

24th PROGRAMME COORDINATING BOARD Thematic Segment

Background Paper : People on the move – forced displacement and migrant populations

1. Overview and purpose

People on the move face barriers to achieving universal access to HIV prevention, treatment, care and support. Well over a quarter of a billion people are on the move worldwide annually, not including the 900 million people who travel each year (World Trade Organization (WTO) estimate). The commitment to universal access made by governments and civil society in 2001 and reaffirmed in 2006 requires that these barriers be recognized and overcome.

In the midst of the current financial and economic crisis there are many uncertainties regarding the direct and indirect consequences of migrant labour supply and demand worldwide. As the crisis unfolds, a two-way increase is expected in the movement of people: overseas migrants returning home after losing their jobs, or those recently laid off at home moving overseas in search of work. As some countries may take increasingly protectionist stances, the options for formal migration will narrow rapidly. Migrants abroad may face increasingly difficult conditions, with fewer employment opportunities, and may encounter greater discrimination and stigmatization. This will lead to more undocumented migrants, unsafe migration and an increased possibility that migrants would find themselves in situations that either put them at risk or make them more vulnerable to HIV infection.

This paper provides background to support productive discussion in the Thematic Segment of the 24th Programme Coordinating Board meeting on People on the Move—Forced Displacement and Migrant Populations on 22 June 2009. It provides basic information on movement of people and discusses the links between mobility and HIV vulnerability, as well as the challenges of ensuring that mobile populations have universal access to HIV prevention, treatment, care and support.

As the title suggests, the Thematic Segment will explore a wide range of mobility patterns related to the different 'push' and 'pull' factors, which can occur once in a lifetime or be cyclic and repeated. The paper points out that mobile people and international migrants are diverse, ranging from highly educated and high-earning professionals, to low-earning unskilled and exploited labourers. Although very different circumstances may drive migration and mobility, it is not mobility *per se*, but the conditions under which people move—and the ways they are treated throughout the migration cycle—pre-departure, in transit, at destinations and upon return—that most determine their vulnerabilities, which in turn affect their risks of acquiring HIV.

These conditions can be modified and governments, communities, the private sector and the United Nations (UN) have the responsibility and ability to understand and improve these harmful conditions. Numerous examples of successful policies and programmes are given in the paper, and others will be discussed during the Programme Coordinating Board meeting.

The challenge for discussion in the Thematic Segment on 22 June is how to provide accessible, and culturally appropriate HIV-related services to diverse mobile populations. How can this be done in an environment in which, for example, stigma continues to be a significant barrier and where migrants and forcibly displaced persons are often accused of bringing problems, including HIV, with them? How can national, multinational and multiregional policies and programmes around HIV and mobility and displacement be developed and improved, so that those who benefit from the productivity of people on the move (States, businesses, communities, etc.) also collaborate with them to meet their needs for health and quality of life, so that whole subgroups do not fall through the gaps and become excluded from HIV prevention, treatment and care and support? What is the role for nongovernmental organizations and civil society in all of this? What is

the role of migrants, refugees and mobile workers themselves? How can mobile populations be better empowered and participate in health and social programme creation, planning and delivery? Answers to such questions will help point towards how to reach national commitments to universal access, which in turn will enable the millions of people on the move to be included in the efforts to meet the Millennium Development Goals by 2015.

Section 2 of this paper provides a brief overview of the flows and distribution of mobile populations. Section 3 explores the types of and reasons for population movement. Section 4 goes on to discuss the kinds of vulnerability and risk associated with movement. Section 5 outlines policy and programmatic responses to address the HIV-related needs of people on the move. This paper concludes with some key issues and questions for further discussion during the Thematic Segment.

The aim of this background paper is not to be comprehensive in covering such a vast subject, but to provide a summary of some of the scholarship, research and programme experience that has taken place on the relevant issues over the past two decades. Annex 1 contains some key definitions of the concepts used in this paper.¹

2. Flows and distribution of mobile populations

Migrants

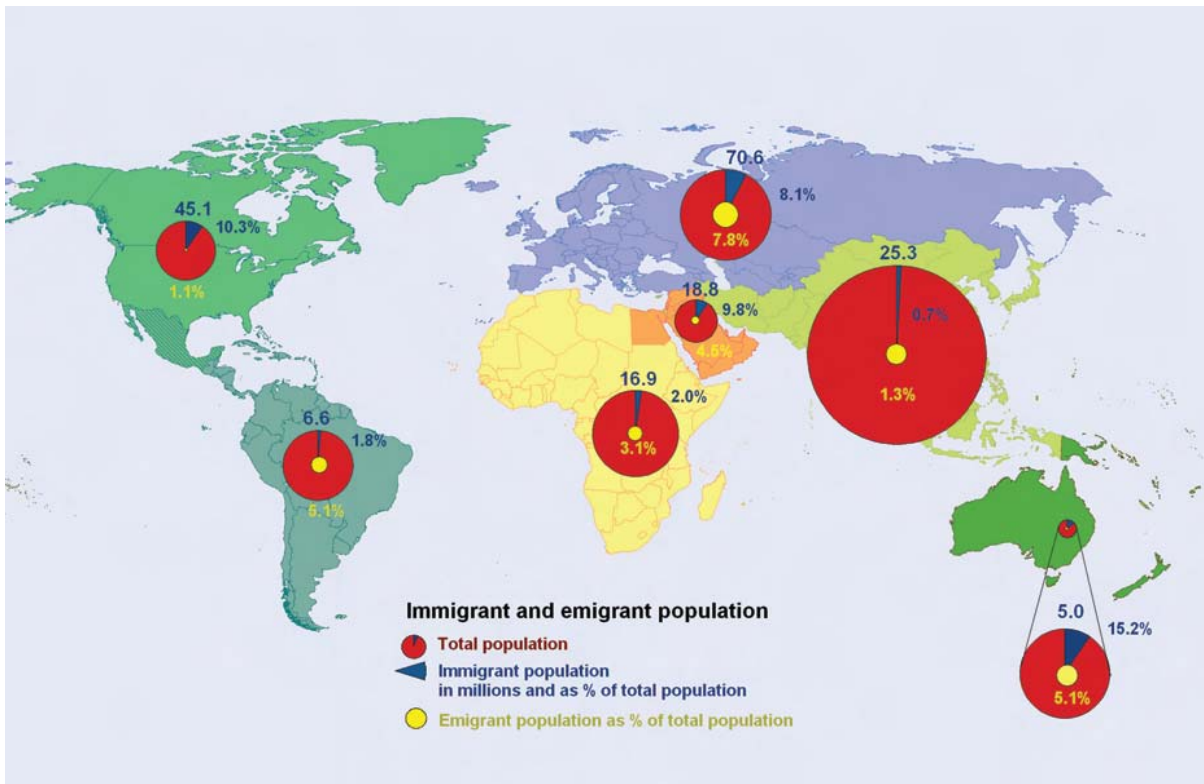
By 2008 more than 200 million people were international migrants (International Organization for Migration, 2008a).

- **Europe:** 64 million international migrants, or 9% of the total population. Significant proportions of Europe's migrants come from neighbouring countries.
- **Asia and the Pacific:** 58 million international migrants. Most have moved within the region.
- **Northern America:** 45 million international migrants. Migration has increased continuously over the past few decades. One out of five international migrants today lives in the United States of America.
- **Latin America and the Caribbean:** 6.5 million international migrants. For every immigrant within the region, another four people have emigrated abroad.
- **Africa:** 17 million international migrants. Migration has long been a significant fact of life in Africa, but most takes place between countries within the region. A great deal of internal migration also takes place within national borders.

Globalization, and the fact that it is easier and cheaper to travel today than it was a generation ago, significantly influence international migration; for example, circular (or short-term) migration has become common, with people who work abroad returning home for regular visits. While experts once made distinctions between migrant-sending and migrant-receiving countries, today virtually all countries are concerned with population movement, and most are simultaneously countries of origin, transit, destination and return (International Organization for Migration, 2008a).

¹ Following the discussion and debate in the Thematic Segment, a revised and fully cited version of this paper will be produced that includes the recommendations from the meeting as well as a geographically diverse array of policy and programme examples.

Figure 1
Total immigrant and emigrant population by region



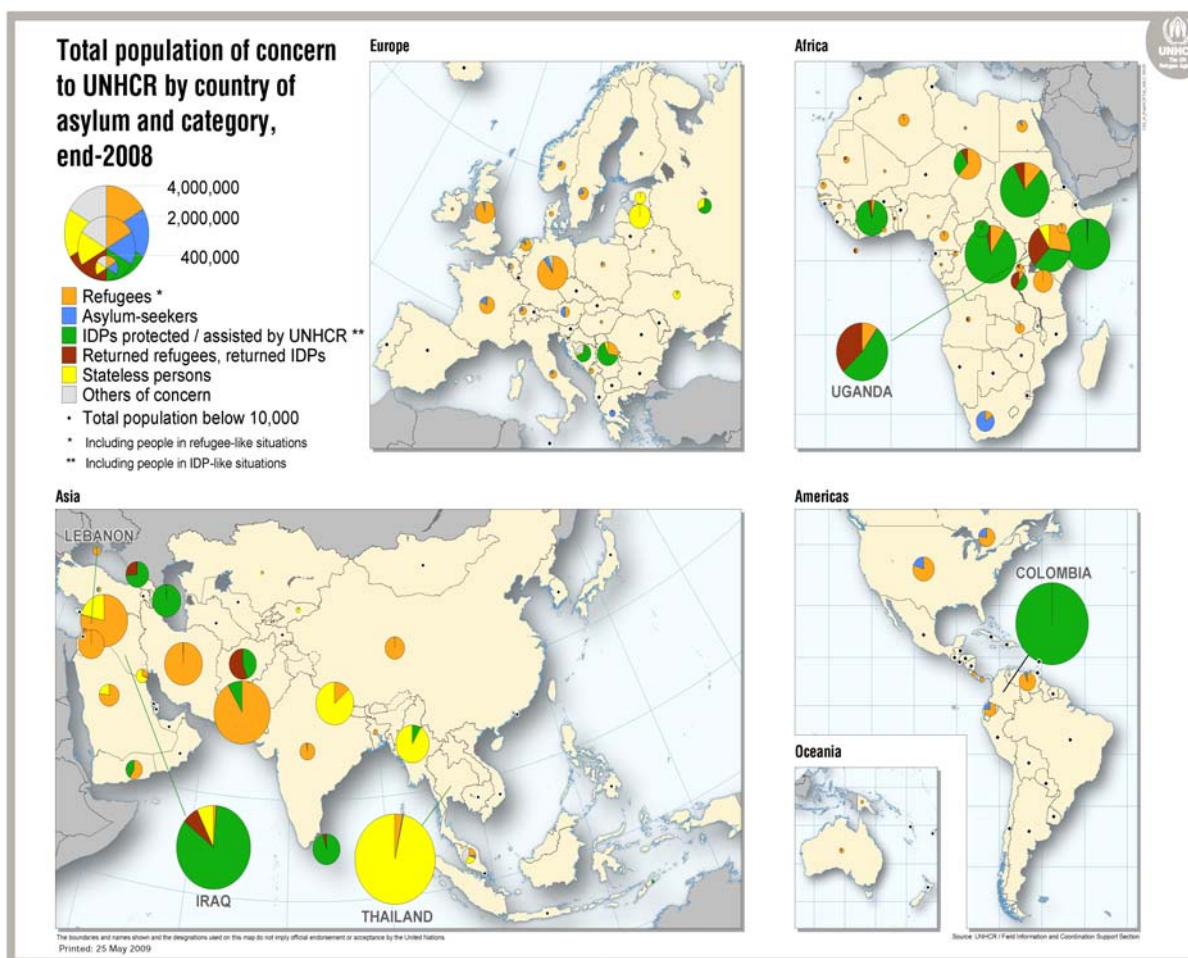
Source: International Organization for Migration (2008a).

Refugees and internally displaced persons

At the end of 2007, approximately 16 million people were refugees—people who crossed an international border as they fled armed conflict, violence, human rights violations or natural or human-made disasters. The majority of the world's refugees are hosted by neighbouring countries, and over 80% remain within their region of origin.

In addition, 26 million persons were displaced due to conflict in 2007 but did not cross an international border (see Figure 2). Africa hosted almost half of the global IDP population (12.7 million), and nearly half of the world's newly displaced (1.6 million) came from the region (Norwegian Refugee Council, 2008). Natural disasters displaced an additional 25 million people within their countries in 2007.

Figure 2
Total refugee, asylum seeker and internally displaced persons population by region



Source: UNHCR, Field Information and Coordination Support Section

Irregular migrants, mobile occupations and tourists

To these numbers must be added 20 to 30 million irregular migrants worldwide (United Nations, 2006), although estimates of clandestine migration are by definition inaccurate. In the European Union in 2007, the estimated number of irregular migrants was between 4.5 and 8 million. Furthermore, there are others who are mobile for reasons of lifestyle or profession, such as nomads and truck drivers. Finally, the World Tourism Organization (WTO) estimates that international tourist arrivals reached a record figure of over 900 million in 2007. Just over half of all such arrivals were motivated by leisure, recreation and holidays, 15% was for business and 27% was for other purposes, such as visiting friends and relatives, religious reasons or health care (World Tourism Organization, 2008). The link between tourism and population mobility is more important than it might first seem:

- Many trips for business or leisure are linked to former migration patterns (e.g. visiting family);
- Tourist trips can generate migration, for example as people decide to move to what were originally their holiday destinations (e.g. Australia, the Caribbean and Portugal);
- Tourism may generate employment, which increases labour migration (e.g. guides, hotel workers, etc., and entrepreneurs developing resorts) (International Organization for Migration, 2008a).

The UN estimates that at any given time at least 2.4 million people worldwide are under exploitation as a result of trafficking (International Labour Organization, 2005). Trafficking of persons² is a human rights violation resulting in the severe exploitation of internal and international migrants.

Decades of research and programme experience show that the following cross-cutting factors affect the experience and the risks of movement:

- Age, sex, family status;
- Degree of choice involved;
- Amount of time available to prepare;
- Available financial resources;
- Legal conditions under which movement takes place (in an organized programme or individually and alone—documented, underdocumented³ or undocumented);
- Degree to which mobility is traditional, or common, in one's family and community of origin;
- Length of the intended time away;
- Distance travelled and whether or not an international boundary was crossed;
- Level of health and social 'capital' of the person;
- Others with whom one migrates or is displaced;
- Degree of language and cultural difference between the origin and host communities;
- Social and economic conditions available to the person at the destination, including available protection, xenophobia, racism, gender inequality, availability of networks of others at the destination for orientation and support;
- Type of work available and carried out by the person in the host community.

These factors must be taken into account by communities, governments, international agencies, programme planners and implementers, and people on the move themselves, in efforts to achieve universal access to HIV prevention, treatment, care and support.

3. Why do people move?

A number of typologies exist for explaining different kinds of population mobility (see Annex 1). Specialists often differentiate between 'voluntary' and 'forced' migration, sometimes explaining mobility in terms of 'pull' and 'push' factors.

Pull factors of mobility

A major reason for moving within and between countries is to seek better working opportunities and conditions. The majority of the world's labour migrants move not from a low- or middle-income country to a high-income country, as is sometimes assumed, but from one low- or middle-income country to another. Although low-skilled migrants still account for the bulk of labour migration, more and more highly skilled people are migrating, especially in the industrialized world. In high-income countries migrants of all skill levels work mainly in the service sectors (construction, commerce, catering, education, health care, domestic and other services). In low- and middle-income countries migrant workers are found mainly in primary-sector activities (agriculture, fishing, mining) and in manufacturing, although the share of migrant workers in services is rising, especially in relation to tourism (International Organization for Migration, 2008a).

² The UN defines trafficking in persons as: "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, abduction, or fraud, of deception, of abuse of power...or the giving or receiving of payment or benefits to achieve the consent of a person having control over another person, for the purposes of exploitation." (United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, supplementing the United Nations (2000) Convention against Transnational Organized Crime.)

³ Underdocumented refers to entering a country with a passport but with a visa that may expire soon or entering with a tourist visa when the purpose is labour migration.

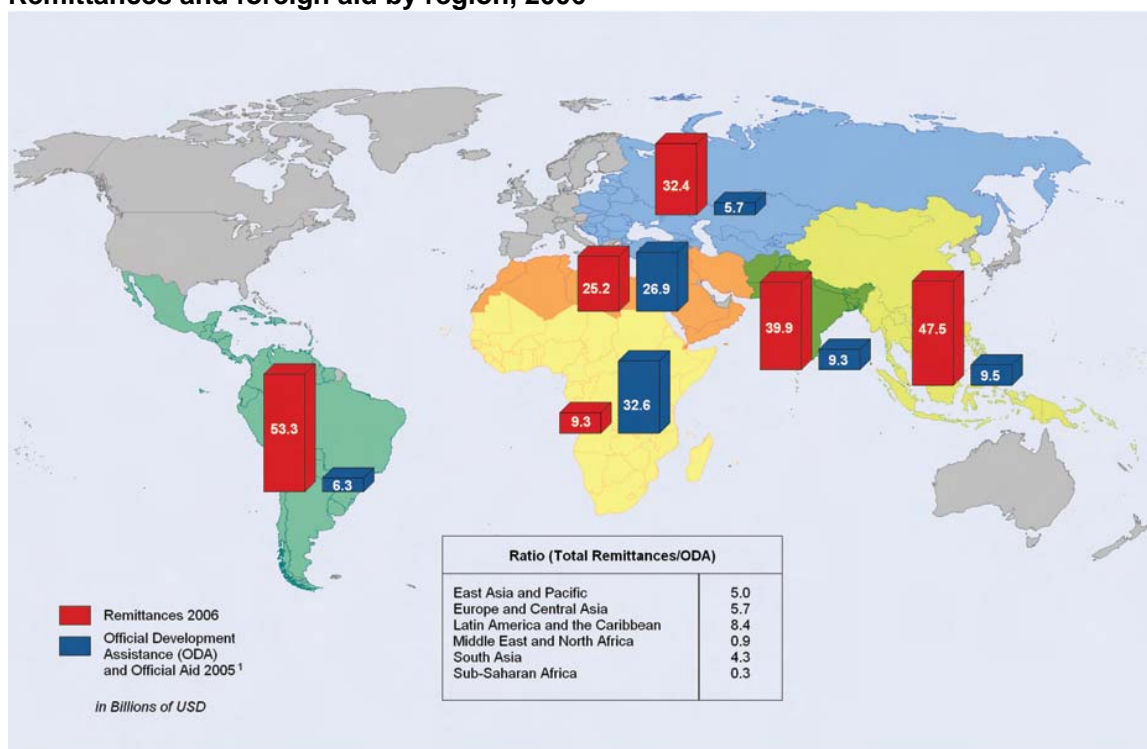
Educational and/or career opportunities abroad are also important pull factors for many people, such as students and health workers, military and uniformed services personnel, business people, and development and humanitarian workers.

For others, mobility is part of their livelihood strategy and/or essential to their survival. Examples include truck drivers and their assistants, seafarers, fisherfolk, nomads and pastoralists. Mobile sex workers can also fit into this category (see Box 3 in Section 4).

The many benefits of migration also act to promote mobility. Migrants contribute to the economic growth and wellbeing of receiving countries and transmit both social and financial remittances to their countries of origin.

- Social remittances include new ideas, information, products and technology.
- Financial remittances (not including the informal sector⁴) were estimated at US\$ 337 billion worldwide in 2007, US\$ 251 billion of which went to developing countries. These will surely be affected by the current world economic crisis: it has been predicted that the recession in Europe and the USA will lead to a decline of between 4.4% and 7.9%, or a US\$ 1 billion fall in remittances in 2009 (Lapper, 2009).

Figure 3
Remittances and foreign aid by region, 2006



Source: International Organization for Migration (2008a).

Push factors of mobility

People may also be pushed or forced out of a community, country or a region as a result of political instability or conflict, by ethnic, sexual or other prejudice, or as the result of a natural disaster. In these cases people move in search of protection as well as food and humanitarian relief. People displaced as a result of conflict and natural disasters may find themselves in refugee or displaced person camps, or in shelters or relief centres, some more permanent than others. Others will live with friends, relatives or simply in 'the bush'.⁵ Some flee without papers and remain

⁴ These figures are likely to double if informal sector transfers are taken into account.

⁵ Since such displaced people are difficult to track, relatively little is known about them.

clandestine or undocumented migrants. Such forced mobility or displacement may be temporary or may last for many years or generations. People who are trafficked are especially vulnerable to the risk of HIV, as their rights and freedoms are virtually eliminated and their welfare and very survival controlled by criminal enterprises.

Gender and age are highly relevant, although often ignored, variables affecting migration. Almost half of today's labour migrants are women, many of whom leave children at home for the months or years they spend working abroad. Women may also migrate to achieve greater independence: for some women, men who have sex with men and transgender people, migrating may provide an escape from cultural constraints and oppressive family situations, including domestic violence (United Nations Population Fund, 2006). These issues apply also to children and young people. In addition, for young people in many cultures around the world, migration is a rite of passage: young people leave home to assert their independence and to become adult (Whitehead and Hashim, 2005; Anarfi et al., 2005). Older people may migrate to return 'home' after having lived abroad to be near family members who need care, or to access better health care (Sherr et al., 2008).

Box 1
Health workers, migration and HIV

Health workers are often actively recruited from abroad and in many cases find it relatively easy to migrate to destinations where working conditions and career opportunities are better. Health workers may also be pushed to migrate by political instability and poor working conditions. HIV can also push health workers to relocate, especially in high-prevalence areas, by increasing stress, fear and discouragement (Rogerson, 2007).

While the international mobility of health professionals is necessary to health systems in industrialized countries, migration of health workers has given rise to a severe depletion of human resources in some low- and middle-income countries. This shortage is felt particularly acutely in countries with high HIV burdens and where many health workers themselves are affected. The result is increased morbidity and mortality, absenteeism and reduced productivity (Bach, 2003; World Health Organization, 2004, 2006a).

The World Health Organization (WHO) has recently called for countries to retain their health staff by improving their working conditions and by investing in training, particularly in rural areas, while at the same time maintaining a healthy balance of migration so that health workers can acquire additional expertise. WHO has also called for high-income countries to train more of their own health workers, thus reducing their dependency on those imported from other countries (World Health Organization, 2004, 2006b).

Box 2
Children and conflict

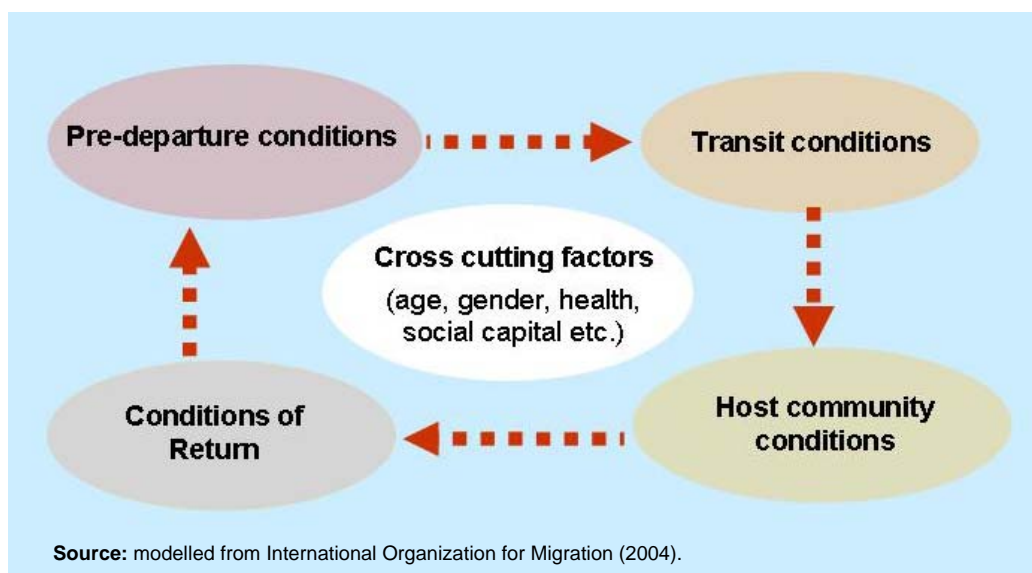
Conflict and HIV are often referred to as a double emergency for children since, when they occur together, they increase children's vulnerability. They do this through parental death and by damaging the families and communities that should protect and care for children. Of the 17 countries with more than 100 000 children orphaned by AIDS, 13 are affected by conflict. (see www.ovcsupport.net). Similarly, in 2003, one in seven HIV-positive children in the world was living in a situation of conflict or of emergency.

When children and young people are forced to flee their homes because of armed conflict, their vulnerability to violence, abuse and exploitation—all key factors in HIV infection—increases dramatically. Children and young people forced to become soldiers are exposed to even more risks (Coalition to Stop the Use of Child Soldiers, *Child Soldiers Global Report 2008*).

4. Population mobility, vulnerability and HIV

Human population mobility consists of a number of overlapping phases: the first phase is in the source country or community, or before people leave their place of origin; the second phase is in transit, or as people travel; the third phase is in the host country or community in which the person then stays; and the final phase is return, or when people are back in their communities of origin.

Figure 4
Conditions during different phases of mobility influence vulnerability to HIV



Migration processes can impact upon health outcomes negatively or positively. The ‘healthy migrant effect’ has often been noted: people who migrate are often in better health than non-migrants and usually they are required to pass health examinations before entering the host country.

While migration in and of itself is not a risk to health, “conditions surrounding the mobility process can increase health vulnerabilities, particularly for those who move under unsafe conditions, involuntarily and those who migrate clandestinely or fall into the hands of traffickers” (International Organization for Migration, 2008b). Mobility and HIV risk are most directly linked for people trafficked for sexual exploitation (United Nations Office on Drugs and Crime, 2008).

Disparities between a migrant’s place of origin and destination often exist. For the present purposes, those related to health determinants and the prevalence of HIV infection are of particular concern, but data characterizing these conditions are scattered and few.

Depending on the conditions surrounding the mobility process, there are three broad kinds of vulnerability that may arise during the above phases of mobility and lead to increased risk of acquiring HIV:

• **Social vulnerability:**

such factors as poverty, lack of protection, discrimination and lack of power are inter-related. They reduce people's possibility to make choices, thus decreasing their ability to avoid risk. In some cases social vulnerability may apply to entire communities, for example when whole communities are displaced and obliged to live in precarious circumstances, or when migrant workers are separated from their families and concentrated in overcrowded and inadequate housing in insecure neighbourhoods.

• **Individual vulnerability:**

the emotional and behavioural response to separation from families and communities, loneliness, fear, alienation and despair, and also the lack of power to act for oneself, also generate vulnerability. When people are away from their home communities, their traditional social norms and networks that influence and regulate behaviours are attenuated, and individuals may experience a state that sociologists refer to as

'liminality', or being in-between, during which they may engage in behaviours that they would not consider at home (Thomas, 2005).

• **Programme vulnerability:** lack of access to prevention, treatment, care and support is a different form of vulnerability. Services may not exist, or where they do exist mobile populations may not have access to them, because of formal barriers such as legal restrictions, because of cost or simply because they do not know about their existence. Other barriers are services that are not adapted to the needs of those of a different language and/or culture, or that are not perceived to be trustworthy.

Box 3

Mobile sex workers

Sex workers are highly mobile both within and across national borders. Documented and undocumented migration for sex work often occurs between neighbouring countries, but there is also considerable inter-regional movement.

The migration and mobility of sex workers can significantly increase their vulnerability to HIV and sexually transmitted infections. Many migrant and mobile sex workers, especially those who are undocumented, are excluded from basic education, legal and public health-care systems, and are vulnerable to violence and other forms of abuse from customers, criminal gangs and corrupt law enforcement officials, with little or no social or legal support and protection. In addition, migrant sex workers face additional cultural and linguistic barriers that adversely impact upon their ability to access local services and support networks. To reduce HIV risk and vulnerability for mobile and migrant sex workers there are key actions that need to be funded and implemented for all sex workers irrespective of their gender (women, men, transgender) or legal status. These include access to HIV prevention and treatment services, comprehensive sexual and reproductive health services, legal information and advice and necessary social services. To support these services, training of health-service providers and law enforcement agencies addressing stigma, discrimination and violence needs to be developed along with occupational health and safety standards to make sex work safer.

Clients of sex workers are also highly mobile and their behaviour determines epidemic speed and severity (Commission on AIDS in Asia, 2008). Currently, few programmes target clients directly to promote safer sexual behaviour. Such programmes should: be provided in the workplace (where appropriate); be based on the different settings where sex work occurs; provide clients with information to protect sex workers, their regular sexual partners and themselves from HIV and other sexually transmitted infections; emphasize client responsibility to treat sex workers with dignity and respect; and incorporate approaches to eliminate gender-based violence in the context of sex work.

To be effective, HIV responses must anticipate and address these three types of vulnerability at each phase of mobility. Since the factors affecting success and risks in the pre-departure and return phases are similar, they are addressed together after the transit and destination phases.

Transit phase

The cross-cutting factors listed in Section 2 influence vulnerability during the transit phase, when people are in the process of leaving one place and moving to another, including the haste of the move, the resources available for making the journey and the liminality mentioned above. People fleeing disasters and conflict often have no access to shelter, food and other necessities and may face dangerous or violent situations. Women, and also men, may experience sexual violence as part of the conflict from which they are fleeing, or be forced to have sex in exchange for safe passage. Women who migrate voluntarily may also be raped during their journey, or have to sell sex to earn money to continue towards their destination (Bronfman et al., 2002; Rowley et al., 2008).

Box 4

Truck drivers and their assistants

Truck drivers (and their assistants) are some of the most studied mobile workforce populations and have long been considered at increased risk of HIV and other sexually transmitted infections. Several studies have documented HIV prevalence as being higher among truckers than in other occupational groups or the general population (Population Council, 2008; International Labour Organization, 2006). A particularly alarming study carried out in 2001 in South Africa, for example, found that 56% of all long-distance truck drivers tested were HIV positive, with rates going as high as 95% at some sites (Medical Research Council, 2001).

Truck drivers and their assistants are usually sexually active men, living and working in stressful conditions and separated from their regular partners for extended periods. They spend much of their time on the road, moving between regions with different HIV prevalence, usually carrying significant sums of money to meet their travel needs. Other factors increasing their vulnerability include: long waiting times at border crossings, during loading and unloading, or for repairs; a lack of suitable accommodation at rest stops; and the easy availability of informal commercial sex in the 'hot spots' where trucks stop. Thus they may be more likely to engage in casual and commercial sexual relationships, and those who make regular trips may also have wives and/or girlfriends or boyfriends along the routes (Stratford et al., 2000).

A recent study in India shows that truck drivers and their assistants may also be at risk through engaging in same sex behaviours. The authors argue that current prevention interventions are geared to providing risk-reduction information and services within a heterosexual context and that comprehensive prevention programmes also need to take into account same-sex behaviours (Mahendra et al., 2006).

Transport corridors and transit areas are prone to developing sex work scenes. These often unprotected sexual relationships put people living or working along the route, and those moving along transport corridors, at risk of acquiring HIV. Truck drivers and tourists are, in a sense, in a continuous transit phase as they are continually on the move, as discussed in Boxes 4 and 5.

Destination phase

A range of vulnerability factors can be defined in the destination phase of the migration process (i.e. when the migrant lives in the host country). Concerning economic or labour migrants, most people who migrate to look for work do not bring their spouses and families along, particularly at first. Housing for such migrant workers is often substandard and overcrowded, offering limited intimacy and no recreational activities. Bars and sex work scenes often spring up in such circumstances.

Many migrants, or their families, have paid a great deal to make their journey, and they may find themselves with considerable debts, including to employment agents and others who have facilitated their journey. Migrants also often work with other disadvantages: their employment conditions may be unprotected or poorly protected by government policies, or existing policies may be poorly enforced. They receive lower wages, are not represented by labour unions, have inadequate access to health and other insurance, and generally have little say about the social

conditions in which they live and work. In the worst forms of exploitation, migrant workers may have pay withheld and their papers taken away. All of these conditions make migrants vulnerable to the risk of HIV.

Female migrants, who often work in unregulated and informal sectors of the economy, are particularly vulnerable to exploitation, discrimination and abuse, as well as to sexual violence⁶ (Population Council, 2008; Perbady, 2005; UNAIDS, 2008). Female migrants often have fewer choices available than do male migrants: they are often less educated, have limited access to information on migration opportunities and are subject to the gender norms of the destination country without access to family support and protection. Many lack information about, or access to, HIV prevention and treatment.

The social vulnerability factors feed individual vulnerability factors when the resulting stress and isolation leads to depression and dislocation and to risky behaviours such as excessive alcohol consumption, substance abuse and unsafe sex with multiple partners (Population Council, 2008).

The regular mobility of some groups, such as transport workers and construction crews, makes it less likely that they will receive sustained prevention messages. Other migrants may not have the language skills necessary to absorb health message or to request services; they may not be aware of local services, or such services may not be feasible to get to, or culturally appropriate. Undocumented migrants may be afraid to access services due to their status. The problems in accessing the necessary services and support are often further compounded by stigma and discrimination.

Box 5

Tourism, sex and HIV

As with other mobile populations, tourists may act differently away than they do at home. They may feel that their behaviour is out of sight of the people who might judge them and that they can enjoy the company of people they will never see again. They may rationalize that they are visiting cultures where sex is 'more natural' and easygoing and their relative wealth may make them feel powerful. Sexual contacts, both commercial and non-commercial, are found in all forms of travel, from package tours to individual tourism. People on holiday may engage in sex with those of the same sex or opposite sex, and in group sex, with other tourists or with local people. Many tourists drink and use drugs abundantly, a combination that increases HIV risk (Richens, 2006; Ward and Plourde, 2006). From the perspective of the local population, tourism creates jobs and encourages both seasonal and permanent migration towards tourist destinations and resorts. Sex work is among the formal and informal jobs created: both adult and underage migrants sometimes sell sex to increase their earnings, and for others selling sex may be their main source of income. Locals may also hope to find tourists who will become an expatriate friend, or who will take them abroad. Travellers usually pay more for sex workers' services than do local clients; at the same time, sex workers may be under pressure, and have increased incentives, to provide services without condoms. All this increases their HIV vulnerability, and that of their families and beyond (Nyanzi et al., 2005; Padilla, 2007).

Box 6

Vulnerability factors for female migrant workers

Women may be forced to engage in sex work to supplement their low wages and/or in exchange for food, jobs and accommodation. The pattern is repeated throughout the world, but is exemplified by several studies such as of women migrants residing on sugar estates in the Dominican Republic, many of whom live in desperate poverty. Those who cross the border without a husband and who cannot immediately establish contact with friends or family to help them settle have little choice but to exchange sex for money or goods to survive (Brewer et al., 1998). Another study with Asian women who migrate to the Arab States to work as domestic workers found that many women engaged in intimate relationships to overcome loneliness, or for economic reasons. Relationships ranged from consensual to forced. Several women experienced sexual harassment or rape (United Nations Development Programme, 2009). Similarly, female farm workers at the South African–Mozambican border often find that they can improve their living conditions for the season if they agree to live with a male permanent worker: living with a man with a well-paying job on the farm will guarantee food, money and 'nice things', as well as financial support for their children

⁶ Male migrants may also be coerced to provide sex and are subject to violence from police and clients.

Migrants living with HIV

Access to HIV services poses a number of additional challenges for migrants who are living with HIV. They rarely have the same health insurance entitlements as nationals, particularly if they are undocumented. At the same time, even those with their papers perfectly in order but living among people they do not know well may feel they have to hide their status and their medications because of stigma, fear of losing their jobs or fear of deportation (CARAM Asia, 2007). Studies among migrants living with HIV in the United Kingdom, for example, consistently show that fear of HIV-related stigma and discrimination, and worry that they may encounter someone they know at the HIV clinic, are significant reasons for delay in seeking HIV care, and also significantly add to the migrant's isolation (Erwin et al., 2002; Green and Smith, 2004; Prost, 2005). Thus migrants living with HIV may fail to seek health and support services to protect their health. With inconsistent adherence to AIDS treatment there are also concerns about drug resistance (Morin et al., 2004; Burns and Fenton, 2006).

Box 7

Universal access and HIV-related restrictions on entry, stay and residence

In the early days of the HIV epidemic, many governments attempted to keep HIV from entering a country by identifying HIV-positive people and denying them entry. They further sought to avoid the possible costs of care and support for HIV-positive foreigners by denying them work or residence visas. It was quickly realized that these restrictions were ineffective in achieving valid public health goals and thus the discrimination inherent in them could not be justified. As early as 1988, WHO advised that HIV travel restrictions were discriminatory, ineffective, impractical and wasteful (World Health Organization, 1988). However, as of 2009, some 59 countries still employ such restrictions (see www.hivtravel.org). A total of 108 countries employ no such restrictions.

While countries have the right to define who is eligible to enter their borders, they are constrained in how they do this by international human rights law, which prohibits discrimination and obliges governments to protect other relevant rights, such as equality before the law and the rights to seek asylum, to freedom of movement, to health, to privacy.

With regard to the governments' attempts to limit possible burdens on public funds, blanket HIV restrictions that deny the right to entry or stay to *all* positive foreigners do not rationally identify specific individuals who may pose a burden. Furthermore, the actual cost of HIV treatment may be inconsequential in relation to a migrant's potential economic, social and cultural contribution in a destination country (see the 2004 UNAIDS/International Organization for Migration Statement on HIV/AIDS-related Travel Restrictions).

In 2008, UNAIDS convened the *International Task Team on HIV-related Travel Restrictions*. The Task Team comprised representatives of governments, international organizations and civil society, and was co-chaired by UNAIDS and the Government of Norway. The Task Team produced a report of findings and recommendations and urged "all States with HIV specific restriction on entry, stay and residence in the form of laws, regulations, and practices, including waivers, to review and then eliminate them, and ensure that all people living with HIV are no longer excluded, detained or deported on the basis of HIV status". Furthermore, the Task Team urged that countries replace such restrictions with access to HIV prevention, treatment, care and support for all mobile people, citizens and non-citizens alike, in the context of global and national commitments to universal access (UNAIDS, 2008).

Some studies have demonstrated that people in the mobile workforce may have higher HIV prevalence than those in less mobile or non-mobile professions. A few studies have found HIV prevalence to be higher among migrant groups than that in the destination country (see Adrien et al. (1999), Castilla et al. (2002) and Srithanaviboonchai et al. (2002) for international migrants to Canada, Spain and Thailand, respectively), and in relatively low-prevalence countries, such as Bangladesh, the Lao People's Democratic Republic, Pakistan, the Philippines and Sri Lanka, returning migrants are a large percentage of the identified people living with HIV in the country. However, it is important to note that these data may be biased, as migrants have to test for HIV to obtain their work permits to work abroad, and thus more

is known about their status than other categories of workers (CARAM Asia, 2007). Due to the paucity of data on migrants, particularly on undocumented migrants, and the range of situations that condition their migration, it is impossible to say whether they have, in general, a higher or lower prevalence than the general population of either their country of origin or destination.

Humanitarian situations

Humanitarian emergencies often destroy or disrupt services. In addition, while camps and shelters are often key to the survival of displaced people, conditions in these group housing situations can also increase risks of sexual exploitation, rape and abuse, especially of girls and women. Recent studies in Haiti and Mozambique, however, found no evidence that sexual and gender-based violence increased in the temporary shelters set up for those displaced by the cyclones. Instead, they found an increase in consensual and transactional sex (Samuels et al., 2008). Transactional sex is also a well-recognized phenomenon in situations of forced displacement.

The above conditions can increase the risks of acquiring HIV, especially where access to condoms is limited. This point is supported in reviews, which find that women living with HIV are more likely to have experienced violence and that women who have experienced violence are at higher risk of becoming infected with HIV (Global Coalition on Women and AIDS, 2004, 2007). A recent systematic review of HIV prevalence in seven conflict-affected countries in sub-Saharan Africa, however, found insufficient evidence that displacement and wide-scale rape increased HIV prevalence at the population level (Spiegel et al., 2007). Clearly, this is an area that requires greater study.

When the local and international response is fast, well-designed and fully funded, refugees may have better access to HIV prevention, treatment and care services in camps than they did in their country of origin (Office of the United Nations High Commissioner for Refugees, 2007a). Considerably less is known about the impact on services to conflict-affected populations that have not been displaced. Recent assessments and case studies (Spraos and Kom, 2008; Women's Commission, United Nations Population Fund, 2007) show that access to HIV prevention services in conflict/post-conflict settings is extremely limited, especially at the outset. The provision of health and HIV-related services often depends on the nature of the health system prior to a rapid-onset natural disaster (Samuels et al., 2008; Samuels and Spraos, 2008; Samuels, 2009; Long and dos Santos Pedro Tinga, 2007; Proudlock and Ruwanpura, 2008). In addition, there is usually a dearth of qualified health workers in all types of emergency settings. In some instances the response to a natural disaster has brought an improvement in services. For example, in Sri Lanka after the 2004 tsunami, as the availability of HIV-testing services in refugee and other centres enabled people to discover their HIV status.

Uniformed services

There is a growing body of evidence, in particular in conflict situations, of HIV-related vulnerabilities in uniformed services, especially military personnel. Increased HIV vulnerability among soldiers may be driven by a range of factors, including: their age group; being away from spouses or regular partners for long periods of time; peer pressure that embraces hypermasculine behaviour and risky behaviours; drugs available for injection; injuries requiring blood transfusions; and sufficient means to purchase sex or to use power and weapons to force sexual relations. Furthermore, rest-and-recreation areas set up for the entertainment of military personnel often provide brothels and bars, which in turn attract sex workers. The sexual partners of uniformed personnel, both in mission areas and in their home communities, are therefore also at increased risk of exposure to HIV.

Pre-departure/return phase

Migration can also cause HIV vulnerability for people who have remained behind in the place of origin. Early in the South African epidemic, for example, it was migration that initially appeared to fuel the spread of HIV by increasing links between locations with substantial prevalence

differences, such as migrant work sites and their rural home areas.⁷ Similarly, in Mexico it has been shown that an increase in HIV in rural communities is probably due to migrants acquiring infection while in the USA and subsequently returning to their home community (Sanchez et al., 2004).

Subsequent work in South Africa shows that women left behind in rural areas may find themselves with no support when their partners migrate to work. They may have sexual relationships in exchange for economic and social support for themselves and their children, thus increasing their risk of contracting HIV (Lurie, 2006). Their risk of acquiring HIV also increases when their partners return, as women are often unable, or unwilling, to negotiate safer sex behaviour in such a situation. To this social vulnerability is added programme vulnerability: HIV-related information and services are often lacking in the source communities. HIV prevention messages may target men who move but neglect the spouses and partners left at home (Hirsch et al., 2002).

Returns, either permanent or for visits, can also be a source of HIV vulnerability: migrants living in the United Kingdom and visiting home countries have been shown to be more likely than other travellers to engage in sexual relationships during their short stays (Fenton et al., 2001). Migrants who have been away for considerable periods of time often face a range of stresses coming home, including high expectations and social and financial obligations that can increase risk (Ghosh, 2000). Return migrants may also return unwell but have limited access to health services. The strains on their families as they care for their family members who have migrated and who return home with HIV may affect entire communities and may last for generations. Such realities are rarely mentioned in HIV education in either source or destination countries.

When a humanitarian situation subsides, people who return home, or who are repatriated (sometimes after decades in a host country) face an array of challenges when trying to re-integrate and build a new life. Experiences in Mozambique and Angola suggest that vulnerability increases during conflict, but that, as already mentioned, it does not necessarily result in an overall increase in HIV transmission. Rather, the greatest HIV risk may occur in the post-conflict phase, as people move around, return home and often engage in increased unprotected sex with more partners. There are added stress factors and risks for demobilized ex-combatants and the communities into which they reintegrate, including sexual and gender-based violence (Inter-Agency Standing Committee, 2005; UNAIDS, Office of the United Nations High Commissioner for Refugees, 2008).

5. Towards universal access: policy and programmatic responses and services

A wide range of responses and services have been developed to address the HIV-related vulnerabilities and needs of mobile populations. Evidence on the coverage and quality of these policy and programmatic responses is scattered and scarce. Evaluations of programme and policy effects on HIV are even more limited. Nonetheless, it is possible to outline key approaches, and to provide illustrative examples. The examples included below are based primarily on a request to UNAIDS Secretariat regional offices and cosponsors. Other examples of policies and programmes that seek to extend universal access to people on the move will be presented during the Programme Coordinating Board breakout sessions, and in materials available for viewing between sessions.

Policy responses

A number of international and regional conventions, protocols and policy commitments have been made that recognize the rights of migrants in general and their access to health in particular.

⁷ As the epidemic progressed, however, and as HIV prevalence rose in rural areas, the distinction between areas of high- and low-prevalence blurred, and rural epidemics may have become self-sustaining.

These include:

- The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.
- The 2001 United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS, which calls for “national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrant and mobile workers” and also includes wording on refugees and internally displaced persons.
- The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, and the Protocol against the Smuggling of Migrants by Land, Sea and Air.
- The World Health Assembly Resolution on Health of Migrants.

These policy instruments strongly reaffirm that all human rights apply to people on the move, and the governments that have signed the instruments have obligated themselves and their agents to protect these rights and promote universal access to HIV prevention, treatment, care and support for people on the move. These commitments notwithstanding, 59 countries still uphold HIV-related travel restrictions (see Box 7).

Policy dialogue

Dialogue among key ministries within countries (e.g. health, interior, justice, labour, social welfare, education), between different provinces or states of a given country and across national boundaries provides an effective means to promote protection of human rights for people on the move and coherent and consistent access to HIV prevention, treatment, care and support. For example:

- In response to calls from several Asian labour-sending countries, the Ministerial Consultations for Asian Labour Sending Countries were held in 2003 in Colombo—known widely as the ‘Colombo Process’. The ten initial participating countries made recommendations for the effective management of overseas employment programmes and agreed to regular follow-up meetings.
- The Abu Dhabi Dialogue (January 2008) is a dialogue between the 11 Colombo Process countries and nine other Asian countries. The Abu Dhabi meeting recognized the joint responsibility of countries of origin and destination to enforce compliance by recruitment agencies and other parties engaged in the recruitment process with the requirements of national laws and regulations pertaining to the employment of temporary contractual labour, thus providing further protection to workers.
- The Joint United Nations Initiatives on Mobility and HIV and AIDS in Southeast Asia and Southern China brings together governments, leading nongovernmental organization networks and the UN family to promote universal access to HIV prevention, treatment, care

Box 8

ASEAN (Association of Southeast Asian Nations). A regional platform prompts multistakeholder dialogue and regional joint action to promote universal access for people on the move

The ASEAN region has built up a new momentum to advocate for the rights of both migrant populations and HIV-positive citizens. In January 2007, at the 12th ASEAN Summit in Cebu, Philippines, ASEAN leaders adopted two new declarations, namely: ASEAN Commitments on HIV and AIDS and ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers.

Most recently, following-up on the 2007 commitments, a multistakeholder dialogue on HIV prevention, treatment care and support in the ASEAN region brought together for the first time high-level government officials from ASEAN ministries of foreign affairs, health and labour, as well as civil society organizations and UN agencies. Key recommendations endorsed by the participants include: (i) putting into place the necessary policies and legislation to ensure that migrant workers have equal access to HIV prevention, treatment, care and support; and (ii) ensuring that HIV testing of migrant workers adheres to international standards, including informed consent, confidentiality and counselling. The meeting strongly encouraged governments to review laws, policies and practices related to HIV-specific restrictions on entry, stay and residence and to ensure that people living with HIV are no longer excluded, detained or deported on the basis of HIV status.

and support for mobile and migrant populations throughout the migration cycle in a region that provides approximately 70% of global labour migration.

- The Great Lakes Initiative on AIDS is a regional HIV policy and programme response for Burundi, the Democratic Republic of the Congo, Kenya, Rwanda, Uganda and the United Republic of Tanzania to enhance prospects for coordinated approaches. It establishes HIV prevention, treatment, care and mitigation programs for mobile and vulnerable groups such as refugees, transport sector workers and highly affected/infected populations within the region.
- The Intergovernmental Authority on Development (IGAD) Regional HIV/AIDS Partnership Program Support Project seeks to: (i) increase preventative action and reduce misconceptions about cross-border and mobile populations, refugees, internally displaced people, returnees and surrounding host communities concerning HIV prevention, treatment and mitigation in selected sites in the IGAD member States; and (ii) establish a common and sustainable regional approach to supporting these populations in the IGAD member States.⁸
- The South African Development Community Policy Framework on Communicable Diseases in Migrant and Mobile Populations is currently being developed and will address issues of access to health services and harmonization of treatment protocols and prevention efforts.
- A subregional initiative for the ports of the Red Sea and the Gulf of Aden includes pooling human and technical resources between countries, building intercountry referral systems and capacity-building in HIV prevention, treatment, care and support to people living with HIV. The initiative is developing common strategies and policies and enhancing coordination, partnership and communication on policies between national AIDS councils and national AIDS programmes with concerned sectors across countries (e.g. national governments, the UNAIDS Middle East and North Africa Regional Support Team and the International Organization for Migration (IOM)).

Ensuring that policy development platforms include all affected constituencies helps to promote dialogue and joint learning between governments, the private sector and civil society and permits the development of practical strategies that meet the real needs of affected source and destination communities as well as people on the move. These are but a few examples that illustrate the feasibility of multicountry, multistakeholder strategies to activate political leadership, build bridges across national boundaries and develop and share knowledge, in order to engage and reach out to vulnerable populations on the move and meet the need for coordination and harmonization of HIV policies and programmes.

Programme responses

While policies create the enabling environment for action, successful programme responses are essential to ensuring that universal access is extended to people on the move. A range of important response strategies that can be implemented at the national, regional or global levels are apparent in the extensive literature and are presented here to help orientate discussion and creative thinking during the Thematic Segment. These are illustrated with a few of the many available examples of successful applications of these strategies. These strategies are not mutually exclusive. Many strong programmes include multiple strategies.

Example 1. Gathering data, documenting issues and needs

Gathering accurate information on the size and diversity of people on the move, with specific attention to the cross-cutting factors listed in Section 2, is necessary to inform both policy and programmatic actions. Methods that protect human rights, build trust and do no harm (e.g.

⁸ The IGAD members states are Djibouti, Ethiopia, Kenya, Somalia, Sudan and Uganda.

participatory methods, ensuring anonymity, negotiating with authorities for protected space for research, etc.) are essential when populations face stigma and/or a threat of detention or deportation. Below are a few examples of the kinds of information collection that are useful for overcoming barriers to universal access for people on the move that have been undertaken.

- Studies on the HIV dynamics related to labour migration in southern Africa, including HIV vulnerability patterns along major corridors in Namibia and Mozambique, have been recently conducted, as have quantitative and qualitative studies to assess the prevalence of HIV among people on the move in comparison with non-mobile people.
- A review of all laws in the South African Development Community countries pertaining to migrants' access to health services has been carried out.
- A regional baseline assessment and literature review called Addressing the Health Needs of Trafficked Women in East and Southern Africa has been carried out.
- A preliminary analysis of HIV-related risks and vulnerabilities in the ports of Aden and Hodeida, Yemen, was carried out that included the mapping of key nongovernmental organizations and partners that actively work with and have the trust of migrant populations. Partnership with these actors led to overcoming challenges to accessing migrant populations.
- Hot-spot mapping in Somalia generated essential information on HIV risks and vulnerability and led to identification of mobile populations as a key risk group to receive HIV services in a successful Global Fund to Fight Aids, Tuberculosis and Malaria (Global Fund) Round 8 proposal.
- A rapid assessment on HIV and mobility in the 10 ASEAN member countries was recently produced, together with an inventory of all regional organizations working in the same area. This product is aimed at policy-makers and practitioners and will enable better definition of their programmes.
- Behavioural surveillance studies among displaced populations and their surrounding communities are conducted under the Great Lakes Initiative on AIDS and the Internally Displaced Persons Return and Reintegration Assistance Programme to determine HIV behavioural risk factors and HIV prevalence and ensure targeted, comprehensive HIV programmes.
- Joint multisectoral, multiagency HIV situation analyses in internally displaced populations in the Central African Republic, Côte d'Ivoire, the Democratic Republic of the Congo, Nepal and Sri Lanka have been instrumental in gathering basic information in a short period to guide planning of and advocacy for specific HIV programme activities.

Example 2. Raising awareness of, and combating stereotypes, stigma and discrimination against, forcibly displaced people, migrants and mobile populations and informing them of their rights

In order to normalize and sustain HIV information and services for people on the move, it is important to break the myths surrounding migration and mobility and to confront stereotypes and prejudices. Raising awareness with key stakeholders such as immigration officials, social welfare policy-makers, health service providers and HIV programme leaders can help, as research on HIV-related stigma has shown that people who stigmatize are often unaware that their words and actions cause harm, and can communicate the correct picture to the general population.

- A study entitled *HIV Vulnerabilities of Migrant Women: from Asia to the Arab States* focuses on the risks and vulnerabilities of female domestic workers and outlines the prevalence of abuse and marginalization faced by women in the host country as well as upon return. It also cites successful policy responses that origin and host governments have used to protect the rights, dignity and health of non-national employees (United Nations Development Programme, 2009).

- The Partnership on HIV and Mobility in Southern Africa focuses on six sectors characterized by high population mobility and labour migration: construction, transport, commercial agriculture, maritime, mining and informal cross-border trade. It has developed and implemented numerous public awareness activities to raise awareness of the daily challenges of migrants in southern Africa and trains immigration officers on HIV and gender.
- A comprehensive health promotion model to work with migrant-receiving and migrant-sending communities has been developed in southern Africa. The model uses social change communication as the basis for change and encourages reform of the underlying norms and attitudes that stigmatize people on the move involving both beneficiaries and other key stakeholders.
- The Global Task Team on HIV-related Travel Restrictions confronted the myth that travel restrictions largely affect privileged people living with HIV who seek to attend international conferences. The reality is that much greater numbers of labour migrants and tourists are affected by HIV-related travel restrictions (UNAIDS, 2008).
- TAMPEP, the European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers, has developed a multilingual (French, English, Spanish and Russian) web-based directory of health and social support services across 25 European countries (www.services4sexworkers.edu) that aims to strengthen referral routes and increase access to services for sex workers. The website also provides information concerning sex work and migration legislation and the possibilities for health care for migrants in each partner country.
- Tapping into the powerful social networks of migrant construction workers, who often come from the same villages in China, the Hometown Fellows campaign delivers peer education in dormitories and nearby entertainment areas. This was reinforced by group training in companies as well as by educational messages delivered through television and radio in 850 major train stations and on local buses.
- Through drama and theatre, but also through the touring Positive Lives Exhibition, displaced persons and surrounding communities are brought together to discuss issues around HIV-related stigma and discrimination in western Africa.

Example 3. Catalysing and supporting discussion and joint planning between key parties and sectors that do not usually come together, in order to support improved policy formulation, build joint activities and align policies and laws with the goals of universal access (see also the Policy Responses section)

- A number of regional and country consultations in southern Africa have taken place, bringing together stakeholders from governments, civil society and the international community on HIV responses in the transport sector and commercial agriculture sector. These consultations have facilitated an exchange of information and lessons learned and networking and have increased collaboration and cooperation between the key stakeholders. In June 2009, a regional meeting on Migration Dialogue for Southern Africa will be held in the United Republic of Tanzania, which will bring together senior government officials from the ministries of health and home affairs and the national AIDS commissions of the South African Development Community to discuss migrants' access to health in the region.
- Integrating population mobility into national AIDS plans and inclusion of migrants and refugees in UNGASS reviews has also helped raise awareness and the provision of HIV programming for previously neglected groups.
- In Morocco, the first plan on migration and HIV was developed through dialogue between the ministry of health, the ministry of the interior, nongovernmental organizations, migrant associations and international partners. This resulted in programmes for HIV prevention, treatment, care and support for migrants integrated in the national strategic plan on AIDS and financial resources mobilized through the Global Fund.

Example 4. Working upstream to reduce vulnerability in situations and at places known to create vulnerability

The importance of programmes to address the ‘upstream’ causes of vulnerability and risk is widely cited in the literature on people on the move. For example, major construction projects (the Chad pipeline, dam construction sites, road works, etc.) draw workers from far afield and may displace local residents. Organizations, including employers, can invest in safer environments for workers and the affected communities. By protecting the rights and dignity of people on the move, economic stresses that push people into risky behaviour can be lessened or averted.

- The Lower Kihansi hydropower project in the United Republic of Tanzania evaluated the benefits of planning and action to reduce the impact of HIV on the communities affected by the construction project. A health component included HIV communication, condom social marketing, strengthening of health services, including sexually transmitted infection services, and provision of HIV counselling and testing. The project not only improved reported HIV risk behaviour in the affected community, but showed a 50% slower increase in HIV prevalence than in the control areas (World Bank, 2005).
- Anglo American, a global leader in the mining and natural resources sectors, has been recognized for its comprehensive HIV programme that covers both prevention (promoting large-scale voluntary counselling and testing for HIV infection in the workforce and in the surrounding community) and treatment (making antiretroviral therapy available at the

Box 9

Private–public partnership responses for truck drivers

Private companies are increasingly realizing that the costs of caring for employees are a direct threat to business sustainability, as the costs of absences and of replacing and training skilled employees place a considerable financial burden on enterprises and can severely affect profits. For example, a study of a transport enterprise in Zimbabwe found that the total cost to the company arising out of HIV was equal to 20% of profits (Stover and Bollinger, 1999).

The North Star Alliance, a public–private partnership, was founded in 2006. Coordinating with national and regional programmes, as well as local health service providers, North Star has established a network of drop-in health clinics, or wellness centres, at ‘hotspots’ (truck stops, borders, ports) where large numbers of transport workers (truckers, seafarers, railway workers, air crews) and sex workers congregate and sex work and other informal trade flourish. The centres are connected by an IT system; in the near future, clients will be issued an electronic health passport that allows them to access services anywhere in the network.

The centres provide sexual health education, counselling, condoms, HIV testing, treatment for sexually transmitted infections and common work-related ailments, tuberculosis and malaria services and medical referrals. Currently there are eight wellness centres in six countries, with plans for a further 11 in 2009 (Disney, 2009). Extensive research has been done on the transport corridors in southern and eastern Africa, and over 100 potential hotspots, approximately 50 of which are considered high-priority locations, have been identified (De Blois and Thow, 2007).

company’s expense and partnering with the government to reach out beyond the workplace). Through its membership in the Global Business Coalition and the Board of the Global Fund, Anglo American is providing leadership to the private sector on strategies to empower employees and reduce their vulnerability to HIV.

- Jordan’s Ministry of Labour developed a Special Working Contract for Non-Jordanian Domestic Workers from India, Indonesia, Nepal, the Philippines and Sri Lanka in 2001. This memorandum of understanding, negotiated with UNIFEM, established the rights and responsibilities of employers of overseas workers. The contract prohibits employers from withholding the passport and other documents of the worker, requires employers to pay wages aligned with those paid to Jordanian nationals and to pay within seven days of the due date, among other features.

Example 5. Facilitating access to HIV prevention, treatment, care and support

The successful programmes are far too numerous to summarize here, but key elements include: ground-up mobilization of the communities involved, including

capacity development so that affected communities develop and run their own programmes;

providing information and services where the people are, using language and materials that are accessible and culturally appropriate; peer education and mutual support; and continuity, across time and distance. The following provide a few examples:

- In Ethiopia, HIV prevention in the transport sector has been supported since 2001 through a comprehensive approach that includes workplace policy development, company HIV committees, targeted training for and education of truck drivers, condom distribution and materials development. Continued support is being provided for the national sectoral plan for the transport sector and to mainstream HIV prevention into the logistics operations of emergency food relief programs.
- In the textile and apparel industry in Lesotho, the ALAFA nongovernmental organization has facilitated comprehensive HIV workplace programmes covering policy development, prevention and HIV care and treatment. Services are delivered in the workplaces through contracted service providers and have provided access to prevention programmes to 36 000 (86%) workers. A total of 31 000 workers (74%) also have access to care and treatment through workplace clinics.
- In Egypt, the first programme for HIV prevention among refugees was established in 2005. Essential for implementation was partnering with community-based nongovernmental organizations.
- Integration of migrant and refugee population needs in national strategic plans and Global Fund proposals (by Egypt, Morocco, Sudan and Somalia) have resulted in increased awareness and resources for programme implementation and access to antiretroviral drugs in selected countries. This approach helped to counter the policies of providing antiretroviral drugs solely to the citizens of the country.
- Peer outreach in Morocco, where migrants were trained as peer outreach workers integrated in the nongovernmental organization programmes on AIDS. Joint awareness sessions with national nongovernmental organizations helped to overcome the challenges of lack of trust and reluctance to seek services, including voluntary counselling and testing.
- At the national level, some receiving countries, especially in Europe, have had extensive programmes for migrants and ethnic minorities since the 1990s. These focused in the early years mainly on prevention, but more recently there has been increased attention given to care issues (<http://www.aidsmobility.org/index.cfm>).
- In some labour-exporting countries (e.g. Cambodia, Indonesia, the Philippines and Viet Nam), intending migrant workers receive HIV education before departure, which, among other things, informs them where they can get help if necessary while abroad. Some programmes, such as peer education sessions implemented by ACHIEVE in the Philippines and interactive learning sessions developed by the National Board of Placement and Protection for Indonesian Overseas Workers target migrant women domestic workers.
- Programmes for migrants in their host countries include the PHAMIT (Prevention of HIV/AIDS among Migrant Workers in Thailand) programme, which provides information on HIV and reproductive health to migrants and distributes targeted materials in the migrants' languages. This strategic partnership between eight nongovernmental organizations and the ministry of health has created 38 drop-in centres that provide information and referral to services located near migrants' workplaces.
- The Cambodian Ministry of Public Works and Transport adopted a policy mandating HIV education in the transport sector, such as professional training programmes in driving schools, in 2006. However, in the absence of adequate human and financial resources, challenges remain in implementing such policies and plans.
- Some governments are taking steps to integrate mobile populations into the national response: Lesotho and Zambia both make explicit reference to mobile populations, including transport workers, in their national AIDS plans. The South African Department of Transport has had an HIV and AIDS strategic plan since 2001.

- In Ecuador, the National Network of Sex Workers is working with UNHCR and UNFPA to ensure access to youth-friendly reproductive health and HIV services. Peer education and awareness campaigns have been organized in order to encourage attitude and behaviour change, as well as to improve the knowledge and capacity of adolescents to protect their own health.
- Continuation of antiretroviral therapy for a large number of people during the post-election violence in Kenya was challenging, since many were displaced and services were disrupted. Within a week, the ministry of health issued an advertisement on antiretroviral therapy interruption management, and within a few weeks Médecins sans Frontières had established a toll-free telephone hotline for antiretroviral therapy service information.

Example 6. Monitoring and evaluation, sharing information, documenting policy implementation, problems and abuses and using them for advocacy

- The emergency home-based care programme in Zimbabwe had an elaborate monitoring and evaluation system that helped inform and strengthen the monitoring and evaluation of the regular home-based care programme within the national response post-emergency.
- The Canada South East Asia Regional HIV/AIDS Programme (CSEARHAP) (2004–2008) was a five-year regional programme to implement the regional strategy of the UN Regional Task Force on Mobility and HIV Vulnerability Reduction, to implement the Regional Strategy of the Task Force in four greater Mekong subregion countries (Cambodia, the Lao People’s Democratic Republic, Thailand and Viet Nam) with a budget of US\$5 million. While this funding ended in December 2008, CSEARHAP’s key activities included participatory policy self-audits, which reviewed the implementation of international, regional and national agreements on HIV and mobility.

6. Conclusion and points for discussion

Mobility in all its forms is a defining feature of the 21st century. It is beneficial when people affected by humanitarian emergencies can move to a safer place. It is beneficial when people can freely seek employment, study and recreation beyond their national borders. Migration has become a part of the economic functioning of many countries—both those countries that send and those that receive migrants. However, people on the move are often not perceived as individuals with rights. Without action to educate governments, civil society and mobile people themselves about their rights, and depending on the resources available to them on their journey, mobile people can be exploited, subjected to unequal pay and working conditions, and marginalized and stigmatized throughout the migration, mobility or displacement process. Studies show that mobile populations are vulnerable to discrimination, exploitation and harassment at home and abroad. People on the move often have little or no access to legal or social protection, and many countries deport foreign nationals due to their HIV status, the authorities declaring them as ‘unfit’ to work abroad, resulting in a severe economic loss for migrant workers and their families.

Given the large numbers of people on the move, ensuring their rights and access to HIV prevention, treatment, care and support services is a crucial component of an effective regional response to AIDS. The analysis presented in Sections 1–4 makes several key points about how to achieve this. First, it highlights that mobility is a process that affects not only the person who moves but also their communities of origin and destination, and the people encountered on the way. Mobility is dynamic, and HIV-related programmes for people on the move are stronger, more coherent and more humane when they can consider the whole migration cycle. Second, people move for many reasons, and many of the reasons are beyond the individual’s control. However, it is the conditions under which people move that cause the social and programme vulnerability that impedes access to the required HIV prevention, treatment, care and support. Governments, businesses, civil society and the UN have roles to play in defining the harmful conditions, and in changing them for the better. Third, a wide range of policy and programmatic responses demonstrate that providing access to HIV prevention, treatment, care and support to mobile populations is indeed possible. Removing barriers that prevent people on the move from protecting

their own health and wellbeing is sometimes just a matter of reaching out across institutional, sectoral and national boundaries to provide a harmonized and effective continuum of HIV prevention, treatment, care and support services.

More examples, from a wider array of countries, will be represented during the Thematic Segment breakout panels and in the Gallery Walk. The objective of the Thematic Segment is to share and disseminate such experience, so that people attending the Programme Coordinating Board meeting can be informed, and can identify policy and programme actions that should be advocated



and supported. A scaled-up and strengthened international response to the issues of HIV and mobility will ultimately result in improving the lives and welfare of people on the move, and this Thematic Segment offers the opportunity to consider and identify practical actions that can be taken and advocated by governments, civil society and UNAIDS Cosponsors and partners.

The following points can be considered in the breakout session discussions, and in follow-up actions after the Thematic Segment day.

Photo credit: United Nations Development Programme, 2008.

Data

High-quality and comprehensive data are essential for defining the problems and needs of diverse people on the move, and to convince communities and governments that negative stereotypes about migrants, refugees and displaced people are invalid. Rigorous evaluation of policies and programmes is more than ever required in order to demonstrate that funding is being spent effectively. Yet experts have sometimes hesitated to gather and publish data about migrants, ethnic minorities, refugees, asylum seekers or other mobile groups, partly for fear of further stigmatizing populations that are already stigmatized. In addition, among other challenges, the populations concerned are often hard to reach, and both numerators and denominators are poorly defined. It is critical that knowledge about effective programming and analyses of failures are shared.

Some examples of effective, rights-based data gathering and knowledge-sharing exist, including strategies that engage the communities concerned. What are the lessons learned for overcoming obstacles to gathering the needed data, while respecting the rights and the trust of the populations? What research is most needed? Are there other strategies for supporting evidence-informed advocacy and for increasing programme effectiveness?

Box 10

Access to care in humanitarian emergencies

Populations affected by conflict have been largely excluded from international discourse on, and funding for, HIV treatment and care, largely because it was felt that providing safe and effective access to antiretroviral therapy requires a stable health infrastructure, the very thing that is often lacking in humanitarian emergencies. Refugees, however, often live for years in relatively stable settings in their host countries (by the end of 2003, refugee populations remained in their host countries for an average of 17 years). Furthermore, the concern about possibly creating antiretroviral therapy resistance by stopping and restarting therapy is not necessarily more warranted for conflict-affected populations than for other populations. Moreover, ensuring continuation of treatment during a crisis is crucial, for HIV and also for opportunistic infections, including tuberculosis (Inter-Agency Standing Committee, 2004). It has been shown, in fact, that with appropriate contingency planning and managed treatment interruption plans, the risks associated with non-adherence or interruptions due to humanitarian situations can be minimized (Samuels and Spraos, 2008; Westerbarkey, 2009; Olupot-Olupot et al., 2008; Office of the United Nations High Commissioner for Refugees, 2007b).

An antiretroviral medication policy for emergency contexts has been developed, as have clinical guidelines on antiretroviral therapy for displaced populations (Office of the United Nations High Commissioner for Refugees, 2007a, 2007b).

An example is Zimbabwe, where, as a result of 'Operation Murambatsvina', the number of chronically ill people assisted decreased drastically. Home-based care programmes were developed in which community volunteers were trained to provide people living with HIV with basic nursing and palliative care, as well as to give guidance on the nutritional requirements that are essential for effective HIV treatment. Faith-based organizations played a critical role in this effort, including in ensuring continuation of HIV services, as they were able to access the caseloads in a highly politicized environment.

organizations have about including people on the move, and how can these concerns be overcome? How should HIV be linked to other social and health issues without losing impact and cost-efficiency?

Reaching out

Dialogue and cooperation across groups, sectors and national boundaries are essential to address the challenges of issues ranging from social exclusion to the 'brain drain' of health workers, and from continuity of AIDS treatment to reduction of irregular migration. Cooperation between sending and receiving countries, but also—since national programmes are more likely to deal with people who are citizens of the country in question—diaspora communities, international agencies, nongovernmental organizations and the private sector, is also essential. Communities in destination countries can reach out to migrants, refugees and displaced people, and can hold their leaders accountable for providing the required support.

A number of statements, agreements and protocols have been made, and there are some examples of successful regional or cross-border collaboration. In addition, the AIDS field has created a remarkable range of alliances of people from very different points of view who work

Inclusion

Many of the groups covered under the term 'population mobility' are marginalized in the societies in which they live. Their concerns are often ignored, especially when their presence serves as a reminder of social divides, conflicts or other economic and social inequalities. Particularly in a climate of limited and shrinking financial resources, there may be a tendency to fall back on protecting the welfare of local people, and to scapegoat new people or outsiders ('us' rather than 'them').

There are, however, examples of innovative and creative programming that promote inclusion, reduce social and programme vulnerability and provide access to effective HIV prevention, treatment and care at various phases of the mobility process.

How do the successful programmes include and engage people who are on the move or are returning home without marking them or otherwise increasing stigma? What concerns do governments, private sector employers, faith-based groups and other community

effectively together towards a common goal. What lessons can be learned from each of these, and applied to the field of HIV and population mobility?

Communication and advocacy

People on the move, and their communities of origin/return and destination, are woefully uninformed, or misinformed, about their diverse realities and their universal human rights. Effective advocacy is necessary if displaced, migrant and mobile populations are to be included in national, regional and international AIDS policies and programming in a way that respects their dignity and human rights. Undocumented migrants and forced migrants, including victims of trafficking, may have the greatest need and yet face the greatest barriers to universal access.

A range of stakeholders have effectively advocated for the HIV-related rights and needs of people on the move. What lessons learned can be extracted to guide others who might advocate? Are they speaking to the right people? Specifically, what roles can and should be taken by UNAIDS, governments, employers and civil society, including the communities or groups affected? How can they best support one another? What special dangers are to be expected due to the current global economic crisis? Are special evidence-based advocacy efforts needed in order to manage the impact of the crisis on people on the move and their communities?

Annex 1

Some key definitions:

Migration: a process of moving, either across an international border, or within a State. It is a population movement encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people and economic migrants.⁹

Forced migration: general term used to describe a migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes (e.g. movements of refugees and internally displaced persons as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects).¹⁰

Mobile populations: people who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons.¹¹

Economic migrant: a person leaving his/her habitual place of residence to settle outside his/her country of origin in order to improve his/her quality of life. It also applies to persons settling outside their country of origin for the duration of an agricultural season, appropriately called seasonal workers.¹²

Migrant worker: a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national.¹³

Internally displaced person: persons or groups of persons who have been forced or obliged to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.¹⁴

Irregular migrant: someone who, owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorized to remain in the host country (also called clandestine/illegal/undocumented migrant or migrant in an irregular situation).¹⁵

Undocumented migrant: foreign citizens present on the territory of a State, in violation of the regulations on entry and residence, having crossed the border illicitly or at an unauthorized point: those whose immigration/migration status is not regular, and can also include those who have overstayed their visa or work permit, those who are working in violation of some or all of the

⁹ International Organization for Migration. *International Migration Law: Glossary on Migration*. Geneva, International Organization for Migration, 2004, p. 41.

¹⁰ International Organization for Migration. *International Migration Law: Glossary on Migration*. Geneva, International Organization for Migration, 2004, p. 25.

¹¹ International Organization for Migration/UNAIDS. *Population Mobility and AIDS: Technical Update*. Geneva, UNAIDS, 2001.

¹² International Organization for Migration. *International Migration Law: Glossary on Migration*. Geneva, International Organization for Migration, 2004, p. 21.

¹³ United Nations. *1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*. General Assembly resolution 45/158, 18 December 1990. Available at: www2.ohchr.org/english/law/cmw.htm.

¹⁴ United Nations. *Guiding Principles on Internal Displacement*. UN Doc E/CN/4/1998/53/Add.2. New York, United Nations, 1998.

¹⁵ International Organization for Migration. *International Migration Law: Glossary on Migration*. Geneva, International Organization for Migration, 2004.

conditions attached to their immigration status: and failed asylum seekers or immigrants who have no further right to appeal and have not left the country.¹⁶

Refugee: people who are outside their country of nationality or habitual residence, and have a well-founded fear of persecution because of their race, religion, nationality, membership of a particular social group or political opinion. People fleeing conflicts or generalized violence are also generally considered as refugees, although sometimes under legal mechanisms other than the 1951 United Nations Convention Relating to the Status of Refugees.

Asylum seeker: someone who has made a claim that he or she is a refugee, and is waiting for that claim to be accepted or rejected. The term contains no presumption either way - it simply describes the fact that someone has lodged the claim. Some asylum seekers will be judged to be refugees and others will not.

Risk: probability that a person may acquire HIV infection. Certain behaviours create, enhance and perpetuate risk, e.g. unprotected sex with a partner whose HIV status is unknown, multiple unprotected sexual partnerships, injecting drug use with contaminated needles and syringes.¹⁷

Vulnerability: results from factors that reduce the ability of individuals and communities to avoid HIV risk; these include: (i) personal factors (lack of knowledge, skills) (ii) factors pertaining to the quality and coverage of services, (iii) societal factors, e.g. social and cultural norms, practices, beliefs and laws that stigmatize and/or disempower certain populations.¹⁸

¹⁶ UWT/Undocumented Worker Transitions. *Undocumented Migration Glossary*. Work Package 5, EU Sixth Framework Programme Contract Number: 044272, prepared by the Roskilde University and Working Lives Research Institute, with contributions from all project partners, 2008.

¹⁷ UNAIDS. Addressing societal causes of HIV risk and vulnerability. *Report on the Global AIDS Epidemic 2008*. Geneva, UNAIDS, 2008.

¹⁸ Ibid.

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