of thousands of people to the neighboring countries, especially Thailand. These migrants have to work in places that are shunned by local Thai workers such as the construction sites, fishing, saw mills and plantations. Because of the illegal migration status, they have to live in a very poor living condition and sanitation. Many Burmese people are being forced out of their homes by poverty and violations of human rights with limited access to resources and knowledge on HIV/AIDS and other reproductive health problems. The vulnerability to HIV/AIDS among this population is compounded by the limited mobility due to lack of official documents and denial of access to medical care in their country of destination, Thailand. The annual United Nations report shows that AIDS continue to spread in Burma and its border region. Seroprevalence data from Cambodia, Burma and Thailand indicate that populations in provinces with international border crossings have higher levels of HIV infection than the populations living further away from the borders. This situation is the

clear evidence of the negative impact of human rights violations on health. Burmese migrant's workers' situation is a strong evidence on the fact that violations of human rights encountered in their country of origin, and country of destination, are critical in every migrant's life and has a direct impact on all aspects of their health. The root cause of migration from Burma is mainly due to the country's political crisis and violations of human rights. This problem will continue as long as the atrocities and repression continue in Burma.

It is imperative that health professionals and health care workers understand the fundamental linkages between health and human rights and the way in which those linkages can influence the course of health practice. Building and strengthening the information and education about health and human rights is required in order to implement the concept.

## **Introduction**

By the end of 1997, over 30 million people were living with HIV/AIDS, including 12.1 million women, 17.4 million men and 1.1 million children. In 1997, 5.2 million adult women and men and about 600,000 children newly acquired HIV infection. The mortality due to AIDS-related illnesses in 1997 alone amounted to 20% of the total AIDS-related mortality since the beginning of the epidemic. The developing world accounted for most of all new HIV infections in 1997 (Gruskin, 1998).

The latest UNAIDS estimate (December 2001) records 40 million persons living with HIV/AIDS (PLWHA) in the world. While sub-Saharan Africa remains the hardest hit area of the world with 70% of all PLWHA, UNAIDS cautions that there are 7.1 million PLWHA in Asia and there is a serious threat of major, generalized epidemics.

The impact of the movement of people on the spread of HIV/AIDS is both obvious and complex. The relationships between population migration and situations of risk that lead to HIV/AIDS infections are well documented. People, particularly those from rural and low-income communities and countries that are economically disadvantaged are becoming increasingly attracted by the diverse offerings of the cities in economically booming areas. Increasing migration between countries throughout Asia has raised a wide-range of critical and complex issues. The massive influx of migrants from Burma into Thailand is one of the largest migrant populations in Southeast Asia Region (United Nations Development Program, 2000). The continued violations of human rights, continued use of civilians for forced labor projects, poor economic situations and unemployment have led to migration of thousands of people to Thailand.

Currently, approximately one million migrants from Burma are residing in Thailand as illegal migrants without any official documentation (Chanratrithirong, 1995).

The terminology “illegal migrants” is used to those people without any official paper, whereas another 120,000 people live in refugee camps located along the Thai-Burma border region. The terminology “refugee” is referred to those people, who are officially recognized by UNHCR (United Nations Human Rights Commissions for Refugees). The majority of illegal migrants are vulnerable to HIV infection since they are unable to seek or negotiate appropriate health care services due to their illegal status (fear of arrest, detention and deportation), lack of funds and Thai language skills.

The increasing frequency and incidence of violence encountered in their country of origin, country of destination, communities and homes are critical factors in every migrant’s life and has a direct impact on all aspects of health, mainly HIV/AIDS. It is necessary to protect the human rights of migrant workers to reduce their personal vulnerability to HIV and of the societies in which they live.

### **Specific Aims**

The primary goals of this study are:

1. To identify individual, social and cultural beliefs, attitudes, behaviors and vulnerabilities related with HIV/AIDS.
2. To identify those factors which particularly impact on migrants’ health, especially HIV/AIDS.
3. To identify on the fact that protection and promotion of the rights to health is directly related and has impact on the equitable provision of public health and medical care service.

4. To add the notion of human rights as one of the determinants of health.

## **Literature Review and Background**

### **Burma at a glance**

Burma is one of the Southeast Asia countries with a population of 48 million from diverse ethnic and religious background. It has an area of 676,552 square kilometers (261,218 square miles). To the north of Burma is China, to the west India and Bangladesh, and to the east Thailand and Laos. The coastline of India Ocean forms a natural boundary to the south. At one time Burma was considered one of the Southeast Asia's richest countries. Burma today is in the list of LDC (least developed country) with very poor health standards, a record of human rights violations and an extremely low standard of living. Burma gained independence from British colony in 1948. After 14 years of democracy, in 1962, a group of army generals staged a military coup, installed a new government dominated by the military and eradicated all traces of democracy in Burma. The military controlled every aspect of Burmese life, including the media, education and the economy.

Finally, in August of 1988, due to extreme political oppression and economic hardship, Burma erupted with "People's Power" street demonstrations. The peaceful demonstrators were brutally gunned down by the army troops killing thousands of people, mostly students (Smith, 1996).

Soon after the massacre, with mounting international pressure, the regime had no other choice but to allow the establishment of political parties. An election was held in May 1990, and the party led by Aung San Suu Kyi (winner of the 1991 Nobel Peace

Prize), won a landslide victory, sweeping 82% of the parliamentary seats. Rather than concede power to the elected party, the military regime ignored the election result and launched a strengthened campaign of intimidation, torture and detention. The repression and hardships became worse and continue to the present day.

### **Current status of health and human rights in Burma**

Since 1962, the country has been ruled by the military junta, which has censored all media, ignored the results of democratic elections, and committed widespread human rights violations (Rapporteur, 1993). Censorship of all media is one of the junta's central domestic policies. As the Burma scholar Martin Smith has argued, this censorship has had profound negative impacts on the health of the Burmese people. People of Burma have very little knowledge on health problems, especially on HIV/AIDS. In year 2000 WHO rating of overall health system performance in 191 member countries, Burma stood 190th position, just one position higher to Sierra Leone (April, 2002). No HIV/AIDS cases were detected until 1988, when the first injecting drug user (IDU) with HIV was found in Rangoon, the capital of Burma.

Ten years later in 1998, the director of the UNAIDS stated that Burma was one of the epicenters of HIV epidemic in Southeast Asia. It was estimated that 550,000 to 700,000 people are HIV positive cases, of which 100,000 were AIDS (Chelala, 1998). Women are particularly vulnerable to HIV infection because of unprotected sexual relationships with infected male partners, untreated STDs and transfusion of infected blood after childbirth because of anemia or poor antenatal care. No blood products are screened except in a few big cities and in military hospitals.



Burma's HIV epidemic has components attributable to multiple risks and vulnerabilities: needle sharing among the large population of heroin injectors; unsafe blood supply and lack of universal precautions in health care settings; heterosexual transmission facilitated by a growing sex industry, trafficking of Burmese women and girls into regional sex industry, untreated STDs, very low condom use and availability, and lack of sexual health information (Chelala, 1999).

HIV/AIDS education, drug treatment and care programs remain inadequate and under sourced. The lack of both individual and community awareness of common health problems is alarming.

### **Health and human rights status of migrant population**

The Burmese migrants in Thailand have to work in places that are shunned by local Thai workers such as the construction, fishing, sawmills and plantations. Because of the illegal migration status of the workers, they have to endure unsafe working conditions and long hours of work for much lower wages. The workers have to live in over crowded bare-minimum housing with poor sanitary facilities and little or no opportunities to receive health education and/or health care services. Serious health problems arise from this condition including malaria, diarrhea, respiratory tract infections, tuberculosis, sexually transmitted diseases and HIV/AIDS. Among the HIV sentinel surveillance of high-risk groups, the highest rates of infection were found in Burma's cross-border points with Thailand (Chintayananda, 1997).

Many migrant workers with little or no knowledge on HIV/AIDS, have experienced family separations and easy access to sex services, leading to high prevalence of sexually transmitted diseases and HIV/AIDS. Many of them, especially

women are reluctant to leave their work places due to fear of arrest. This makes women vulnerable to mistreatment, harassment and sexual assault by male employers and co-workers. To ensure the survival of themselves and their families, women and girls fleeing Burma from human rights abuses became part of the growing sex industry in Thai-Burma border. Some of them are married and return home to their husbands and families across the border.

The spread of HIV in migrant populations has burdened host country Thailand and has the potential to amplify the epidemic in their home country Burma on their return. Burma is the world's largest opium producer and Burmese heroin exports to India, China and Thailand have fueled regional outbreaks of drug use and HIV infection in border areas. The Chinese ministry of public health reported that 80.4% of all HIV infection and 60% of all confirmed AIDS cases were detected in the Burma border province, Yunan. The prevalence of HIV is rapidly increasing in Burma's neighboring countries, and most particularly, the epicenter of the disease appears to be in border areas of Thailand, Burma, southern China and the Lao PDR in the so-called "golden triangle" area of opium production (Development, 1999).

### **HIV/AIDS epidemic and human rights**

*... communities, like individuals, cannot respond to the challenges of HIV unless they can express the basic right to be involved in decisions that can affect them.*

**-- Jonathan Mann**

The first time that human rights were explicitly named in a public health strategy was in the late 1980s, when the call for human rights and for compassion and solidarity with people living with HIV/AIDS was embodied in the first WHO global response to

AIDS. This approach was motivated by the recognition that women's health issues, including violence, and the vulnerability to HIV/AIDS are linked with human rights situations.

Fifty years ago, the United Nations General Assembly adopted the Universal Declaration of Human Rights (UDHR) to guarantee all people security, dignity and well-being in every country of the world. Article 25 of UDHR stated "Everyone has the right to standard of living adequate for health and well-being of himself and of his family, including food, clothing, housing and medical care, and necessary social services, and the right to security...". Human rights are legally guaranteed by human rights law, protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. The rights to the highest attainable standard of health was first reflected in the WHO Constitution (1946) and then reiterated in the 1978 Declaration of Alma Ata and in the World Health Declaration adopted by the World Health Assembly in 1998. There are complex linkages between health and human rights, and their linkages can be explained by two approaches.

Firstly, health policies and programs can promote or violate human rights in the way they are designed or implemented. Secondly, violations or lack of attention to human rights can have serious health consequences (Mann, 1999). Thus, concerns for health and human rights share the common goals of alleviating suffering and promoting the well-being of all people. In fact, vulnerability and the impact of ill health can be reduced by taking steps to respect, protect and fulfill human rights.

## **Risks and vulnerability**

Almost two decades since the beginning of the HIV/AIDS epidemic and over a decade after the inception of the WHO (World Health Organization) Global AIDS strategy, a dual gap continues to grow – between the rapid spread of the HIV epidemic and the limited prevention efforts; and between the rising needs for care and support, and the insufficient response to these needs. HIV prevention and control programs tend to focus on responding to immediate needs for prevention, such as public education and condom distribution (Organization, 1979). But for most of the affected populations, these responses are inadequate.

The response to HIV epidemic has shied away from addressing the root causes of the epidemic in societies and communities. To contain and control the HIV/AIDS epidemic, the response should be expanded and enhanced, with the target to individuals and populations that are at risk. It should also be combined with actions directed towards factors that lower people's vulnerability to HIV/AIDS.

In the context of HIV, risk is defined as the probability that a person may acquire HIV infection. Risk arise from individuals engaging in risk-taking behavior for reasons such as, lack of information on HIV, inability to negotiate safer sex, or lack of access to condoms.

Vulnerability is the converse of empowerment. A person who is genuinely able to make free and informed decision is least vulnerable (empowered) and the person who is ill-informed, unable to make informed decisions freely and carry them out is most vulnerable. Personal vulnerability to HIV/AIDS involves both cognitive and behavioral dimensions. Cognitive factors involve information and knowledge about HIV/AIDS,

sexuality and services. Behavioral factors may be the personal character, which includes emotion, perception of risk and attitudes towards risk-taking, substance abuse etc. Literatures addressed on the vulnerability of women and youth to HIV/AIDS, and the societal vulnerability, such as cultural influence and religion on HIV/AIDS (Caoette, 2000).

There is also an empirical data suggesting the linkage between poverty and HIV. Both absolute poverty and relative differences between rich and poor shape both sexual behavior and care seeking behavior (Wodak, 1998).

Viewing the HIV/AIDS pandemic from a perspective of vulnerability creates major challenge for public health. The more recent approach to HIV/AIDS, in 1998 WHO (World Health Organization) expanded global response to HIV/AIDS, focused on risk and vulnerability reduction. The ultimate aim of vulnerability reduction is to expand peoples' capacity to exert control over their own health. By identifying the social issues that constrain or promote this ability, contextual analysis stresses the need for positive interaction between the services, programs and other initiatives and the social environment.

### **Vulnerability and Human Rights**

The vulnerability to HIV/AIDS depends upon the extent to which human rights are realized and human dignity is respected within and among the societies. Identifying and addressing the root causes of migration on illegal migrants would create an opportunity to intervene the problem at the deepest societal level and thereby combat the pandemic. Implementing a repatriation policy to combat the high number of migrants in Thailand could reduce the number of migrants, but only for a short term. The central

problem of HIV infection among illegal migrants is human rights violations. So, the problem cannot be solved with deportation process, nor risk reduction approaches such as posters, information campaigns or condom distribution systems. In the mean time, human rights analysis has rarely been used in public health and especially, vulnerability to HIV/AIDS has not been sufficiently linked to issues of human rights and dignity. The future of HIV/AIDS prevention and control will depend on the ability of health professionals and health workers to understand the nature of individual and collective vulnerability to HIV.

### **Conclusion**

In addition to an adequate standard of living, necessary conditions for health and well-being include access to basic services such as education, housing, nutrition, and public health, and to medical care of the highest quality attainable. The right to a standard of living adequate for health and well-being is being denied to vast numbers of people all over the world through increasing disparities in income and in wealth, and human rights violations. Many people have no access to health care because of discrimination on the basis of social factors, such as prisoners, refugees, or undocumented immigrants. The role of the health workers in protection of the rights to health is important, since it has direct impact on the equitable provision of public health and medical care services. In addition, vulnerable people must be protected. Findings in this study will contribute to the workers in public health field to respond to sensitivity and special needs of illegal migrants and their vulnerability to HIV. And then it will determine ways to get needed services to vulnerable populations. It is imperative that health care workers understand the

fundamental linkages between health and human rights and the way in which those linkages can influence the course of health practice.

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