https://doi.org/10.32394/pe.76.40

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RECENT PERSPECTIVES ON THE LINK BETWEEN MIGRATION, HUMAN RIGHTS AND HIV AMONG WOMEN

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ABSTRACT

There is a well-documented link between infectious diseases, especially HIV, armed conflict, lack of respect for human rights and migration. War leads to disruption of services, increased vulnerability to violence and social hardships that put individuals and especially women at risk of infections such as HIV. HIV in Europe is highly associated with migration, with over 40% of new infections being diagnosed among migrants. Our aim was to provide an overview of the factors that put migrant populations, and especially migrant women, at risk for HIV infection and to illustrate this from three different perspectives: 1) recent migration from the Ukraine, and Polish experiences in provision of HIV care to Ukrainian migrants; 2) successful HIV programs targeting African migrant women in the United Kingdom (UK); 3) the impact of the prolonged crisis and women's rights violations during the internal Afghanistan conflict.

We conclude that although they may be dramatically different, situations having detrimental health effects in women often share common underlying causes, and therefore may potentially be addressed by applying universal principles that emphasise the importance of self-management of health needs, empowerment of vulnerable communities and building community strengths. As crisis situations are often unpredictable, and shortage of resources common, empowerment of communities and creation of systematic policies that proactively address women's specific needs is crucial to ensuring that vulnerable populations are able to thrive in their new environment, thereby becoming contributors to, rather than being seen as burdens to society. This can only be achieved by continuous dialogue between women's communities, health care providers, policy makers and other stakeholders involved in the care of women.

Key words: *HIV, women, prevention, migration, conflict, human rights*

STRESZCZENIE

Istnieje dobrze udokumentowany związek między chorobami zakaźnymi, zwłaszcza HIV, konfliktami zbrojnymi, brakiem poszanowania praw człowieka i migracją. Wojna prowadzi do zakłóceń w świadczeniu usług, zwiększonej podatności na przemoc i trudności społeczne, które narażają jednostki, a zwłaszcza kobiety, na ryzyko infekcji, takich jak HIV. HIV w Europie jest silnie związany z migracją, przy czym wśród migrantów diagnozuje się ponad 40% nowych zakażeń. Naszym celem było przedstawienie przeglądu czynników, które narażają populacje migrantów, a zwłaszcza migrantki, na ryzyko zakażenia HIV i zilustrowanie tego z trzech różnych perspektyw: 1) niedawna migracja z Ukrainy i polskie doświadczenia w zapewnianiu opieki HIV do migrantów ukraińskich; 2) udane programy HIV skierowane do afrykańskich imigrantek w Wielkiej Brytanii; 3) wpływ przedłużającego się kryzysu i łamania praw kobiet podczas wewnętrznego konfliktu w Afganistanie. Dochodzimy do wniosku, że chociaż mogą się one dramatycznie różnić, sytuacje mające szkodliwe skutki zdrowotne u kobiet często mają wspólne przyczyny leżące u ich podstaw i dlatego potencjalnie można się nimi zająć poprzez zastosowanie uniwersalnych zasad, które podkreślają znaczenie samodzielnego zarządzania potrzeba-

mi zdrowotnymi, upodmiotowienia słabszych społeczności i budowanie mocnych stron społeczności. Sytuacje kryzysowe są często nieprzewidywalne, a brak wspólnych zasobów, upodmiotowienie społeczności i tworzenie systematycznych polityk, które proaktywnie uwzględniają specyficzne potrzeby kobiet, ma kluczowe znaczenie dla zapewnienia, że słabsze populacje będą w stanie prosperować w nowym środowisku, stając się w ten sposób współtwórcami, a nie postrzegane jako obciążenie dla społeczeństwa. Można to osiągnąć jedynie poprzez ciągły dialog między społecznościami kobiet, świadczeniodawcami opieki zdrowotnej, decydentami politycznymi i innymi zainteresowanymi stronami zaangażowanymi w opiekę nad kobietami.

Słowa kluczowe: *HIV, kobiety, profilaktyka, migracja, konflikt, prawa człowieka*

INTRODUCTION

Infectious diseases remain a significant public health problem all over the world, and any conflict, including war, promotes factors that lead to their increased incidence. Destruction of infrastructure, mass migration, overcrowding, poor sanitation, malnutrition and chronic stress are just some of the factors that increase the risk of infection-related morbidity and mortality (1). Conflicts are often connected with violations of human rights including health rights, which further exaggerates the problem (2). In addition, during conflicts, prevention initiatives, including, but not limited to, vaccination programs, stop working effectively. Of infections with epidemic potential, HIV/AIDS and tuberculosis are becoming increasingly important (1).

We know from a historical perspective that conflicts promote the spread of HIV. This was observed during the civil wars in Uganda and Somalia (3), and in Syria, the number of provinces with voluntary counselling and testing centres dropped from 14 to 5 (4).

In addition to disruption of local services due to military action, armed conflicts often cause massive displacement of populations fleeing the conflict zones. For example 1.7 million people were internally displaced during the initial conflict in Ukraine in 2014 (5). Migration puts individuals at particular risk for acquisition and poor outcomes of infectious diseases. Although the epidemiology of particular infections in the country of origin plays an important role, there is also an increased risk of exposure during the period of migration as well as during the period of settling in the host country (6). While initially in this period, primary health needs relate mainly to psychological support for survived trauma as well as management of chronic diseases, poor sanitary conditions and crowding in temporary settlements may result in outbreaks of respiratory and gastrointestinal disease. In addition, access to treatment and preventive services such as vaccination and testing for chronic infections and other diseases may be compromised. As a result of lack of appropriate treatment, the outcomes of chronic infections such as tuberculosis, viral hepatitis or HIV may be worsened, especially when there are difficulties in registering in the health care systems of host countries, and high mobility.

The aim of this paper is to provide an overview of the factors that put migrant populations, and especially migrant women, at risk for HIV infection and to illustrate these from the following perspectives, all of which affect, or are relevant to, migrant women in Europe: 1) recent migration from the Ukraine, and Polish experiences in provision of HIV care to Ukrainian migrants; 2) successful HIV programs targeting African migrant women in the United Kingdom (UK); 3) the impact of the prolonged crisis and women's rights violations during the internal Afghanistan conflict.

MIGRATION AND HIV IN EUROPE

In Europe, a considerable proportion of HIV infections are diagnosed among migrants. In 2020, 44% of people diagnosed with HIV in the EU/EEA region were migrants, 15% of whom originated from countries in sub-Saharan Africa, compared to 10% from Latin America and the Caribbean, 9% from other countries in central and eastern Europe and 3% from other countries in western Europe (7). Of interest is the fact that new HIV diagnoses among migrants from non-high prevalence countries are increasing in the EU/EEA (7).

Studies assessing the association of HIV with migration status demonstrate that 30-45% of infections are acquired post- or during migration, varying from 2% to 60% depending on the country of origin and the host country (8). A study by Mardh et al. in 2019 found that approximately 35% of migrants to Europe acquired HIV in their destination country and not in their country of origin (32% for Africans, 37% for Europeans, 45% for Asians and 45% for other regions). The median CD4 count at diagnosis for Africans was around 270 cells/mm3 compared to 410 cells/mm3 for migrants from Europe or other countries, and women were more likely to be diagnosed late than men. Older women were at greater risk of late diagnosis, however migrant status was itself not associated with late diagnosis (9). Understanding the factors that contribute to HIV acquisition in the destination country is critical

to monitoring the local and regional epidemic and to designing appropriate and effective strategies for testing and prevention.

Social hardships are common after arrival in a new host country, including unstable housing, lack of formal residency status and socioeconomic difficulties. Hardships experienced during migration constitute a significant driving factor for acquiring HIV shortly post-migration, and women have been shown to be especially vulnerable (10), often being exposed to sexual violence (11). Sexual risk taking, including multiple partners and unprotected sex, tends to be more common after migration resulting in higher HIV incidence compared to non-migrant counterparts (12).

Gaps exist in access to care and ensuring the HIV continuum of care among migrant populations in the EU/EEA, especially among undocumented migrants or migrants belonging to key populations such as men who have sex with men, people who inject drugs and sex workers (13). A high proportion of migrants are diagnosed with late infection, suggesting lack of access to, or ineffective screening practices. A review found that although a number of different infectious diseases screening approaches for migrant populations are in place in many European countries, they are often suboptimal. For example, the screening is often limited in scope to single diseases and/or to a narrow subset of migrants, and coverage is often low (14). Moreover, even if policies support health care provision, there exist important barriers to access, including language difficulties and lack of language-cultural mediators, or high organizational complexity of the local health care systems. Lack of resources in these health care systems also plays a role (15).

In addition, undocumented migrants may deliberately avoid contact with health services due to fear of identification and the need for registration with national migration authorities (15), which for people living with HIV may be further complicated by the fear of disclosure of their positive serostatus (16). Fear of disclosure may also affect adherence to treatment, for example if staying with family or friends unaware of their HIV status. A study by Murnane et al. showed that non-work related mobility, especially among women, was related to significantly decreased adherence (17). This may be also relevant to the current migration wave resulting from the war in Ukraine. A substantial proportion of Ukrainian refugees find shelter with families or friends or in the private houses of people willing to provide assistance.

EXPERIENCES FROM POLISH PERSPECTIVE ON THE WAR IN UKRAINE

The Russian Federation and the Ukraine are among Eastern European countries with the fastest growing number of HIV cases. Initially, until 1987 the most prevalent route of transmission has been intravenous drug use, but nowadays heterosexual transmission, and consequently vertical transmission has started to predominate. Drivers of the ongoing epidemic among Ukrainian women include inadequate education about HIV, social and cultural factors, stigma, and HIV-related discrimination (18). Importantly, Ukraine differs from other European countries in that only about half of all people with HIV are diagnosed, significantly below the 90% target (18).

It is important to remember that the conflict in Ukraine started much earlier than 2022, and occupation by Russian forces in the East of Ukraine created conditions that threatened HIV control in the region long before the 2022 invasion. This is likely to have a significant impact on the numbers of refugees in Poland who will need hospitalisation for complications of untreated HIV infection, as well as those needing to continue life-long antiretroviral therapy (ART) (19). Additionally, in preparing the Polish Health Care System to provide care for refugees, it should not be forgotten that tuberculosis-HIV coinfection and multidrug resistant tuberculosis are more frequently observed in Ukraine (20).

Since 22 February 2022, infectious diseases specialists in Poland have faced new challenges, with little experience of how to handle HIV care under such circumstances. By July 2022, over 2,000 Ukrainian patients were registered for ART in Poland. This is in addition to the expected annual increase in the number of patients of approximately 1,000-1,500 (21). These specialists must cope with the rapidly increasing number of patients in the HIV Outpatient Clinics, lack of medical records, language barriers, the psychological traumas experienced by refugees, as well as navigating the challenges posed by therapeutic regimens not available in Poland, all of which makes it very difficult to provide adequate medical care (22).

In connection with the above, strategies are needed to optimize health care systems to cope with humanitarian crises, to define the most important challenges to appropriate support for Ukrainian refugees living with HIV, both diagnosed, and already on ART, as well as those who are unaware of their infection. In optimizing these systems, it is important to remember that refugees living with HIV may experience additional health consequences such as depression, social isolation and post-traumatic stress disorder (23). This is especially important for women,

as over half of people living with HIV in Ukraine are women, with the majority of refugees living with HIV migrating to Poland being women with children.

CHALLENGES AND TRIUMPHS OF MIGRANT AFRICAN WOMEN LIVING WITH HIV IN EUROPE

Reasons for migration of Africans to Europe are many and complex, but include work and educational opportunities, family reasons and governance/security at home (9). Virtually no data exist on the numbers of migrant women living with HIV in Europe because of inadequacies and inconsistencies in reporting in some countries.

On moving to a new country migrant women face many challenges, of which inability to speak the local language is one of the most important. Increasingly, many women migrate on their own and so have no family support, and for those who enter Europe via unofficial channels, insecure immigration status means that they are unable or afraid to access services or engage with wider society for fear of being deported or incarcerated. Additionally, many face barriers to accessing healthcare and/or are unable to navigate the health system in their new country. Women who migrate with, or to join their spouses may lack opportunities for work or training, and for many women, financial insecurity raises the risk of trafficking and exploitation.

Nevertheless, it is important to understand and acknowledge the diversity that exists among female migrants to Europe. Despite the fact that many view migrants as impoverished and poorly educated, the reality is that huge variations exist with regard to social class, level of education and other socioeconomic factors. For example, in the UK, the level of education among women living with HIV infection is generally high, with 80% having a bachelor's degree or higher (24). Despite this, as is the case in the rest of Europe, many migrant women struggle to find employment, or if they do, are employed in low paid jobs (25).

Many African migrant women come from environments in which communities often come together to resolve challenges so that individuals who are struggling can receive the support they need. Most models of HIV care advocate for peer support to empower people living with HIV to support others to manage their diagnosis, increase their knowledge of HIV, to reduce feelings of isolation and signpost them to appropriate support services (e.g. online support MyHIV.org.uk). These concepts are very familiar to migrant women, successful examples of which include the work of the 4M Network of Mentor Mothers, a unique peer-led programme by migrant women who train women living with HIV across the UK to provide psycho-social support to peers during and after pregnancy (https://4mmm.org/). The Sophia Forum, a UK charity for women living with HIV has developed several innovative programmes to support women ageing with HIV (Sofia Forum, https://sophiaforum.net/index.php/women-with-hiv-growing-older-wiser-and-stronger-grows/), and there are examples of similar programmes in other European countries.

Thus, peer support provides a means by which migrant women can be trained and empowered to support themselves and each other and make useful contributions to their community, facilitating retention in care as well as providing a useful resource for HIV and other services (26).

WOMEN'S RIGHTS IN AFGHANISTAN AND EMPOWERMENT TO DECIDE ON THEIR HEALTH

Before 2021, after many years of substantial political and human rights activism in Afghanistan, promising changes have occurred. Women's rights were supported by Afghan legal precedent based on the 1964 and subsequent Constitutions, as well as ratification by Afghanistan of several international treaties (27). However, after Kabul fell in August 2021, the Taliban regime, a radical Islamic movement, took control, and as a top priority began to limit women's rights as previously happened in areas controlled by Talibs.

Currently women cannot come to health centres without a mahram (allowable male escort), and it is estimated that thousands of women have been deprived of their rights to access to health care. According to the Daily Outlook of Afghanistan, the estimated number of widows in Afghanistan ranges from 600,000 to 2 millions (28), as a consequence of the prolonged armed conflict in the country, leaving women without mahrams, and therefore unable to access medical care. Poverty, inadequate health facilities, and lack of education are also major barriers (29).

A survey conducted by Physicians for Human Rights (PHR) in 2001 showed that women in Taliban controlled areas as compared to other Afghan women reported worse physical (84% vs. 63%) and mental health (85% vs. 54%). Specifically, the rates of major depression and suicide were extremely high and much higher as compared to women living in non-Taliban controlled areas, 76% vs. 28% and 16% vs. 9%, respectively. The majority of women (65-94%) who were exposed to Taliban edicts attributed their depression to official Taliban policy (30). According

to World Bank report, the extremely low status of the women in Afghanistan is also a key risk factor for HIV infection, as without proper education and denied the right to decide for themselves they are unable to protect themselves. Denied access to education and jobs and often not allowed to leave their homes without a male relative, they lack access to information on how to protect themselves (31).

Of note the situation is similar in terms of equal rights and access to healthcare also in other countries. A study from Saudi Arabia in 2014 found that women with heart symptoms were twice less likely than men to report to a doctor, had to wait for a male's permission to seek medical help and prioritized household duties over their own health, believing that they should not be attracting attention (32). In Oman, less than 1% of women reported using contraception before their first child because it was believed that decisions about contraception should be made by the husband (33). The Eastern Mediterranean Region has one of the lowest rates of female physicians in the world, only 35%, even though many Arab men prefer for female family members to receive care from women healthcare providers, which further restricts women's access to healthcare. At the same time, women make up 79% of nurses, who are often underpaid and viewed as having less authority than doctors (34).

The current status of women's rights overlaps with other factors having a profound effect on Afghan women's health, including lack of educational opportunities, resulting in illiteracy, lack of employment opportunities and poverty (29). These problems require far more attention and assistance from international communities than is currently being offered, especially given the size of population affected and the likely irreversible impact of these challenges on the common wellbeing.

DISCUSSION AND CONCLUSION

We discuss three different perspectives on women's health in connection with conflicts, migration and human rights violations. We focus on infectious diseases, and specifically HIV, but it should be noted that crisis situations in general create specific health vulnerabilities both in the conflict areas and among migrant communities in the countries to which they flee, that can be addressed or made worse by the decisions of policy makers. At the same time these different situations share characteristics that may enable their resolution by similar means.

The ability to capitalize on a critical strength, the strong tradition of many communities to support each other in times of crisis, has been instrumental in successfully enabling African women migrating to the UK to be retained in HIV care and other health services. The grass-roots initiatives of local Polish communities have helped thousands of refugees from Ukraine to find basic support, allowing time for a government response. However, although communities are able to react fast, they need public support and empowerment in the long run. We note that empowerment of people living with HIV has long been held as critical to HIV prevention and care; such empowerment could help migrants to tackle the challenges arising from these recent crises of conflict and forced migration. Where these resources already exist, they could be used to set up HIV prevention, linkage to and retention in care programs for women fleeing the war in Ukraine and other migrants.

On the other hand, the detrimental consequences of women's lack of ability to make decisions about their own health can be clearly observed, for example, among women in Afghanistan, a situation exacerbated by the ongoing conflict. However, even if human rights are respected, migrating populations, and especially women, may have limited possibilities to address their health needs due to language difficulties, cultural differences and lack of resources during and after migration. Stigma related to HIV diagnosis and lack of trust may result in avoiding services altogether, and these factors make migrating populations especially vulnerable. An additional threat to access to care is the frequent diversion of resources from health care, and destruction of healthcare infrastructure during times of conflict. The unpredictability of such situations makes it difficult to find appropriate resources in countries that receive substantial numbers of migrants as was the case recently in Central/Eastern European countries, where the existing capacity and focus of HIV care were not sufficient to address the additional pressures.

All of this underlines the need for evidence-based planning and identification of existing and other resources that can be mobilized in times of increased migration. In addition, because of their often-higher levels of vulnerability, it is crucial to proactively implement systematic policies to address women-specific needs. This can only be guaranteed by continuous dialogue with women, communities, health care providers and policy makers. Actions should include putting women first, empowering vulnerable individuals and creating communities of support. Importantly, respect for human rights should be at the forefront of all interactions with communities, whether vulnerable or not.

Acknowledgments.

We would like to acknowledge all presenters and participants of 2nd Women in Circles of Infectious

Diseases conference for their input and inspiring discussions.

We would like to express our gratitude to professor Jerzy Przyborowski, Rector for Development of Education at the University of Warmia and Mazury in Olsztyn, for official endorsement for the conference.

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