MIGRATION LABOURERS VICTIMIZED IN HIV/AIDS: A SUMMARY NOTE ON GAJAPATI DISTRICT

Mr. Junas Sabar[1]*
[1]Ph.D in Women's Studies, WSRC, Berhampur University & *Odisha State Child Protection Society (OSCPS), Dept. of W&CD and Mission Shakti, Govt. of Odisha.

Abstract: This paper discussed about migration labourers victimized in HIV/AIDS in Gajapati district. Migration for variety of reasons is age old practice but it is increasing at a faster pace over last decades. India as a national has seen a high migration rate in recent years. More than 30 million people in India are seasonal migrant labourers. Odisha share is 2.5 million and considered a key state for supply of migrant labourer. Mostly in the Gajapati district peoples are migration to Surat, Arunchal Pradesh, Gujurat, Kerala and Andra Pradesh. Basically, from rural area peoples are highly migrations to urban areas. People of a particular area tend to move from one place to another place with a scope of earning and better standard of living. This particular drift is primarily driven by the socio-cultural, political and environmental factors. India is growing rapidly with a huge investment plans and policy implications. Serious efforts are being made in India to stem the tide of the AIDS epidemic. A long-standing area of concern has been the transmission of HIV to married women in rural districts which constitute source areas for employment and out-migration of men. Some micro-level studies have shown that married women were infected by their husbands who were predominantly migrant workers and also indicated that high male out-migration leads to the development of local sexual networks in the source districts that facilitate the spread of HIV.

Keyword: Migration Labourers, Women's Healthcare, HIV/AIDS, Stigma, Discrimination, Human Rights.

Introduction: Population Council in 2008 indicated that a majority of returning migrants had accessed local sexual networks during their absence, thereby exposing non-migrant sexual partners to the risk of infection that their sexual partners were both unmarried women and married women who had been left behind by their migrant husbands. It is clear that factors other than returning migrant husbands have contributed to the increased risk of HIV for married women in districts with high out-migration. In Ganjam district of Odisha has experienced a high rate of out-migration. It also has recorded high HIV prevalence more than 3 percent among women attending ANC clinics during the past five years. In Ganjam district has been identified as one of the 14 most critical districts affected by HIV in the country. According to HIV sentinel surveillance data, HIV prevalence among women attending ANC clinics in this district was significantly higher than in the other districts of Orissa. According to state HIV statistics, 43 percent of all HIV-infected persons in the state of Orissa were from Ganjam district alone. Anecdotal information also suggests that a high rate of out-migration was one of the reasons for

high HIV prevalence among married women in Ganjan district. Men from this district migrated for work to Surat in Gujarat and to Mumbai and Thane in Maharashtra. The Ganjam data suggest in Surat alone there were about 600,000 Oriya migrants mostly from Ganjam working in the unorganised sector in the power loom, diamond polishing and construction industries.

Throughout history, many diseases have carried considerable stigma, including leprosy tuberculosis, cancer, mental illness and many STDs. Now HIV/AIDS is the topmost in the list of diseases that leads to devastating patient stigmatization. Despite international efforts to tackle HIV/AIDS, stigma and discrimination remain among the most poorly understood aspects of the epidemic. In the face of numerous intervention strategies, HIV/AIDS continues to spread and to pose a threat to the socio-economic transformation of South Africa. The broad objective of this study was to investigate how the stigmatisation of HIV-Positive women is made manifest and look at how successful the National Association of people living with HIV/AIDS in South Africa has been in achieving their objectives and goals of changing the perceptions people have about HIV/AIDS and creating awareness about the debilitating effect stigmatisation has in the society, especially when it viciously targets HIV-positive women.

NACO India claims that, "Migration is fuelling India's HIV epidemic" [Sinha, K: 2013]. Due to the size of India's migrant population and its current number of PLHIV, the highest in the region, events in India will be at the centre of the Asia Pacific regional response. India is both a destination and a source of huge numbers of migrant labourers. It is estimated that 258 million Indian men are migrant labourers. Primary destinations of these internal migrant labourers include: Maharashtra, Andhra Pradesh, Haryana and Karnataka—states that also have high HIV prevalence [Saggurti, N: 2008].

In 1987, the late Jonathan Mann, then director of the WHO Global Programme on AIDS, identified three HIV/AIDS epidemic-defined phases: the epidemic of HIV (detecting the virus), the epidemic of AIDS (developing the disease), and the epidemic of stigma, discrimination, and denial (coping with the condition in society). He noted that the third phase is "as central to the global AIDS challenge as the disease itself" *[Mann: 1989]*. Despite international efforts to tackle HIV/AIDS since then, stigma and discrimination (S&D) remain among the most poorly understood aspects of the epidemic. As recently as 2000, Peter Piot, Executive Director of UNAIDS, identified stigma as a "continuing challenge" that prevents concerted action at community, national, and global levels *[Piot: 2000*].

To understand the ways in which HIV/AIDS-related stigmata appear and the contexts in which they occur, we first need to understand how they interact with pre-existing stigma and discrimination associated with sexuality, gender, race, and poverty. HIV/AIDS-related stigmata also interact with pre-existing fears about contagion and disease. Early AIDS metaphors—as curse, as death, as horror, as punishment, as guilt, as shame, as otherness—have exacerbated these fears, reinforcing and legitimizing stigmatization and discrimination. These perceptions, as I will show later, contribute substantially to the difficulty in containing the spread of the disease worldwide, in general, and in developing countries, in particular. HIV/AIDS-related stigma is most closely related to sexual stigma. This is because HIV is mainly sexually transmitted and in most areas of the world, the epidemic is

largely associated with populations whose sexual orientation and proclivities deviate from the "norm." HIV/AIDS-related stigma has therefore appropriated and reinforced pre-existing sexual stigma associated with sexually transmitted diseases, homosexuality, promiscuity, prostitution, and sexual "deviance" (*Gagnon., Weeks: 1981).* HIV/AIDS-related stigma is also linked to gender-related stigma. The impact of HIV/AIDS-related stigma on women reinforces pre-existing economic, educational, cultural, and social disadvantages and unequal access to information and services (*Aggleton., etal: 1999).* In settings where heterosexual transmission is significant, the spread of HIV infection has been associated with female sexual behaviour that is not consistent with established gender norms.

Stigmatization associated with AIDS is underpinned by many factors, including lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, disease and death, and drug use. Stigma can lead to discrimination and other violations of human rights which affect the well-being of people living with HIV in fundamental ways. A stigmatizing social environment poses barriers at all stages of this cycle by virtue of being, by definition, non-supportive. HIV-related stigma and discrimination undermine prevention efforts by making people afraid to find out whether or not they are infected, to seek out information about how to reduce their risk of exposure to HIV, and to change their behaviour to more safe behaviour lest this raise suspicion about their HIV status.

The fear of stigma and discrimination also discourages people living with HIV from disclosing their HIV infection, even to family members and sexual partners. The stigma and discrimination associated with HIV and AIDS also mean that people living with HIV and AIDS are much less likely to receive care and support. Even those not actually infected but associated with the infected, such as spouses, children, and caregivers, suffer stigma and discrimination. This stigma and discrimination needlessly increase the personal suffering associated with the disease. This may be exacerbated in cases where individuals are members of particular groups that are already isolated and stigmatized, such as injecting drug users, men who have sex with men, and sex workers, or migrants. In settings where medical care is available, stigma may increase the difficulty of adhering to treatment regimens. These patterns of non-disclosure and difficulty in seeking treatment, care and support themselves feed stigma and discrimination, reinforcing the cycle. This is because stereotypes and fear are perpetuated when communities often only recognize people living with HIV when they are in the debilitating and symptomatic final stages of AIDS, and denial and silence reinforce the stigmatization of these already-vulnerable individuals.

Objectives

- Increase knowledge and understanding of national laws and legal relief for women affected by HIV/AIDS faced with property denial and domestic violence.
- Increase availability of high-quality and stigma-free legal services for these women and promote uptake of these services.
- Increase knowledge and skills of civil society and affected communities to advocate for rights of women affected by HIV/AIDS.

What Is Stigma?

Stigma has been described as a dynamic process of devaluation that 'significantly discredits' an individual in the eyes of others. The qualities to which stigma adheres can be quite arbitrary—for example, skin colour, manner of speaking, or sexual preference. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy. HIV-related stigma is multi-layered, tending to build upon and reinforce negative connotations through the association of HIV and AIDS with already-marginalized behaviours, such as sex work, drug use, and homosexual and transgender sexual practice. It also reinforces fears of outsiders and otherwise vulnerable groups, such as prisoners and migrants. Individuals living with HIV are often believed to deserve their HIV-positive status as a result of having done something 'wrong'.

Images of people living with HIV in the print and visual media may reinforce blame by using language that suggests that HIV is a 'woman's disease', a 'junkie's disease', an 'African disease', or a 'gay plague'. Religious ideas of sin can also help to sustain and reinforce a perception that HIV infection is a punishment for deviant behaviour.

Stigma is expressed in language. Since the beginning of the epidemic, the powerful metaphors associating HIV with death, guilt and punishment, crime, horror and 'otherness' have compounded and legitimated stigmatization.

What Is Discrimination?

When stigma is acted upon, the result is discrimination. Discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals who are stigmatized. Stigma and discrimination are interrelated, reinforcing and legitimizing each other. Stigma lies at the root of discriminatory actions, leading people to engage in actions or omissions that harm or deny services or entitlements to others. Discrimination can be described as the enactment of stigma. In turn, discrimination encourages and reinforces stigma. Discrimination is a violation of human rights. The principle of non-discrimination, based on recognition of the equality of all people, is enshrined in the Universal Declaration of Human Rights and other human rights instruments.

Because of the intimate connection between stigma, discrimination and human rights violations, and the fact that people living with HIV are stigmatized and discriminated against in many different settings, simultaneous, multi-pronged action is needed and must be sustained over time. In order to create an environment in which stigma, discrimination and human rights violations are no longer tolerated or practised, the following actions are necessary (Richard, Parker: 2007)

HIV Epidemic in Orissa and Ganjam:

Orissa is a low HIV prevalent state (NACO-2006). Since the highly HIV affected coastal belt of Andhra Pradesh is in continuation with its costal belt through Ganjam district, there exists a fear of HIV epidemic every time. Department for International Development sponsored ORG-Marg, 'HIV vulnerability' ranking of districts has identified ten (six southern district including Ganjmn) districts of Orissa as highly vulnerable (Odisha: 2005) Orissa State AIDS Cell's 2003 report is suggestive of nearly half of the HIV/AIDS burden of Orissa was in Ganjam (Ganjam: 2004). HIV Sentinel Survey 2005 has identified Balasore, Puri, Khurda, Koraput as high HIV prevalent districts after Ganjam.

Table 1.1 ICT Centers, Berhampur, Ganjam

Year	Number of test in PPTCT	Number of pregnant women found HIV positive	Prevalence of HIV among pregnant women in PPTCT
2005	475	8	1.68
2006	14724	41	0.27
2007	41698	71	0.17

***Source:** Reports received from ICT Centers, Berhampur, Ganjam,* 2007

The above figure comparison of number of tests performed in the PPTCT, number of pregnant women found positive and the prevalence of HIV among pregnant women in the PPTCT Odisha 2005-7.

Table 1.2 Sentinel Sites of Odisha since 2005 to 2007

Year	Antenatal Clinic	Sexually Transmitted Disease	Female Sex Workers	Injecting Drug Users	Migrant Labourers	Men Sex with Men	Trucker	Fisherman Folk	Total
2005	5	7	2	-	-	-	-	-	14
2006	23	7	2	1	5	-	6	1	45
2007	30	7	5	3	-	2	-	-	48

***Source:** Reports received from ICT Centers, Berhampur, Ganjam,* 2007

Table 1.3 Sentinel Sites of Odisha since 2005 to 2007

HIV positivity, ANC 2010-11 and 2012-13					
SL. No	Dist.	Name of the Site	HIV Prevalence		
			2011	2012-23	2014-15
1	Gajapati	Gajapati, D.H.H	0.75	-	-
2	Ganjam	City Hospital, Berhampur	0.75	0.88	0.75

***Source:** Reports received from ICT Centers, Berhampur, Ganjam,* 2007

Migration and HIV: Across the Asia Pacific region, large migrant populations moving both within nations and across international borders have been a challenge to study and provide healthcare services. Although countries' epidemiological profiles take different shapes, there are also clear similarities that help to understand the region's epidemic. While prevalence among the general population is generally low, key populations such as sex workers, male clients of sex workers, men who have sex with men and people who inject drugs continue to have extremely high prevalence rates at specific geographical locations. Along with these high-risk groups, each country in the Asia Pacific now classifies migrant populations, both international and internal, as groups vulnerable to HIV infection [Chaudhury: 2013].

Being a migrant is not a risk factor itself but causes for poor health and HIV vulnerability among migrants include: discrimination, gender inequality, sexual violence and exploitation, dangerous working environments, poor living conditions and lack of access to education, social services and, maybe most important, lack of access to healthcare. Migrants often lack access to mainstream healthcare, education and social services. Many migrants do not have legal status within their destination countries and live in isolation, making it difficult to protect themselves against the people who might exploit them or sexually abuse them. Social isolation and other factors may lead migrants to participate in high-risk behaviour, including use of drugs and alcohol. Male migrants away from home may also partake in the services of female sex workers, while the female migrants might look to sex work when they need money and have no social network to support them. All of these situations and activities increase the vulnerability of migrants to HIV infection [Chaudhury: 2013].

Migration: Migrants can be defined in several ways, most simply as either international migrant's i.e. external migrants or as internal migrants who have left their home communities for a lengthy period of time but who remain in their nation of citizenship. Seasonal labourers, for instance, are often internal migrants. External migrants may have legal status in their host country or may be undocumented. Undocumented international migrants are often estimated to comprise the majority of the migrant population in a given country, complicating efforts to collect data, conduct outreach and provide health services [Lawe, D: 2006]. However, data show that in the Asia Pacific the most highly mobile migrant populations, such as truck drivers, fisherman and itinerant labourers have the highest prevalence of HIV among migrants [Asia report]

Why Migrants Are Vulnerable to HIV

While many migrants and mobile populations have an increased vulnerability to HIV, migrant status itself is not necessarily a risk factor for HIV and migrant groups face different levels of vulnerabilities. The International Organization for Migration has illustrated the vulnerabilities faced by migrants and mobile populations as a cyclical process in which individuals face different types of vulnerability depending on what type of migrant they are and in which part of the cycle they find themselves. The cycle identifies points at which gains can be made in providing services and strengthening the policy environment.

Discrimination, Harassment and Isolation

Discrimination and stigma directed toward migrants is common across the region and compounds the vulnerabilities caused by illegal status, lack of social support, and isolation. Whether it takes the form of a restrictive legal environment or is experienced in day-to-day interactions with host country citizens and authorities, the existing vulnerabilities, such as the likelihood of engaging in risk-taking behaviours, are magnified by this discrimination over time [UNDP-2012].

Gender Inequality and Migration

The effect of gender inequality on vulnerability to HIV is a complex interaction but it is essential for HIV prevention and treatment programs to focus. Although gender norms vary among nations and regions, in general, women of low-income in the Asia Pacific experience inequality in their relationships with spouses or intimate partners, a position, which is usually compounded by a lack of education [UN, Asia : 2008]. Such a position renders women more vulnerable to HIV because they are often economically dependent upon the work of their migrant male partners; this is especially true in regions where there are few opportunities for women to earn income additional to that provided by their partner. The ramifications of gender power imbalance extend to women's freedom to negotiate condom-use with their husbands who may have had unprotected sex with sex workers and other casual partners in the course of their time away from home [Bangkok: 2011].

Lack of Healthcare Access

Many of the issues that migrants face culminate to limit access to healthcare services. For international migrants, in addition to legal barriers imposed by host governments, there are language barriers, movement restrictions imposed by employers and authorities, lack of knowledge of health issues and available services, and discrimination by service providers [Sciortino, R: 2013].

Key Messages on HIV and Migration

The National Human Rights Commission of India has recommended intensifying public health action to address mother-to-child transmission of HIV at the central and State level; legislation to prevent discrimination against children living with HIV; addressing school fees and related costs that keep children, especially girls, from going to school; providing all children both in and out of school with comprehensive, accurate and age-appropriate information about HIV and AIDS; providing care and protection to children whose parents are unable to care for them owing to HIV-related illness; establishing institutional arrangements for extending medical aid to children with HIV; realizing the right of people living with HIV to receive adequate treatment and ensuring health professionals are aware of their duty to provide these services. Workshops and seminars have been held to raise awareness among stakeholders in various regions.

National institutions can also work together with national AIDS programmes and community organizations delivering prevention, treatment, care and support, to assess the human rights dimensions of programmes and services, including their availability, accessibility, acceptability and quality.

Needs and rights of women

- Access to information and education about HIV and sexual health for women and girls;
- Availability of male and female condoms at affordable prices;
- Access to programmes for pregnant women for the prevention of mother-to-child transmission of HIV and for HIV treatment of mothers.

Needs and rights of young people

- Access to information and education about HIV, sexual health and life-skills training for young people in and out of school;
- Availability of male and female condoms and voluntary HIV testing and counselling at affordable prices and through youth-friendly distribution channels;
- Protection for girls against sexual violence in schools.

Needs and rights of vulnerable groups

- Availability and affordability of treatment and care, including geographical coverage and measures taken to ensure availability for members of vulnerable populations;
- Existence of community-based and home-based care programmes for people living with HIV;
- Access to information about sexual health and HIV for sex workers, men who have sex with men, prisoners and people who use drugs;
- Availability of HIV harm-reduction measures and prevention for people who use drugs e.g., sterile injecting equipment, drug substitution therapy;
- Availability of male and female condoms at affordable prices for members of vulnerable groups, such as sex workers, prisoners and men who have sex with men;
- Availability of voluntary HIV counselling and testing (VCT) inside health-care facilities and in separate VCT facilities;
- Social support for elderly and poor caregivers and for children orphaned by AIDS.

Public education campaigns

In addition to the targeted programmes outlined above, national institutions can launch general public awareness campaigns against HIV-related stigma and discrimination, and gender inequality, which makes women and girls particularly vulnerable to HIV. National institutions can also develop public education programmes that disseminate information on how people can claim their rights in the context of the epidemic. In designing campaigns and programmes, national institutions should consult with community organizations, people living with HIV, women's rights groups, the private sector, religious leaders and others, to identify how best to reach the widest possible audience and work through their networks of community leaders [UNAIDS: 2007].

Conclusion

Migration per se is not a risk factor for HIV infection. However, a wide variety of underlying factors and conditions associated to migration make migrants more vulnerable and more likely to engage in risky behaviours. Interventions that target these root causes are a necessary aspect of HIV prevention. Root causes include shaky legal status for migrants, controls on freedom of movement in destination countries and poverty, compounded by lack of health care access. Addressing poverty and violence against women at the same time as addressing condom usage, for instance, will aid in closing the gap between vulnerability and risk reduction programming. Many countries can offer social protection schemes and set up bilateral agreements for cross border assistance on social protection. For internal

migrants specifically, strengthening social protection schemes and making it easier for migrants to access their schemes even when they are not on home soil is extremely critical. For single women particularly, there could be shelters and access to sexual, reproductive health care and other protection mechanisms that guarantee equal rights in the source as well as destinations. Relaxing restrictions on migrant access to national healthcare services will help maintain good health as well as promote prevention and treatment of HIV. In addition, STIs such as syphilis that heighten the risk of HIV transmission can be treated. Promoting access to basic healthcare for migrants in destination regions will require multi-sectoral, cross-border cooperation.

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