Migrants' Right to Health

UNAIDS *Best Practice* Collection

KEY MATERIAL

Acknowledgements

Migrants' Right to Health
Text by Margaret Duckett
Paper prepared for UNAIDS and the International Organization for Migration.
All aspects of the publication process were coordinated by the Information Centre, UNAIDS, Geneva.

UNAIDS/01.16 E (English original, March 2001)
ISBN: 92-9173-057-2

© Joint United Nations Programme on HIV/AIDS (UNAIDS) 2001. This document is not a formal publication of UNAIDS and IOM and all rights are reserved by these bodies.

The document may, however, be freely reviewed, quoted, reproduced or translated, in part or in full, provided the source is acknowledged. The document may not be sold or used in conjunction with commercial purposes without prior written approval from UNAIDS (contact: UNAIDS Information Centre).

The views expressed in documents by named authors are solely the responsibility of those authors.

The designations employed and the presentation of the material in this work do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers and boundaries.

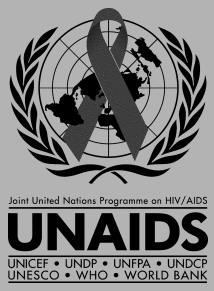
The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by UNAIDS in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

UNAIDS - 20 avenue Appia - 1211 Geneva 27 - Switzerland
Telephone: (+41 22) 791 46 51 - Fax: (+41 22) 791 41 87
E-mail: unaids@unaids.org - Internet: http://www.unaids.org

UNAIDS

BEST PRACTICE COLLECTION

Migrants' Right to Health



Geneva, Switzerland
March 2001

No man is an island entire of itself; every man is part of the main . . . Any man's death diminishes me because I am involved in mankind, and therefore never send to know for whom the bell tolls; it tolls for thee.

John Donne, 1572-1624

"Devotions Upon Emergent Occasions," Meditation 17, 1624.

Affluent and mobile people are ready, willing, and able to carry afflictions all over the world within 24 hours' notice.

Joshua Lederberg, Rockefeller University 1997

"Infectious Disease as an Evolutionary Paradigm", Emerging Infectious Diseases, Vol. 3, No. 4, October - December 1997

Given the migration within the region, HIV/AIDS can never be eradicated for as long as other countries take a laissez faire approach and remain reservoirs of infection.

Marvellous Mhloyi, University of Zimbabwe 1999

"The Challenge of the Current HIV Paradigm: Why has it not worked?" Plenary

Table of Contents

Summary v
I. Introduction..... 1
II. Setting the scene..... 3
III. Balancing international treaties versus States' rights..... 13
IV. Access to health..... 21
V. Promising approaches to explore/expand in the future..... 30
VI. Implications for policy-makers..... 38
VII. Conclusion..... 40
Recommendations..... 41
Appendix. International instruments (and relevant clauses)..... 42
Bibliography..... 45

Summary

The world is on the move.

Every year, over one million people emigrate permanently and in most years, nearly as many seek asylum. If we include in-country mobility, then there are probably two billion people on the move globally each year.

This paper addresses some of the issues involved in relation to the rights of migrants to health.

Firstly, there is no agreed definition of what is a migrant. Each country uses its own definitions in its regulations as to categories of travellers, migrants and new settlers. The paper utilizes a broad definition of migrants that encompasses all aspects of mobility in any population.

Secondly, what is encompassed in relation to rights to health? The Constitution of the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." In relation to non-citizens, most countries have defined their health-related obligations in terms of essential care or care in emergency situations, with this concept being interpreted in different ways in different countries. Health care professionals often play a crucial role in deciding if a situation can be called an emergency. Could all health issues related to HIV/AIDS[1] be seen as falling within a global emergency?

This paper argues for a number of changes to improve migrants' health (particularly in regard to HIV/AIDS, other sexually transmitted infections and reproductive health), at global, national and local levels. In summary, these include:

- Acknowledgment of the right to the highest attainable standard of physical and mental health. In relation to migrant populations, this might require attention to the right to affordable and accessible health services, the right to healthy working and living conditions, and the right to appropriate health education.
- Attention to, and compliance by all countries with international treaties and agreements to which they are a party, and to relevant international customary law. It appears that many countries sign international treaties/ agreements but do not put in place the measures required for compliance with the letter and spirit of such agreements.
- General application of, and compliance with, the International Health Regulations.
- Measures to ensure major that sending, transit and receiving countries have joint/ tripartite health access programmes in place to address all possible time and place points on the moving continuum for citizens/migrant workers, including pre-departure, the migration itself, the initial period of adaptation, successful adaptation, return migration, and reintegration into the original community.

[1] HIV = human immunodeficiency virus, AIDS = acquired immunodeficiency syndrome.

- Health care services for travellers and migrant populations that move beyond emergency care, and address physical, mental and social well-being, particularly in relation to HIV/ AIDS, other sexually transmitted infections, and reproductive health.
- Greater attention to prevention in health service policy and delivery for migrant/ mobile populations, including widespread development and implementation of community-level interventions.
- For migrants and for mobile populations within countries, measures to ensure good access to health-related HIV/AIDS/STD/reproductive health prevention and care for all members of such populations. For example, appropriate health education may require the production of highly specific information material in a range of languages.
- Attention to the gender disparities often involved in migrant movements, both within countries and across borders, and to gender/ power relationships which frequently govern women's access to information and health care.
- Understanding by major sending countries that contributions to the Gross National Product by migrant workers sending money back to their families may be balanced by pressure placed on health and social services, if a migrant worker returns to their home country ill or disabled.

The paper outlines key existing laws, policies and best practices in relation to the rights of migrants to health, and associated care, treatment, support and prevention, particularly in relation to HIV/AIDS/STD and reproductive health. The paper uses this framework of existing laws and policies to address ethical and economic dimensions, and to consider the effects of globalization and the implications of policies for migrant health. It concludes with recommendations for the development of policies to improve the health status of migrant populations.

Section Two of the paper sets the scene: A number of papers have documented an association between human mobility and an increased risk of HIV infection. However, being a migrant, in and of itself, is not a risk factor; it is the activities undertaken during the migration process that are the risk factors.

The International Labour Organization (ILO) recently estimated that over 90 million people (migrant workers and their families) are currently residing, legally or illegally, in a country other than their own. Some countries are major senders of migrants, some major receivers, and in many cases, countries are both substantial senders and receivers of migrants. Movement within and between countries may often be focused on particular regions, with some regions in a country having disproportionately large numbers of population movement.

A number of reports have documented the reduced access to health care and the health consequences for migrants in many parts of the world. In general, the tendency for migrants to have less access to health care and resultant poorer health status is more marked for recent arrivals or for 'groups' who are otherwise more socially disadvantaged in the host society. In addition, migrant workers with health problems often return to their home countries.

Migration and gender issues are inextricably linked. Despite the perception that a typical migrant is male, the ILO *Migrant Workers Report* notes that about half the entire 1999 migrant population worldwide is female, with concomitant increased vulnerability to exploitation and abuse.

Any international concerns in relation to movements of peoples are not expected to self-resolve. Substantial global movement of peoples is expected to increase during the coming years, with the numbers and proportion of illegal and marginalized migrants also expected to increase significantly.

Section Three of the paper considers issues involved in balancing international treaty obligations versus States' sovereignty, focusing on relevant declarations and treaties, the use of the International Health Regulations in respect of international spread of disease, and the effect of globalization. Section Four discusses access to health in terms of the financing of health care, the "new" public health, levels of access, the priority for early intervention, and the scope of intervention. Section Five describes a number of projects illustrative of some of the promising interventions under way in different parts of the world. Section Six outlines some of the particular implications for policy-makers of issues addressed within the paper.

The paper highlights a number of significant issues for policy-makers, including:

- The positive and negative effects of globalization;
- The ethical and economic imperative to ensure health care access for mobile and migrant populations;
- The real-life limitations on individual State's rights imposed by an international epidemic; and
- The need to address all time and place points on the moving continuum, including pre-departure, the migration itself, the initial period of adaptation, successful adaptation, return migration, and re-integration into the original community.

Progress in preventing the spread of HIV to and from migrants, and ameliorating the impact of HIV upon HIV-infected migrants has been made. Projects addressing other sexually transmitted infections and reproductive health for migrants and mobile populations are available in a number of countries and settings. The challenge now is to address more comprehensively the complex issues involved, in all countries and at all levels.

I. Introduction

The world is on the move.

In 1995 the World Bank estimated that at least 125 million people lived outside their country of origin.[2] Every year, over one million people emigrate permanently and nearly as many seek asylum. However, if short-term visitors are included in the definition of mobile people, then there are over one billion international travellers every year. In some tourist destination countries, the annual number of short-term visitors exceeds the resident population.[3] If we include in-country mobility, then there are probably two billion people on the move globally each year.

There is no agreed definition of what is a migrant. Haour-Knipe and Rector[4] devoted several pages to their definition(s). As summarized by Decosas and Adrien:[5] "Migrants may be defined by their legal status or ethnicity, or migration can be categorized using parameters of duration, motivation, and distance. If we exclude short-term visitors (tourists, for example), the most important categories are labour migration, refugee migration, resettlement migration, internal migration, and commuting." Lurie[6] uses a different approach: "most studies simply classify people as either 'migrants' or 'non-migrants'. In reality the situation is considerably more complex; there are in fact many different types of migration, and each type may carry with it different risk factors. In addition, people's migration status is likely to change several times over the course of their lives."

Each country uses its own definitions in its regulations as to categories of travellers and migrants. International law distinguishes between people who are and are not national, e.g. citizens, aliens, immigrants, and recognizes other specific categories, e.g. refugees, asylum-seekers, migrant workers.

This paper will utilize a definition of migrants that encompasses all aspects of mobility in any population. The paper will focus on people who are currently crossing or have ever crossed borders. These include people mobile for professional and educational reasons, as well as youth. Excluded from this paper will be refugees (covered elsewhere) and ethnic minority communities (for whom the issues may be quite different). The issues for refugees are similar to those for all migrants, but the basic problems are usually exacerbated. As noted by many authors, including Forrest:[7] "forced or unplanned migration due to civil or natural disaster presents significant stress on populational health status and nutrition, medical care and public health systems, favouring emergence and dissemination of disease."

---

[2] World Bank. *Workers in an Integrating World: World Development Report 1995*. Oxford, Oxford University Press, 1995

[3] Hendriks A. "The right to freedom of movement and the (un) lawfulness of AIDS/HIV specific travel restrictions from a European perspective." *Nordic Journal of International Law* 59: Fasc. 2/3, 1990

[4] Haour-Knipe M and Rector R. *Crossing borders: migration, ethnicity and AIDS*. London, Taylor & Francis, 1996

[5] Decosas J and Adrien A. "Migration and HIV". *AIDS* 1997, 11 (suppl. A): 577-584

[6] Lurie M, Garnett G, Abdool Karim S, Sturm W, Wilkinson D, and Williams B. *Research Protocol. Migration and the Spread of HIV and Other Sexually Transmitted Diseases in South Africa: Interlocking Urban and Rural Cohort Studies*. January 1998

[7] Forrest DM. "Control of Imported Communicable Diseases: Preparation and Response". *Canadian Journal of Public Health*, Vol. 87, No. 6. November-December 1996 p369

The paper outlines key existing laws, policies and best practices in relation to the rights of migrants to health, and associated care, treatment, support and prevention, particularly in relation to HIV/AIDS/STD and reproductive health matters. The paper uses this framework of existing laws and policies to address ethical and economic dimensions, and to consider the effects of globalization and the implications of policies for migrant health. It concludes with recommendations for the future development of policies to improve the health status of migrant populations.

II. Setting the scene

A. Migration and mobile populations

The International Labour Organization (ILO) recently estimated[8] that over 90 million people (migrant workers and their families) are currently residing, legally or illegally, in a country other than their own. It should be noted that this lower estimate, compared with the 1995 estimate by the World Bank of 125 million people living outside their countries of origin, does not include people who had officially changed their original nationality.[9] Table 1 below (taken from the ILO report) breaks down this figure by region.

Table 1. Estimate of the number of non-nationals by major region in 1995, excluding asylum-seekers and refugees (in millions) [10]

Region	Economically active	Dependants	Total
Africa	6–7	12–14	18–21
North America	8	8–10	16–18
Central and South America	3–5	4–7	7–12
South, South-East & East Asia	2–3	3–4	5–7
West Asia (Arab States)	6	2–3	8–9
Europe	11–13	15–17	26–30
Overall Totals	**36–42**	**44–55**	**80–97**

Some countries may be major senders of migrants, some major receivers, and in many cases, countries may be both substantial senders and receivers of migrants. The ILO has stated that in 1990, over 100 countries were major senders or receivers of migrant labour, with 68 countries listed as major receivers, 56 as major senders, and 24 as both a sending and receiving country.[11] Italy, Japan, Malaysia and Venezuela were noted to be among the new major receiving countries, and Bangladesh, Egypt and Indonesia among the new major senders.

[8] ILO. *Migrant Workers, International Labour Conference, 87th Session 1999, Report III (Part 1B)*. Geneva, 1999
[9] The lower estimate by the ILO may be due to naturalized citizens being excluded as part of migrant populations, but included within the World Bank scope of people living outside their country of origin.
[10] The estimate refers to foreign passport-holders, not to foreign-born persons because the latter include an unknown proportion of naturalized persons who no longer hold the nationality of their country of origin. The figures given here include both regular migrants and migrants whose status may be irregular as regards entry, stay or economic activity.
[11] ILO. *Migrant Workers*, 1999, op. cit., p4

In 1996 about 7 million (~3%) of the United States population were born in Mexico. Of these, 2.7 million were estimated to be unauthorized migrants. Between 80 and 90 per cent of these migrants are male, mostly single or unaccompanied, between 15 and 34 years of age.

Movement within and between countries may be disproportionately heavy in some regions: in a region of Ziguinichor, Senegal, 82% of men aged between 20 and 40 migrate each year.

However, despite the perception that a typical migrant is male, the ILO *Migrant Workers Report* notes that about half the entire 1999 migrant population worldwide is female.[12] The *Report* draws the attention of governments to the particular vulnerability to exploitation and abuse of women migrant workers: "No longer only to be found among accompanying family members, women now make up an increasing proportion of migrant workers: for instance, nearly half a million Sri Lankan women are working in the Middle East, while there are 12 women for every man among migrants from the Philippines to other Asian countries… The Committee notes in particular the increasing tendency to 'import' women migrant workers for commercial – including sexual – exploitation through arranged marriages with foreigners or by getting them to sign contracts of employment that look tempting but rarely reflect the real situation. Their vulnerability lies principally in the fact that they are employed abroad and hence outside the legal protection of their country of origin, but is also due to the fact that they often hold jobs for which there is little protection under social legislation: domestic workers, manual workers (in agriculture, factories or export processing zones), hostesses or entertainers in nightclubs or cabarets, etc. Their situation is made worse by the lack of autonomy and the strong relationship of subordination that are typical of the jobs usually held by these workers; added to this is the fact that these women are usually young and poor, living in fear of losing their jobs, having had to leave their families in their countries of origin, do not speak the language of the country of employment, are unaware that they have rights that are being infringed, and usually do not know where to go for help."

Migration and gender issues are inextricably linked. As Singhanetra-Renard[13] notes "Since women migrants almost invariably possess lesser bargaining power and legal rights than locals and particularly local men, the role of migration in the victimisation of women, and thus, the spread of HIV infection, cannot be ignored." In addition, a particular risk for women migrants is the wide scale and syndicated trafficking of women worldwide. These women, most of them very young and from economically depressed countries or communities, may be forced into sex work, frequently including unprotected sex.[14]

[12] ibid, p105
[13] Singhanetra-Renard A. "Population movement and the AIDS epidemic in Thailand", Paper presented at the IUSSP Seminar on Sexual Subcultures and Migration in the Era of AIDS/ STDs, Bangkok, Thailand, March 1994, p14
[14] Ybanez RFC. "Breaking Borders: Migration and HIV/AIDS" *AIDS action*, Issue 40, July-September 1998

There are often specific pressures placed on workers who migrate. A WHO Background Paper on Long Term Travel Restrictions and HIV/AIDS[15] notes: "Newly industrialized States may welcome migrant workers. But at the same time, they may seek to prevent such workers from acquiring long term settlement rights, so they can be sent home if they cease to be economically useful because of changing labour demands or because of age, illness or disability. Fixed term employment contracts and work permits may be imposed on migrant workers to ensure that they provide the employer and host country with a 'rotating stock of temporary labour'.[16]

The ILO has noted that, in general, countries adopt three approaches to social policies involving migrants:

- countries which accept migrants for permanent settlement on entry, such as Australia and Canada, appear more likely to favour social policies aiming at both social integration and 'multiculturalism'
- countries which issue permanent resident status after a number of years in the country are more likely to focus on 'assimilationist' policies
- countries who view migrants as primarily temporary workers are likely to favour voluntary repatriation and reintegration assistance. For example, Germany does not admit migrants for permanent settlement on entry, and devotes much of its social policy objectives to encouraging voluntary repatriation through the institution of the Coordinating Agency for Promoting the Reintegration of Foreign Workers.

Germany has become one of the main migratory destinations in Europe. Officially, almost 10% of the population is composed of migrants. However, if those living and working irregularly were included, the percentage would be significantly increased.

There are also three types of provisions relating to illegal immigration in national laws and regulations: those directed at migrant workers in an irregular situation; those aimed at punishing persons who organize or facilitate clandestine or illicit migrations; and those penalizing the illegal recruitment and employment of migrant workers. The ILO[17] noted with concern that measures to combat clandestine movements of migrants were advocated to be targeted at the demand for clandestine labour rather than the supply; however, in practice, sanctions against migrants in an irregular situation are very widespread, both in sending and receiving countries. Sometimes these sanctions may be directed against the dependants of illegal migrants rather than the migrants themselves: for example, an Amendment in California, United States, in 1996, which attempts to discourage irregular immigration by barring children of undocumented migrants from state-funded education (from kindergarten to university).

[15] WHO. *Background Paper: Long Term Travel Restrictions and HIV/AIDS*. WHO Global Programme on AIDS, October 1994, p4

[16] Papademetriou DG. "International migration in North America and Western Europe: trends and consequences" In Appleyard R (ed). *International migration today: Volume 1, trends and prospects*. Paris, UNESCO, 1988, as quoted in WHO Background Paper, ibid.

[17] ILO. *Migrant Workers*, 1999, op. cit., p130

Between 1989 and 1996, there were more than 900,000 refugees, 1.1 million internally displaced persons, and 4.2 million repatriates in the Commonwealth of Independent States (CIS). Environmental degradation has also resulted in hundreds of thousands of ecological migrants. In addition, legal and illegal transit migration increased. Between 500,000 and one million illegal migrants, particularly Afghans, Iranians, and Iraqi Kurds, are estimated to be living in the Russian Federation alone. Emigration, largely to the CIS, has increased dramatically from countries with ongoing armed conflict, such as Armenia, Georgia, and Tajikistan.

With some notable exceptions, the greatest number of current migrants have moved for economic reasons, and in contrast with most other such movements, the age composition of the migrant population is very similar to that of the general population.

As noted in the UNAIDS Technical Update on Migration and HIV/AIDS[18], population movement has increased in recent years because of:

- greater availability of rapid and (relatively) inexpensive air transport
- opening of once-closed borders, notably in Eastern European countries and the Commonwealth of Independent States (CIS), South Africa, and Economic Free Zones along China's east coast
- rising international trade and commerce, along with deregulation of trade practices and promotion of regional free trade
- increasing awareness of these imbalances including by populations in poorer countries.

Substantial global movement of peoples is only expected to increase during the coming years. Migration has always been based on the desire for greater prosperity and/or escape from civil or natural disasters. By the year 2000, only some 20% of the world's population will live in developed countries, and economic polarization may contribute to increased migration. Similarly, as noted by Gellert,[19] environmental problems associated with increasing industrialization such as rising sea levels from global warming, desertification and deforestation, may lead to significant increases in the numbers of ecological refugees.

Given the growth in the numbers of countries adopting policies to lower immigration,[20] combined with this external pressure of increased global movement, the numbers and proportion of illegal and marginalized migrants in many countries can also be expected to increase substantially in the future.

[18] UNAIDS. *Technical Update on Migration and HIV/AIDS*, UNAIDS, 2000
[19] Gellert GA. "International Migration and Control of Communicable Diseases", *Soc. Sci. Med*. Vol. 37, No. 12, 1993, pp1489 - 1499
[20] See, for example, *Crossing Borders*, op. cit.

B. Health needs and equity

Health has been recognized as a fundamental human right. The Constitution of the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." In relation to non-citizens, most countries have defined their obligations in terms of essential care or care in emergency situations, with this concept being interpreted in different ways in different countries. Even in relation to officially accepted migrant workers, special arrangements to ensure real equity in access to health (compared with nationals) are rarely put in place.

There have been a number of reports documenting the reduced access to health care and the health consequences for migrants in many parts of the world.[21] Bollini and Siem argue that the poor health outcomes observed are linked to the lower entitlements for migrants and ethnic groups in the receiving countries.[22] They note: "Not only are they exposed to poor working and living conditions, which are *per se* determinants of poor health, but they also have reduced access to health care for a number of political, administrative and cultural reasons which are not necessarily present for the native population, and which vary in different societies and for different groups. Language, different concepts of health and disease, or the presence of racism are examples of such selective barriers."[23]

Of course, 'migrants' do not form a homogeneous group–Bollini and Siem note that the general trend to poor health outcomes may vary from one group of migrants to another and for individuals within a group–however, the general statement holds true in most parts of the world.

In general, the tendency for migrants to have less access to health care and resultant poorer health status is more marked for recent arrivals or for 'groups' who are otherwise more socially disadvantaged in the host society (e.g. North Africans in France, Bangladeshis in the United Kingdom, Indonesians in Malaysia). Tan[24] offers the term 'ethnic distance' to illustrate the elements of cultural differences and risk inherent in moves from one country to another, even where the same sending and receiving countries are involved. Using an example of two nationals of the Philippines moving to Hong Kong for work purposes, Tan notes that the ethnic distance for a young Filipina from a small village going to work as a domestic helper in Hong Kong is much greater than that for a young Filipino male executive also going to Hong Kong to take up a job with a multinational corporation. In cases where the sending and receiving countries are highly disparate in cultural values, this ethnic distance can be even more substantial.

[21] See, for example, European Project AIDS and Mobility: *AIDS & STDs and Migrants, Ethnic Minorities and other Mobile Groups; the State of Affairs in Europe*, de Putter J (ed.). June 1998; Haour-Knipe M and Rector R. *Crossing borders: migration, ethnicity and AIDS*. London, Taylor & Francis, 1996; ILO: *Migrant Workers*, International Labour Conference, 87th Session 1999, Report III (Part 1B). Geneva, 1999; Mishra SI, Conner RF and Magana JR (eds.) *AIDS. Crossing Borders: The Spread of HIV Among Migrant Latinos*. Colorado, Westview Press, 1996

[22] Bollini P and Siem H. "No Real Progress towards Equity: Health of Migrants and Ethnic Minorities on the eve of the Year 2000", *Soc. Sci. Med*. Vol. 41, No. 6, pp819-828, 1995

[23] ibid, p821

[24] Tan M. "Migration and Risk", *AIDS action*, Issue 40, July-September 1998, p2

In addition, migrant workers with health problems often return to their home countries due to financial conditions, lack of proper immigration documents and ill health —this return is increasingly related to HIV/AIDS. Many countries have now experienced substantial numbers of nationals returning to die among their relatives or original communities.

This raises questions about the delicate balance required by governments and policy-makers between recognizing that migrants may be at risk of infection in their new environment, while avoiding, because of a common tendency to blame the 'other', any scapegoating of migrants for bringing HIV with them into the country/ community. A recent initiative appears to be a good example of how to achieve this balance—Greece's Ministry of Health and Welfare is promoting an information programme with the slogan: "Taking Care of Migrants' Health at the Same Time as Our Own."

However, in the past there have only been rare instances of such approaches.

CARAM-Asia has reported on a number of violations of human rights of migrant workers that have an impact on their health and well-being. They have found that many migrant workers in South and South-east Asia experience oppressive working conditions, such as working 12 hours or more a day for six or seven days a week; inadequate food and unhealthy sleeping quarters provided by the employers, and other breaches. They note that sexual and physical abuses are yet other occupational hazards many migrant workers are confronted with. All these severe and abusive conditions of life and work can directly affect the immune system, and thus lead to migrants becoming immuno-compromised to various types of diseases and infections including HIV.

National statistics on disability and mortality may in particular underestimate the outcomes for semi-skilled and unskilled migrant workers—for example, Egger[25] et al. found that Swiss data missed out on significant numbers of these groups who had suffered occupational accidents and related disabilities but had then left Switzerland when they were too disabled or sick to work.

In spite of the fact that migrant workers are selected for their good health and ability to work (the 'healthy migrant effect'), there is evidence that later in life many end up with a substantial burden of disability (the 'exhausted migrant effect').

However, specific interventions can be surprisingly effective: for example, Bollini and Siem[26] note that pregnancy outcomes (stillbirth and perinatal mortality) in Sweden were slightly better for foreign women than for Swedish women, even though many come from countries (notably Turkey) where perinatal mortality rates were very high compared

[25] Egger M, Minder CE and Smith GD. "Health inequalities and migrant workers in Switzerland", *Lancet* 816, Sept 29, 1990
[26] Bollini and Siem, op. cit., p823

with Sweden. They speculate that this may be due to the fact that, as reported by Sachs[27], considerable attention has been paid in Sweden to understanding cultural differences in mother and child care between Swedish and Turkish women, and to the provision of culturally appropriate services.

One area of frequent neglect in respect of migrants' health needs is that of reproductive rights. The 1994 Cairo Conference redefined sexual and reproductive health within an ethical framework. The Conference acknowledged that:

- failure to address people's reproductive health needs is a matter of human rights and social justice;
- people have a right to make free and informed decisions about their reproductive lives;
- people have a right to information and care that will enable them to protect their health and that of their loved ones; and
- people have a right to benefit from scientific progress in health care.

Dr Gro Harlem Brundtland, Director-General of WHO, has stated that "defining reproductive ill-health as not only a health issue but as a matter of social justice provides a legal and political basis for governments to act."[28] She noted that "between 5 and 15% of the global burden of disease is associated with failures to address reproductive health needs. This burden hits people—particularly women—in the prime of their life, it hits when their potential, responsibilities, and productivity are at their highest. Globally, among women of reproductive age, more than 20% of total years of healthy life lost are due to three main groups of reproductive health conditions—sexually transmitted diseases including HIV/AIDS, maternal mortality and morbidity, and reproductive tract cancers. A further 10% of healthy years of life are lost due to conditions affecting the newborn." Anecdotal evidence appears to show that migrant women are affected disproportionately.

Another major lack in most countries is attention to the issue of migration and psychosocial health. As stated by Carballo and Siem, "The culture shock that often accompanies initial contact with a new sociocultural system can be psychologically complex and involve far more than the simple negation of access to local health and social services. Social integration and then acculturation is a complicated process involving linguistic, social, cultural, and conceptual transference processes that can denude migrants of everything they have previously been used to and which may have provided the basis for their identity. The migration of people from rural and often very traditional communities…to major industrial cities can equally involve a confrontation of widely different values, expectations, and ways of life. It is a process pregnant with psychological and psychosomatic problems which have remained poorly understood and even less well addressed by receiving countries."[29]

In addition to any specific issues, and as has been noted in many countries, the prevailing attitude towards immigration and 'foreigners' (or subgroups of 'foreigners') influence the response of the health care system to their special needs.

---

[27] Sachs L. *Evil Eye or Bacteria. Turkish Migrants and Swedish Health Care*. Stockholm Studies in Social Anthropology, University of Stockholm, 1993

[28] World Health Organization. *Statement by Dr Gro Harlem Brundtland, Director-General, World Health Organization, ICPD + 5 Forum*, The Hague, 8-12 February 1999, p6

[29] *Crossing Borders*, op. cit. p36

C. Concept of personal risk-takers

A number of papers have documented an association between human mobility and increased risk of HIV infection. For example, Chardin reported that while migrants make up 6% of the population of France, 14% of the reported cases of AIDS occur in migrants.[30] However, as Decosas and Adrien[31] note, there are problems with many epidemiological surveys because they often lead to a focus on migrants rather than on the factors increasing vulnerability in mobile populations.

Being a migrant, in and of itself, is not a risk factor; it is the activities undertaken during the migration process that are the risk factors.

People move for all kinds of reasons: business, pleasure, fleeing from political persecution or armed conflicts, seeking a better life for themselves and their children. This movement may not involve the crossing of any borders: in China, for example, about 100 million people are considered mobile between rural and urban areas, and from one urban area to another.

Increasingly, compared with earlier generations, many individuals in a number of countries have become bi-local or even multi-local, within a country or in a different country than the country of origin. Particularly for students but increasingly for many others, a pattern of circular mobility is part of life. As Singhanetra-Renard notes in regard to Thailand, "daily commuting, seasonal migration, periodic, short- and long-term circulation are undertaken by both the rural and urban population for employment, education, entertainment, as well as for other socio-cultural reasons."[32]

People's mobility tends to follow opportunities, taking place more frequently from rural to urban areas and/or from poorer to richer countries. But it definitely can be a two-way traffic: migrants who do well in the city or in another country will often return to their home villages bringing evidence of the good life.

And, while moving may increase vulnerability and lead to people engaging in higher risk behaviour, it is by no means axiomatic. For example, as Tan[33] writes: "rural women may not be able to break out of their low social status if they stay in their village. Their future is limited to an early marriage, often with little bargaining power and little support for reproductive and sexual health. Migrating to cities is still an option for social mobility and could actually mean a better quality of life and health. A shift to an urban environment, where sexuality-related issues can be more openly discussed, may also be beneficial."

However, one of the characteristics of many mobile individuals, particularly those who are voluntarily mobile, is that they are risk-takers—they are gambling that a different

[30] Chardin C. "Access to new treatments for migrants living with HIV and AIDS: The Policy Maker's Point of View – the Political and Juridical Situation in France" in *Access to New Treatments for Migrants Living with HIV and AIDS - Second Annual Seminar, National Focal Points, European Project AIDS & Mobility*. Clarke K and Bröring G (eds) October 1999, p15
[31] Decosas and Adrien, 1997, op. cit., p578
[32] Singhanetra-Renard, op. cit., p2
[33] Tan M. op cit, p2

environment will be beneficial to them. This concept of risk-taking may then lead on to choices they make in their private lives.

Sometimes people are able to move with their entire families. However, for much labour migration, this is not the case. In Asia, there is a large regional movement of female workers who provide domestic services; in many other parts of the world, single sex migration is predominantly male to sustain industries such as mining, construction and agriculture.

The changed circumstances may lead to increased personal risk: perhaps separated from family, from a regular sex partner, in single-sex housing, and with the stresses and vulnerabilities associated with the migration process. For some, there is a strong need for money to buy necessities or on which to subsist while waiting for employment. For others, the anonymity of being a foreigner, especially in transit areas, can increase sexual activities. Similarly, loneliness, frustration and peer pressure combined with easier access to drugs can make it hard for some to resist injecting drugs. And, of course, there may be drug dealers exploiting this vulnerability.

In some cases, moving may be undertaken so that the individual may engage in what might be illegal or considered shameful in their own neighbourhood. For example, CARAM-Asia has noted that "thousands of poor Vietnamese women come to Cambodia to earn [money] by engaging in sex work…one third of the commercial sex workers reported being born in Vietnam."[34]

In many cases, mobility is related to a perceived upward social mobility. Singhanetra-Renard[35] documents that ways to social mobility for rural Thai can include:

- "Secure salaried employment in government, service, manufacturing or business enterprises even at the lower end of the hierarchy such as janitor, cleaner, or gardener, since it signifies a connection with city dwellers who have position, politically, financially or socially;
- Professional employment such as police, soldier, nurse, or secretarial job or any other position, including informal sector work, in which employees wear uniforms;
- Employment in enterprises which symbolize modernity or Western influence such as golf courses, discos, coffee shops, cocktail lounges, and karaoke bars;
- Marriage to a government official, Chinese, or others who have position, wealth, or connections."[36]

However, Singhanetra-Renard also notes that routes to social mobility differ for men and for women, and that women will "often take a short-cut through commercial sex-work."

The numbers and proportion of communities affected by migration are not small: for instance, surveys in Africa found that between one-fifth and one-third of men and women reported living apart from their regular sexual partner, with one of two major consequences—sexual abstinence or having multiple partners.[37]

---

[34] *Coordination of Action Research on AIDS and Migration,* op. cit., p20
[35] Singhanetra-Renard, op. cit., p9
[36] ibid, p9
[37] Cleland J and Ferry B. *Sexual behaviour and AIDS in the developing world*. London, Taylor & Francis, 1996, as cited in Haour-Knipe M and Aggleton P, "Social enquiry and HIV/AIDS", *Critical Public Health*, Vol. 8, No. 4, 1998, p261

This may lead to an outcome such as reported by Kane et al: a study of the nexus between migration and HIV status of Senegalese villagers found that 27% of the men who had previously travelled in other African countries and 11.3% of the spouses of such men were HIV-infected. In contrast, from the control group (414 people) who had not travelled outside Senegal in the previous ten years, only one man and one woman were HIV+.[38]

In Mexico, 25% of people reported to be living with AIDS in rural regions have a history of temporary migration to the United States.

[38] Kane F, Alary M, Ndoye I et al. "Temporary expatriation is related to HIV-1 infection in rural Senegal." *AIDS* 1993, 7:1261-1265

III. Balancing international treaties versus States' rights

A. Relevant declarations

The HIV/AIDS epidemic has shown a consistent pattern through which discrimination, marginalization, stigmatization, and more generally, a lack of respect for the human rights and dignity of affected and at-risk individuals and groups heighten their vulnerability to HIV/AIDS.

It is thus essential to understand and utilize the basic human rights instruments that establish international standards in order to address this issue. Most industrialized countries also have national anti-discrimination legislation.

The Commission on Global Governance[39] stated in *Our Global Neighbourhood*: "Comparatively recent in origin, international law includes the body of legal rules and principles that apply among states and also between them and other actors, including those of global civil society and other international organizations. Scholars once argued that international law was not law in the true sense, as there was no international police force to enforce it, no sanctions if it were disobeyed, and no international legislature. But with the growth in use of international law, these arguments are heard less often today. [...] Although states are sovereign, they are not free individually to do whatever they want...global rules of custom constrain the freedoms of sovereign states."[40]

International law and human rights declarations establish the principles of non-discrimination, equality before the law, freedom of movement, the right to seek and enjoy asylum and other humanitarian principles (see the Appendix).

The Universal Declaration of Human Rights was adopted in 1948.[41] The Universal Declaration is built on the fundamental principle that human rights are based on the "inherent dignity" of every person. This dignity, and the rights to freedom and equality, which flow from that, is seen as undeniable.

Although the Declaration does not have the binding force of a treaty, it has acquired universal acceptability. Many countries have cited the Declaration or included its provisions in their basic laws or constitutions. And many human rights covenants, conventions and treaties concluded since 1948 have been built on its principles.

[39] The Commission on Global Governance was established in 1992 in the belief that international developments had created a unique opportunity for strengthening global cooperation to meet the challenge of securing peace, achieving sustainable development, and universalizing democracy. It involved an independent group of 28 world leaders with diverse experience and responsibilities. They proposed a 'global civil ethic' based on the notion of balancing rights and responsibilities and involving seven core values that must guide global governance: respect for life; liberty; justice; equity; mutual respect; caring; and integrity.

[40] *Our Global Neighbourhood: The Report of The Commission on Global Governance*. Oxford University Press, 1995, p305

[41] After thorough scrutiny and 1,400 rounds of voting on practically every word and every clause.

The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights entered into force in 1976. They take the Universal Declaration a step further by making provisions legally binding. A majority of the world's countries are parties to the two Conventions, thereby opening the door to international monitoring of their human rights practices.

Specifically, the International Covenant on Economic, Social and Cultural Rights explicitly recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In addition, Article 2 (1) provides that each State Party to the Covenant undertake to take steps, individually and through international assistance and cooperation, to achieve progressively the rights in the Covenant.

Since 1948, some 60 human rights treaties and declarations have been negotiated at the United Nations. Additional examples are:

- International Convention on the Elimination of All Forms of Racial Discrimination (1965)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)
- Convention on the Rights of the Child (1989)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)

However, the last-named treaty has not yet entered into force because it needs ratification by at least 20 Governments and as of May 2000 only some twelve countries were recorded as fully or partly through the process: Azerbaijan, Bosnia and Herzegovina, Cape Verde, Colombia, Egypt, Mexico, Morocco, Philippines, Senegal, Seychelles, Sri Lanka, and Uganda. Unfortunately, none of these countries are members of the G7 group,[42] major industrial powers or major recruiters of migrant labour, and thus even if they all complete the process the overall impact will not be great.

It should be noted that the right to enter a State is confined to nationals of that State, and States have broad discretion to choose the grounds by which to exclude and expel aliens. Nevertheless, the international treaties do impose some limitations (albeit often only implicitly) on States' prerogatives. In addition, as *Our Global Neighbourhood* states: "The norms of international law—particularly on human rights—are already guiding judges in cases in individual countries as they rightly seek to ensure, to the extent allowed by their legal system, that universally recognized norms and values are protected domestically."[43]

Indeed it has been argued by Somerville and Wilson that "there should be a presumption that all visitors to a country should have a right of entry, unless the state can show justification for excluding them; that while the state may exclude immigrants, including on medical grounds, such exclusion should comply with principles of human rights and justice; and that refugees should never be excluded on the grounds of medical inadmissibility".[44]

---

[42] Seven countries acknowledged as major international economic powers
[43] *Our Global Neighbourhood,* op. cit., p325
[44] Somerville MA and Wilson S. "Crossing Boundaries: Travel, Immigration, Human rights and AIDS", *McGill Law Journal*, 1998, Vol. 43, p782

Similarly, Ngwena argues that "despite the inclination of governments to treat access to medical treatment as a privilege rather [than] a right, it is no less a right than other rights such as the right to life, human dignity and freedom which are unambiguously inscribed in national constitutions."[45] He notes that Tomasevski[46] (among others) has shown that the recognition and acknowledgment of a universal right to health care in international human rights instruments is not in question. What is in the balance are the parameters and enforceability of such a right.

However, a forthcoming statement by the UN Committee on Economic, Social and Cultural Rights is expected to state their interpretation that health is both a fundamental human right in itself and an indispensable precondition for the exercise of other human rights.

WHO was the first international organization to formulate health in terms of a human right. The WHO Constitution, adopted in 1946, recognizes that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." The WHO Constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Various human rights instruments—treaties as well as resolutions and recommendations—have been adopted since which proclaim health as a human right and include many provisions referring to the broad description of health as set forth in the WHO Constitution. The latter does not imply that everyone has a right to be healthy, but above all imposes a duty upon States to respect, protect and fulfil the aspirations enshrined in WHO's definition of health.[47]

> The right to healthy working and living conditions, the right to health education, and the right to affordable and accessible health care are three examples of rights that governments should guarantee for their migrant populations.[48]

When discussing cross-border movement restrictions, in general it should be noted that: "restrictions aimed at reducing or regulating in-migration are mainly imposed by countries that are either developed countries or at an intermediate stage of development, but may bear heavily upon the nationals of developing countries who are affected by them."

It should also be noted that restrictions that discriminate against people with HIV infection or AIDS, or people from countries with high rates of reported AIDS cases violate a number of provisions of international law (and in many cases also national law) prohibiting discrimination.[49]

---

[45] Ngwena C. *AIDS and Right of Access to Treatment: The Scope and Limits*, Paper presented at the XIth International Conference on AIDS and STDs in Africa, Lusaka (Zambia), 12 -16 September 1999. p2

[46] Tomasevski, K. 1995. Health rights. In Eide, A., Krause, C & Rosas, A. (eds.) 1995. *Economic, social and cultural rights: A textbook*. Dordrecht, Boston, London, Martinus Nijhoff Publishers, pp125-142; Montgomery, J. 1992. Recognising a right to health. In Beddard, R. & Dilys, DM (eds.). 1992. *Economic, social and cultural rights: Progress and achievement*. New York, St. Martin's Press, pp. 184-203 at 184-186

[47] Hendriks A. "The Right to Health and Access to New Treatments" in European Project AIDS & Mobility: *Access to New Treatments for Migrants Living with HIV and AIDS - Second Annual Seminar, National Focal Points, European Project AIDS & Mobility*. Clarke K and Bröring G (eds) October 1999, p8

[48] CARAM-Asia

[49] Somerville MA and Orkin AJ. "Human rights, discrimination and AIDS: concepts and issues", AIDS 1989, 3 (suppl. 1): S283-287

In 1996, UNAIDS and the Office of the United Nations High Commissioner for Human Rights prepared International Guidelines on HIV/AIDS and Human Rights. With UNAIDS funding, in 1997 the International Council of AIDS Service Organizations (ICASO) prepared and distributed (in English, French and Spanish) an NGO Summary and an Advocate's Guide to the Guidelines,[50] which included tips on how to use the Guidelines to enhance the response to the epidemic and reduce the vulnerability of affected communities.

The International Guidelines on HIV/AIDS and Human Rights were tabled at the UN Commission on Human Rights at its 53rd session, in April 1997. At its 55th session, in April 1999, the Commission adopted a resolution calling on governments to report back to the Commission at its 57th session, in 2001, on the steps they have taken to promote and implement the Guidelines.[51]

Within the International Guidelines, reference is made to the Vienna Declaration and Programme of Action, which was adopted at the World Conference on Human Rights in June 1993. This Declaration "affirmed that all human rights are universal, indivisible, interdependent and interrelated. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, states have the duty, regardless of their political, economic and cultural systems, to promote and protect universal human rights standards and fundamental freedoms."[52]

Beyond the formal legal system, as noted by *Our Global Neighbourhood*, the technical, organizational, and lobbying skills of some NGOs are an efficient means of achieving enhanced compliance. We encourage these groups to continue lobbying and pressuring governments, multilateral institutions, transnational corporations, and other subjects of international law to comply with their international legal obligations."[53] The author of this present paper would add, and to comply with implicit global ethical and economic needs.

B. International spread of disease

The use of restrictive measures as a response to infectious diseases has been discouraged since the mid-19th Century and especially since the establishment of WHO.[54] The International Health Regulations require WHO Member States to refrain from enforcing restrictions for non-regulation diseases: HIV infection and AIDS are not included in the regulations.

As Wahdan has stated: "One of the main purposes for which the International Health Regulations (IHR) were adopted is to bring some order to a chaotic situation that

[50] International Council of AIDS Service Organizations. *An Advocates Guide to the International Guidelines on HIV/AIDS and Human Rights* and *NGO Summary of the International Guidelines on HIV/AIDS and Human Rights*. October 1997
[51] Resolution 1999/49
[52] Office of the United Nations High Commissioner for Human Rights/ UNAIDS. *HIV/AIDS and Human Rights. International Guidelines*. United Nations, New York and Geneva, 1998, p40
[53] *Our Global Neighbourhood,* op. cit., p327

could develop in which every country will be imposing regulations in a manner it chooses —regulations that it considers will protect its population from the occurrence of the diseases already happening in other countries.

IHR are meant to be a universal code of practice to standardise the procedures to be followed by all countries in controlling diseases. [...] It specifies what should be done by whom and for what purpose - whether it is notification or measures for prevention and control.

The policing sense of the old regulations reflected in the emphasis on quarantining of cases and contacts have given way to sensible public health measures. The amendments to the IHR highlighted the fact that the main effective strategy and defence mechanism against international spread of disease is better surveillance through which foci of infection are detected early and dealt with".[55]

The advent of HIV and the emergence (or re-emergence) of other key infectious diseases has caused a substantial review of the role of instruments such as the IHR in the protection of global public health, and in how such international instruments are mandated.

For example, Fidler[56] states: "The HIV/AIDS crisis dramatically illustrated the weaknesses of the health regulations. Since AIDS was not originally (or subsequently) made subject to the regulations, states had, and continue to have, no notification requirements in connection with this new disease. Further, as HIV/AIDS spread globally, many states adopted exclusionary policies that, according to experts, violated provisions of the health regulations. In relation to one of the biggest disease crises of this century, parts of the International Health Regulations were irrelevant, and other parts were openly violated".[57]

Fidler, however, does not feel there are inherent problems in international law, rather a previous lack of attention to its application. He notes, "In connection with emerging infections, WHO is advocating an international legal strategy by recommending revision of the International Health Regulations. This recommendation suggests that WHO acknowledges the need for international legal agreement in dealing with emerging infections. The global threat posed by these infections represents in many ways a test case for international public health law".[58]

Fidler suggests a number of possible strategies for the way forward, including learning from progress in the international environment area.

---

[54] Allin NE. "The AIDS Pandemic: international travel and immigration restrictions and the World Health Organization's Response", *Virginia J Int Law* 1988, 28: 1043-1063

[55] Wahdan MH. "Shortcomings in the Current Version of the International Health Regulations and Difficulties in their Implementation", *WHO Informal Consultation to review the International Response to Epidemics and Application of the International Health Regulations*, December 1995, EMC/IHR/GEN/95.4

[56] Fidler DP. *Globalization,* "International Law, and Emerging Infectious Diseases", *Emerging Infectious Diseases*, Vol. 2, No. 2, April-June 1996

[57] ibid, p80

[58] ibid, p80

C. Effect of globalization

Increasing globalization of all human societies is causing some reconsideration of the concept of total State sovereignty within a country's borders. Of course, major human rights betrayals such as genocide have always attracted outside attention, but there is growing acknowledgement and understanding that "what goes around, comes around".

The 'Global Village' is much more than a global market—in a global village there is one global public health.

Tuberculosis (TB) provides an example of this: in Australia, Hong Kong (China), Malaysia and Singapore, the numbers of tuberculosis cases have not decreased for several years because of the incidence of tuberculosis among new immigrants.[59]

Unfortunately, HIV is causing an associated and increasing epidemic of TB in many of the most severely affected countries—and, while active TB can easily be detected in a clinical examination, it can also relatively easily be transmitted in a work or social situation, unlike HIV. In a plenary address at the XI-ICASA in September 1999, Dr. Okware from the Ministry of Health in Uganda noted that "in some parts of Africa, the incidence of tuberculosis is increasing at an alarming rate—sometimes as high as 8% annually."

While people undermined by HIV infection are more easily infected with the TB bacillus, many already harbour it from childhood. Worldwide, millions of people are already infected with both HIV and the tuberculosis bacillus, and the potential for further growth of co-infection in the developing countries is vast, given the crushing prevalence of TB carriers in the general population (some 30%) and the almost 6 million new HIV infections a year. The expected skyrocketing of TB incidence globally[60] is also expected to be associated with the emergence of a significant number of drug-resistant strains of TB. And perhaps the further spread of multidrug resistant (MDR) strains of TB throughout developed countries, as well as developing countries.

Thus delay in tackling the dual HIV/TB epidemics in developing countries by stronger TB case-finding and treatment—tuberculosis can be cured with antibiotics regardless of whether the person is HIV-infected or not—may directly lead to major problems in the health care sector for all countries.

Our Global Neighbourhood notes that "Sovereignty has been the cornerstone of the interstate system. In an increasingly interdependent world, however, the notions of territoriality, independence, and non-intervention have lost some of their meaning. In certain areas, sovereignty must be exercised collectively, particularly in relation to the global commons. Moreover, the most serious threats to national sovereignty and territorial integrity now often have internal roots.

The principles of sovereignty and non-intervention must be adapted in ways that recognize the need to balance the rights of states with the rights of people, and the interests of nations with the interests of the global neighbourhood."[61]

[59] *Tuberculosis in the Western Pacific*, WHO Regional Office for the Western Pacific, 1999

[60] In industrialized countries, one-quarter of all TB cases occur in the over-65s, compared with only ten per cent in developing countries of Africa, Asia and Latin America. In the developing world, TB is predominantly a disease of young adults: 60 per cent of all cases are young men and women of reproductive age. There are also major gender implications with TB: Tuberculosis is now the single biggest infectious killer of women in the world, and the single leading cause of deaths among women of reproductive age.

[61] *Our Global Neighbourhood,* op. cit., p337

Similarly, Christakis argues that there are some problems that are not worldwide problems but international problems: he cites pollution, ozone depletion, arms proliferation, hunger, and AIDS as examples of problems based on "the direct interrelatedness of the problem in one country with the problem in another".[62]

Much of the past policy concern about migrants has centred on whether they are likely to become a burden on health and social services in receiving countries - thus, there are a number of countries that require HIV negative status at entry or at renewal of work permits.[63, 64, 65] (Restrictions are reported in, or by, both countries with very high, and countries with very low, numbers of reported cases).[66] It should be noted that restrictions may ultimately increase migrants' vulnerability to infection by HIV by undermining trust, increasing hostility, and discouraging individuals who may be affected from coming forward for counselling and support.[67]

Restrictions provide very little benefit to any country. Gilmore states "over sixty countries prohibit one or more classes of HIV infected foreigners from entering their countries. Often this is done in a misguided attempt to prevent transmission of HIV, or to avoid public expenditures involved in HIV care. The former situation might be less of a problem if people already residing in the country did not expose themselves to HIV; excluding infected foreigners does nothing to change behaviours of those who are not foreigners. The economic burden attributed to HIV infected individuals fails to recognize that infected foreigners often work, contribute to their new society, and enrich it by bringing new values and skills to the country."[68]

In general, relatively little attention has been paid to the economic (and ethical) dangers of ignoring the health needs of these workers.

Since the majority of migrants are adults in the prime of their earning potential as well as their reproductive life, HIV could have devastating social and economic effects, should a large number of this sizeable earning population cease contributing to society. This scenario is already the case in many African countries, and is now increasing in importance in other parts of the world with large mobile populations.

The 1998 UNAIDS background paper states "As long as illegal and undocumented migration continues to be viewed only in relation to security and national interests, public health will be neglected".[69] However, this present paper takes a broader view, and would argue that as long as *any* segment of a population (whether or not they are present illegally) is neglected in public health terms, then the global response to AIDS will be limited and there will be concomitant cost and suffering.

---

[62] Christakis NA. "Responding to a Pandemic: International Interests in AIDS Control", " in Graubard, SR (Ed.) *Living with AIDS*, Cambridge, MA, MIT Press. p330

[63] Duckett M and Orkin AJ. "HIV/AIDS-related migration and travel policies and restrictions: a global study". *AIDS* 1989: 3(Suppl. 1); S231-252

[64] Archiv für Sozialpolitik AIDS Archiv. "Restrictions of entry and residence for people with HIV/AIDS: a global survey". Frankfurt am Main, 1991

[65] Laboratory Centre for Disease Control, Health Canada: *Countries with HIV-Related Entry Restrictions*. December 1996

[66] Many countries adopt a double standard: compassionate policies and practices relating to HIV/AIDS in regard to their own citizens, but an approach encompassing economic death in relation to migrants.

[67] *Technical Update on Migration and HIV/AIDS*, op. cit.

[68] Gilmore N. *Human Rights Issues and Migration*, presentation at the 12th World AIDS Conference, Geneva, Switzerland, July 1998

[69] UNAIDS. *Migration and HIV/AIDS*. Paper prepared for UNAIDS Programme Coordinating Board meeting, December 1998, p5

The Alma Ata Conference (1978) undertook a major examination of the underlying principles and focus of health care systems, and led to a re-commitment to a Primary Health Care strategy as the first step in major health improvements for any nation.[70] However, the health impacts of a global recession and of globalization were not considered at Alma Ata, nor the need for human-centred sustainable development.

Nevertheless, the Alma Ata declaration did state that "the attainment of health by people in any one country directly concerns and benefits every other country."

The future will require stronger global action to protect and improve local and national health, by recognizing the interdependence of health among nations.

[70] World Health Organization. 1978. *Primary Health Care. Report of the International Conference on Primary Health Care,* Alma Ata, USSR, 6-12 September 1978.

IV. Access to health

A. Financing of health care

Financing of health care may be predominantly government funded, predominantly privately funded or a mixture. Governments also determine the priorities for available funds: in Zambia, for instance, only 0.8% of the gross national product (GNP) is spent on health care, compared with about 7–10% in most industrialised countries.

It should be noted that financial resources for health are overwhelmingly provided within countries. This situation does not change even in those countries which are the recipients of significant international development assistance from sources such as development banks, bilateral development agencies, international nongovernmental organizations, foundations and UN agencies. For example, in 1994 health spending in low and middle income countries totalled about US$250 billion, of which only US$2 or 3 billion was from development assistance.

Substantial reforms in the health systems of many countries in the past few decades have led in many cases to substantial privatization or significant increases in co-payments by patients. Dr Gro Harlem Brundtland, Director-General of WHO, states in her introduction to the *World Health Report for 1999* that "Active government involvement in providing universal health care has contributed to the great gains of recent years –but many governments have overextended themselves. Efforts to provide all services to all people have led to arbitrary rationing, inequities, non-responsiveness and inadequate finance for essential services." She notes that governments cannot "provide and finance everything for everybody" but also rejects the approach of rationing health services to those with the ability to pay: "Not only do market-oriented approaches lead to intolerable inequity with respect to a fundamental human right, but growing bodies of theory and evidence indicate markets in health to be inefficient as well…But the very countries that have relied heavily on market mechanisms to achieve the high incomes they enjoy today are the same countries that rely most heavily on governments to finance health systems."[71] She calls for changes in all countries to ensure participatory, fair and efficient regulation of the health sector.

In many developing countries and due to many factors, health facilities are often poorly equipped, drugs are not always available and in particular, STD/HIV prevention and care is poor. A recent WHO paper commented on the use of resources within poor countries: "National health systems tend to spend money on poor quality and low-impact interventions."[72] And of course, in some developing countries, the increased mortality of health sector staff due to HIV has started to directly affect the delivery of health services.

[71] WHO. *The World Health Report 1999: Making a Difference*. World Health Organization, 1999, p xiv
[72] WHO. "The Global Health Priority: Reducing the burden on the poor", *World Health Opportunity: Developing Health, Reducing Poverty. Meeting Report*, May 1999, p36

Most industrialized countries provide universal or widespread health insurance for all nationals and legal permanent residents: thus, the burden of health care is rarely substantial for any individual, and in particular drug costs are relatively cheap—in marked contrast to the situation in most developing countries.[73]

Even between neighbouring developing countries, there may be disparate health care provision: Burkina Faso, Ghana and Togo have large numbers of cross-border workers—migrant patients mainly attend clinics in Ghana (sometimes crossing over specifically for this purpose), because health services cost the least among the three countries.

Given that, due to global mobility, health risks can not be addressed adequately if they are only dealt with inside national boundaries, many industrialized countries provide direct funding assistance to health care in targeted developing countries. For instance, the New Zealand (NZODA) South Pacific Regional Health Programme was established in 1997 as a direct result of the concern in New Zealand about the adverse health trends in neighbouring Pacific Island countries, especially those with the closest connections with New Zealand.[74]

Another issue is that of differential cost for access to health care for nationals/ legal residents and others: many industrialized countries allow free access to health care services for legal migrants but require full-cost recovery for non-residents. In a few countries, health care provision may also be regulated by bilateral or multilateral agreements, thus providing full health care access to a national of a country with whom such agreements are in force. For example, Australia has bilateral agreements with Finland, Italy, Malta, Netherlands, New Zealand, Sweden and the United Kingdom.

B. The "new" public health

One of the fundamental public health principles is that major gains in health require the development of preventive and early intervention programmes. The improvements in population health status of this century have exemplified this principle.

Environmental, social and personal changes that promote health and prevent the onset and development of disease hold the most promise for the future, as there is general acknowledgement that therapy and rehabilitation have always been insufficient by themselves to conquer disease. Active prevention is required to achieve such an outcome.

These insights have led in the last twenty years to the development of a "new" public health: one that relies less on exclusion and screening and moves more to inclusion and cooperation with the relevant sub-population. With an increasing emphasis

[73] "The inequities are striking", says Dr Jonathan Quick, Director of Essential Drugs and Other Medicines at WHO. "In developed countries a course of antibiotics can be bought for the equivalent of two or three hours' wages. One year's treatment for HIV infection costs the equivalent of four to six months' salary. And the majority of drug costs are reimbursed. In developing countries, a full course of antibiotics to cure simple pneumonia may cost one month's wages. In many of these countries one year's HIV treatment – if it were purchased – would consume 30 years' income. And the majority of households must buy medicines with money from their own pockets." Quote taken from Press Release WHA/13 22 May 1999 WHO to Address Trade and Pharmaceuticals

[74] New Zealand Ministry of Foreign Affairs and Trade. *NZODA Regional Health Programme Initiatives, 1997-1999*

on illness prevention, aimed mainly at reducing smoking and cardiovascular risks, there has been a substantial change in the public health approach to population-related behaviour modification—because coercive models were proving to be ineffective.

The new model, as described by Haour-Knipe:[75] "This model, one of social learning, of inclusion and cooperation, involves harm reduction, persuasion in modifying lifestyles linked to disease, education, voluntary testing and counselling, protecting privacy and social interests. When emphasis is transferred away from control and towards information, and basic assumptions are transformed in a critical epistemological shift: fruitless and potentially harmful calculation of risks is sidestepped, and all segments of the population are put on an equal level. The assumption underlying obligatory measures, that people will necessarily behave irresponsibly, is replaced by the opposite, that enabled, they will behave responsibly. The ground rules are first and foremost to protect lives and keep the disease from spreading and second to work in collaboration with those who are to be protected to develop and utilize their own possibilities to avoid risk."

Much of this 'new' approach is summarized in the five principles of the Ottawa Charter:[76]

- build healthy public policy;
- create environments that support health and health-improving choices;
- strengthen community action;
- help people develop necessary skills for health-improving choices; and
- reorient health services to prevention and early intervention.

Unfortunately, although there has generally been a philosophical change in approach among public health specialists in the last twenty years, in many countries legislation and regulations still reflect old approaches and attitudes. Various restrictions are in place in both industrialized and developing countries (generally based on the traditional infectious disease/ public health legislation approach of the 19th century). Many of these provisions are not enforced (and, in the case of the developing world generally minimal inward migration makes the application there limited), but nevertheless, the restrictions are there and can legally be used.

Fluss[77] refers to "Incorporating principles of objective risk assessment, evaluation of efficacy, minimization of human rights burdens into communicable diseases statutes encourages decisions based on rational, scientific findings rather than public fear or ignorance."

[75] Haour-Knipe M. Social enquiry and HIV/AIDS, Background paper prepared for the XIV International Conference on the Social Sciences and Medicine, Peebles, Scotland, 2–6 September 1996

[76] Ottawa Charter, WHO/HPR/HEP/95.1. Charter adopted at an International Conference on Health Promotion, November 1986

[77] Fluss S., *Some recent patterns and trends in communicable disease legislation in selected European countries* presentation at the May 1996 meeting of the Biomed 2 Project on Communicable Diseases, Lifestyles and Personal Responsibility: Ethics and Rights

C. Levels of access

Migrants tend to occupy a relatively vulnerable position in terms of access to health in the receiving society, due to general factors such as language barriers, different concepts of health and disease, and racism among service providers and the general society. In addition, undocumented migrants in particular will often be operating in unsafe working conditions and accommodation, and may be exploited for meagre wages. Many migrants may lack the money to buy health services or be unable to access local services due to their legal status.

These general problems are often compounded in relation to HIV/AIDS, and to a lesser extent to STD matters.

Sometimes governments may directly add extra barriers to health care access even for legal migrants. For example, as noted by Bronfman: "The US Congress, presumably motivated by the belief that authorized and non-authorized migrants participate 'excessively' in public assistance programmes, approved migrant-related provisions as a part of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996. This law restricts access to social assistance programmes even to the authorized migrants."[78]

However, the barrier to health care may vary greatly between countries. Decosas notes that in the African context, "some migrant labourers and their families in fact receive health services superior to those available to their communities of origin, and sometimes even superior to those available to their host communities."[79]

There have been a number of specific projects aimed at improving access. Some of these approaches are mentioned later in section five of this paper. Unfortunately, few address the issues of access to prevention and care at the origin, transit places and final destination of migrants. All points on the moving continuum need to be addressed if migrants are to achieve full access to their right to health.

As Gilmore[80] notes, "When non-nationals are deprived of opportunities to be healthy this not only endangers their own health, but also promotes denial and discrimination. It jeopardizes public health efforts, in particular prevention efforts, thereby threatening the public's health."

Speakers at a session on *Mobile Populations and HIV: vulnerability, risk and human rights* at the 12th World AIDS Conference presented clear evidence that "the health of migrant populations has often not fared very well when the matter is left to national instances in either the country they have left or that to which they have gone."[81] It will be essential for more countries to acknowledge that migration is a process that affects two (or more) communities, not just one, and adjust their policies accordingly.

[78] Bronfman M. "Mexico and Central America" in Appleyard R and Wilson A (eds.). "Migration and HIV/AIDS", *International Migration Quarterly Review*, Vol. 36 (4), 1998, p614

[79] Decosas J. *Labour Migration and HIV Epidemics in Africa*, presentation at the 12th World AIDS Conference, Geneva, Switzerland, July 1998

[80] Gilmore N. *Human Rights Issues and Migration*, presentation at the 12th World AIDS Conference, Geneva, Switzerland, July 1998

D. Early intervention is cheapest

Despite the widespread acceptance of the importance of prevention and early intervention, a variety of personal, social and economic forces have generated barriers to the widespread development and implementation of prevention and early intervention programmes.

Traditionally, health only becomes of personal significant concern to people when they are in danger of losing it through injury or disease.

Secondly, as noted by Barlinguer,[82] "the notion of health as a cornerstone of economic growth, as a multiplier of human resources, and most importantly as a primary objective of such growth, has been replaced far and wide by an opposing notion. Public health services and health care for all are now perceived as an obstacle, often as the hardest obstacle, threatening public finance and the wealth of nations; reduction in health expenditure (not rationalisation, which is the imperative everywhere) has become one of the top priorities for all governments.

The model of primary health care as fundamental for the prevention and treatment of diseases has been almost abandoned. The trend is now towards dismantling the whole machinery of public health. Even in countries with minimal resources, priority is given to costly technologies."

Some of the past change in the understanding of the importance to economic growth of health has been perceived to arise out of the policies and approach of the World Bank and the International Monetary Fund. The World Bank is now committed to highlighting that health sector reform is a means rather than an end in itself, and to ensure that there is a focus again on the determinants of health (education, poverty, environment, gender) and on tangible health outcomes.

Ngwena recently noted[83] that, in Africa, "the state health care sectors are overburdened, ill equipped and badly managed. Declining health budgets as a result of reduced government expenditure on public services have seen many public health services collapsing in several African countries. Drugs for common diseases are either unavailable or of poor quality and so is the medical equipment. The structural adjustment programmes that have been imposed by the Bretton Woods institutions to assist Africa in economic reform, are at the same time leaving little by way of adequate resources for health care."

The World Bank announced in July 1999 that it planned in future to take more aggressive action against AIDS. A Bank official noted that AIDS is no longer solely a health problem, but a development crisis that is particularly affecting Africa. Working with governments and other groups, the World Bank has stated it will review its existing efforts in Africa and plans to redirect funding, if needed.

Discussing the World Bank's new emphasis on the African AIDS epidemic, Mr Callisto Madavo, Vice President, Africa Region, said: "With ferocious speed, AIDS has wiped out many of the development gains Africa has achieved over the last decades. It

[81] Haour-Knipe M. *In conclusion*, presentation at the 12th World AIDS Conference, Geneva, Switzerland, July 1998
[82] Berlinguer G. "Indivisibility and Globalisation of Health" in *The Effects of Globalisation on Health*, Report from a Symposium held at the Annual Meeting of the NGO Forum for Health, Geneva, May 1998
[83] Ngwena C. *AIDS and Right of Access to Treatment: The Scope and Limits*, op. cit, p10

has reduced life expectancy in the most-affected areas and now threatens businesses and economies", he said. "Africa is in urgent need of resources and support to turn around this catastrophe. For this reason we are putting the epidemic at the centre of our development agenda, mainstreaming AIDS into all aspects of our work in Africa."[84]

A similar review of the interaction between economic development and AIDS may shortly occur in Asia: the Malaysian Prime Minister called in October 1999 for regional leadership, including "all heads of Governments in the Asia-Pacific region to hold a summit on AIDS so that we may better co-ordinate our efforts …underline the seriousness of the AIDS pandemic and the need for urgent action to combat it." Dr Mahathir also talked about the rights of migrant workers, emphasising "the transborder nature of the epidemic".[85]

An additional major barrier to appropriate emphasis on prevention or early intervention has been that in almost all countries, health care systems have been structured in accordance with acute care models of disease and illness. Health professionals are trained to operate within the usual parameters of the system—and preventive health is rarely where 'the best and brightest' focus their time and energy.

In general, for most countries massive commitments of public monies have been dedicated to supporting acute health care delivery systems. Many decision-makers tend to be oriented toward after-the-fact treatment of disease rather than prevention, perhaps because the benefits of prevention are more long-term and therefore not immediately obvious.

Lomas[86] has taken the problem of heart disease as a tool to examine the effectiveness of possible interventions: the points on an intervention continuum of possible responses to premature death from heart disease comprised:

- rescue, e.g. coronary artery bypass surgery, thrombolysis
- routine medical care, e.g. cholesterol-lowering drugs, hypertension control
- improved access to health care, e.g. 'free' care, increased supply of care
- traditional public health, e.g. lifestyle modification programmes
- family and support services, e.g. home visitors, social support
- social cohesion, e.g. subsidized clubs, reduced income inequality.

The last intervention, social cohesion, is rarely mentioned in health policy discourse. As Lomas states "these are measures to ensure and advance social cohesion. This involves preservation and advancement of social structures such as meeting places, sports leagues, clubs, associations and all the other elements of a community that allow for the exchange of views and values and engender mutual trust."[87] Lomas found, using a cost-effectiveness approach, that interventions to increase social support and/or social cohesion in a community are at least as effective in preventing premature death from heart disease as improved health care access or routine medical care.

---

[84] UNAIDS Press Release: *UN Officials in Lusaka Commit to Increased Action against AIDS in Africa*. Lusaka, 15 September 1999

[85] Report posted on 25 October 1999 on Sea-aids, an independent electronic forum provided by the Fondation du Présent http://www.fdp.org

[86] Lomas J. "Social Capital and Health: Implications for Public Health and Epidemiology", *Soc. Sci. Med*. Vol. 47, No. 9, pp1181-1188, 1998

[87] ibid, p1183

If Lomas' work is able to be extrapolated to HIV/AIDS, which is likely, then greater attention to support services and social cohesion (well within the reach of even the poorest developing country) may result in improved access for migrants (and others) to prevention and care, at no more and possibly less cost than currently. Similarly, if the formation of support groups for people living with HIV and AIDS is useful not only for psychological support of group members, but also understood as part of a necessary strategy in HIV/AIDS cost-effective prevention and care, then greater attention and support for such support groups may eventuate from government and other key players. It should be noted that at the XIth International Conference on AIDS and STDs in Africa (Lusaka Conference), a Satellite conference on the 'Principle of Greater Involvement of People Living with HIV/AIDS' reported that though less than 1% of those who are HIV-positive in Africa have come out in the open declaring their sero-status, they have become powerful change agents in the sub-continent.

In addition, an approach focusing on social support and social cohesion would also imply the need for a greater focus on 'community-level' interventions rather than merely 'community-based'. (Community-level interventions attempt to modify the entire community through community organization and activation, while community-based interventions attempt to modify individual health behaviours.)

Decosas has also stated that "Small improvements in the physical and social environment of migrants and of their communities may in fact reap greater benefits then targeted service provision." He cites the example of some plantations in Côte d'Ivoire, where employers have started improving social infrastructure by providing schools, family housing, and recreational facilities.[88]

The account of a session on 'What Works?' in the HIV/AIDS/STDS and the Community Track at the September 1999 Lusaka Conference reported that the major findings of the session were:

- It is important not to impose programmes on the community but to go in on their invitation
- Communities are able to use their resources and expertise to run effective and sustainable prevention programmes
- It is necessary to involve community mobilizers and facilitators in planning and implementation of programmes
- Linking care to prevention and sustaining volunteer service is indispensable to a successful prevention strategy
- It is important to integrate care of HIV infected and affected in existing structures[89] .

These basic premises should also inform specific programmes aimed at mobile populations.

[88] Decosas J. *Labour Migration and HIV Epidemics in Africa*, op. cit.
[89] AF-AIDS listing no. 408 *Community initiatives – what works?* XIth International Conference on AIDS and STDs in Africa, Lusaka (Zambia) 12 -16 September 1999, September 22, 1999

E. Are only specific HIV/AIDS interventions required?

There is a strong link between sexually transmitted diseases (STDs)[90] and the sexual transmission of HIV infection. The presence of an untreated STD can enhance both the acquisition and transmission of HIV by a factor of up to 10. Thus, STD treatment is an important HIV prevention strategy in any population.

Treatment of STDs, which is relatively inexpensive, is highly cost-effective in its own right. It becomes even more cost-effective when the benefits of reduced HIV transmission are added.[91, 92] In addition, in developing countries STDs are a major public health problem making up the second cause of healthy life lost in women between 15 and 45 years of age after maternal morbidity and mortality.

UNAIDS has stated that "the magnitude of the problem of STDs, and the strong association with HIV transmission, highlight the need to explore new and innovative approaches to prevent and control their spread. One such approach is the adoption of the 'public health package'. This package for STD control consists of the following components:

- promoting safer sex behaviour
- strengthening condom programmeming
- promoting health-care-seeking behaviour
- integrating STD control into primary health care and other health care services
- providing specific services for populations at increased risk
- comprehensive case management
- prevention and care of congenital syphilis and neonatal conjunctivitis
- early detection of asymptomatic and symptomatic infections.[93]

A complementary approach is to broaden out family planning activities so that all people can realize their right to reproductive health. Several countries with significant migrant populations have developed targeted family planning services for their migrant communities—these migrant-specific services could be further developed in line with global changes in family planning. Since the 1994 International Conference on Population and Development, most governments and major donor agencies have pledged a commitment to implementing an agenda which emphasises:

- the need to develop better quality services for reproductive and sexual health care
- the need for gender equality and, therefore, the empowerment of women
- greater male responsibility for their sexual and reproductive behaviour and their social and family roles
- greater attentions to the sexual and reproductive needs of adolescents

[90] Increasingly being referred to as Sexually transmitted infections (STIs)
[91] UNAIDS: *Technical Update: The public health approach to STD control*. May 1998
[92] Piot P. "Sexually transmitted diseases in the 1990s. Global epidemiology and challenges for control". *Sex Transm Dis* 1994 Mar-Apr, 21 (2 Suppl.): S7-13
[93] ibid, p2

- elimination of violence against women
- special efforts to counter the spread of sexually transmitted infections, including HIV)
- wider participation in reproductive health and family planning programmes.

Policy-makers may need to review their existing reproductive health and STD services and expand the scope and/or target populations for these programmes. There are extensive and clear links between the general goal of safeguarding sexual and reproductive health, and the specific goal of containing STD and HIV.

In practice for most countries, migrant and mobile populations have tended to have less access to reproductive health and STD services than non-mobile nationals. Planning and implementing appropriate programmes for migrant and mobile populations thus requires urgent attention in almost all countries.

V. Promising approaches to explore/ expand in the future

Promising approaches to HIV/AIDS/STD prevention and care for migrants cover a variety of interventions including assuring access to condoms, media campaigns to promote HIV/AIDS awareness and knowledge, theatre and small group education sessions, peer education, outreach and mobile health services, and specialized care and support programmes. The most effective are those that involve a number of different strategies.

Many countries have found that it is frequently both cost-effective and less threatening to integrate HIV/AIDS/STD into more general health services which address other health concerns of migrants. It should be noted that health services aimed at migrants need flexibility and commitment from staff, in conjunction with the involvement of target group representatives in the design and delivery of the services. Specialized training and continuous education are also often necessary for all staff and associated personnel.

One particular problem (not only in the migrants and HIV/AIDS/STD field) is the tendency for some successful programmes to be discontinued because of the belief that a target population has been well informed regarding prevention methods and access to care. It should be noted that successful programmes need to be continued (although perhaps modified), even in situations where saturation is estimated to have been reached. New recruits are constantly joining any target population (becoming sexually active, initiating drug use, entering sex work, etc.), while others need to have their knowledge and understanding increased or reinforced. Similarly, sometimes recommendations, guidelines and programmes are not necessarily fully implemented in the field,[94] thus regular review and follow-up is required.

Outlined below are a number of projects: they are included as illustrative of some of the promising interventions underway in different parts of the world. It should be noted that successful interventions can rarely be transferred intact to another setting: these selected projects are mentioned both to show the scope of possible interventions and as a potential prompt for considering modifications of these projects for other settings. The one characteristic that all these projects have in common is that they all target policy-makers at one or multiple levels, in addition to any service delivery aspects of the project.

1. UNAIDS and UN system projects

i) West Africa

In Africa, projects aimed at reducing HIV vulnerability from mobility, migration and sex work (often accompanying migration) are being carried out by the West Africa Initiative, for which the UNAIDS Intercountry Team based in Abidjan serves as the secretariat.

Covering 17 countries and networks of NGOs and people living with HIV/AIDS, and funded (with contributions from the Canadian and German Governments) by the World Bank, the West Africa Initiative has produced a practical manual for organizations

[94] See, for example, an EC-funded Project Report from the Merchant Navy Welfare Board, UK: *Seafarers: EC Co-ordination of Information on HIV and STDs. Final Report 1998*

implementing HIV prevention projects with sex workers and their clients, and has created a strong network of technical experts to assist countries in project development and implementation.[95]

The action-research programme has involved seven countries: Burkina Faso, Côte d'Ivoire, Ghana, Mali, Niger, Senegal and Togo. While some of the these projects are located in important market towns along international trade routes, others have been elaborated in frontier regions characterized by a high intensity of border crossings.

The success of these projects in West Africa has stimulated interest in Central African countries, which are now initiating similar programmes.

The West African Initiative, in collaboration with the United Nations Development Programme (UNDP), is also helping to strengthen associations of people living with HIV.

The Chad government has initiated a project in conjunction with the Swiss Institute of Tropical Medicine to develop a 'One Medicine' approach, grouping together attention to human and veterinary services for nomadic peoples in Chad. The project aims to ensure that access to services encompasses the particular needs of women and children, including nutritional attention, and will address both health care and health education (including STI) in active conjunction with the participating groups.

ii) East Africa

The "Great Lakes Initiative on HIV/AIDS" focuses on mobile populations and HIV/AIDS, and includes Burundi, Democratic Republic of Congo, Kenya, Rwanda, Uganda and United Republic of Tanzania. Activities include information exchange, care support, integration of the response to HIV/AIDS into socioeconomic and development agendas, promotion of operational research, development of mechanisms of coordination and collaboration between countries, and resource mobilization.[96]

iii) Central America and Mexico

Mobility and sex work are the focus of a sub-regional initiative in Central America and Mexico involving governments, bilateral agencies, NGOs and the UN system. The initiative, launched in 1999, will prioritize the prevention of HIV and sexually transmitted diseases among mobile populations, including sex workers and their clients living in border and port communities.[97]

iv) South and South-East Asia

In South and South-East Asia, a similar initiative is under way for truck drivers, whose lengthy absences from home increase their risk of acquiring and transmitting HIV in both casual partners and spouses. The initiative is intended to increase HIV awareness

[95] For full discussion, see UNAIDS Inter-country Team for West and Central Africa, *Findings of the Research-Action 'Migration and AIDS' Project*, available from UNAIDS, Geneva and Abidjan, and from the World Bank, Washington.
[96] Meeting of national programme managers of GLIA countries, Kampala, Uganda, March 1998.
[97] Bronfman M. *Diagnostic, Intervention and Evaluation of AIDS and Migration in Central America and Mexico*, project proposal, 1999.

and condom use among drivers. UNAIDS provided some seed funding; as at mid-1999, the Asian Development Bank and the German technical aid agency, GTZ, had pledged substantial funding.[98]

v) UNAIDS Intercountry Teams

The UNAIDS Intercountry Teams (ICTs) have, for the last few years, concentrated their efforts on facilitating and strengthening collaboration between intercountry and regional bodies on cross-border issues, migration and mobility. For example, the Asia-Pacific Intercountry Team in Bangkok is facilitating intercountry collaboration and regional dialogue on migration and drug use, two issues with particular relevance for the region. The Asia-Pacific ICT is also supporting rapid applied research on HIV vulnerability and migrant labour in the region.

The Cluster Team for the Caribbean intends to address the issue of mobility in the Caribbean - this programme will include research on immigrants, sex work and tourism.

Working with Seafarers in the Pacific

A significant proportion of the populations of most Pacific Island countries are seafarers (or wives of seafarers). The Secretariat of the South Pacific (SPC) is working through the regional maritime training schools and colleges to ensure they provide quality HIV/AIDS and STD training. Some of the main activities include:

Curriculum development – in consultation with the Regional Maritime Training Programme a module has been developed and included in the regional maritime training curriculum to be implemented by 14 colleges in 12 Pacific Island countries.

Train the trainer workshops – for maritime, health department and NGO trainers who are responsible for implementing the module, or who have an on-going role in providing information and/or support to students and seafarers.

Resource support – through in-country assistance by a member of the SPC team in partnership with college trainers. Provision of a training guide, videos, and other training and information materials for students and trainers.

Peer education training – offered through sub regional workshops for young seafarers who are prepared to assume a role as a peer educator.

Small grants – for each participating country to develop their own materials or to translate other materials into local languages.

Condom supply – in consultation with the college principals, condoms will be supplied to colleges during 1999 and 2000.

The project is being implemented in Vanuatu, Fiji, Tuvalu, Solomon Islands, Tonga, Kiribati, Samoa, Federated States of Micronesia, Marshall Islands, and to a lesser extent, in Papua New Guinea.[99]

[98] see http://www.hivundp.apdip.net

2. European projects

i) European AIDS & Mobility Project

The European Project AIDS & Mobility was initiated at the request of the (then) Global Programme on AIDS of the World Health Organization. Established in 1991, it has predominantly focused on HIV/AIDS prevention, targeting travellers and migrants in Europe. In recent years, it has increased its attention to care and support issues.[100,101]

The Project brings together National Focal Points representing 14 European Union Member States, and operates by stimulating collaboration and exchange of information on AIDS activities aimed at ethnic minority and migrant communities. The EU Member States represented include Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Ireland, The Netherlands, Portugal, Spain, Sweden, and the United Kingdom.

During 1999, each of the National Focal Points organized a national seminar with themes based on priorities set at country level with respect to HIV/AIDS and STD prevention and migrant and ethnic minority communities and other mobile groups. Network activities have included regional training programmes, aimed at NGOs and CBOs, and addressing peer education among migrant populations, migrants living with HIV/AIDS, and culturally and linguistically appropriate services.

In addition, the Project provides an information and documentation centre, with material and literature databases connected to the internet.[102] The project regularly publishes an updated bibliography of relevant books, articles and reports, as well as providing a reference service to other organizations in Europe that are active in the field of migration and health.

In their Athens Declaration of November 1999, the Project noted that access of migrants living with HIV/AIDS in Europe to health care, and specifically to HIV treatment, was frequently very restricted. They noted that this was due to such factors as legal and administrative obstacles, socioeconomic problems, lack of culturally and linguistically appropriate information and services, and stigmatization.

The Project has acknowledged the general need to make health services more accessible for migrants. The collaborating parties have noted that they need to work for strengthening of the services that already work with migrants, improved collaboration between the different services, increased involvement by migrant workers, and sensitization of health/ social professionals to cultural and linguistic issues and needs of migrants.

The AIDS & Mobility Project noted that although EU Member States in theory are not allowed to expel migrants with serious health problems to countries where their health needs cannot be met, there are many examples of such people being deported. The Project has called for access to new treatments to be guaranteed for all people with HIV

[99] Armstrong W. Pacific Islands HIV/AIDS and STD project final report, 1998.
[100] AIDS and Mobility Project. *AIDS & STDs and Migrants, Ethnic Minorities and other Mobile Groups; the State of Affairs in Europe*, de Putter J (ed.). June 1998
[101] European Project AIDS & Mobility: *Access to New Treatments for Migrants Living with HIV and AIDS - conclusions and recommendations*. August 1999; European Project AIDS & Mobility: *Access to New Treatments for Migrants Living with HIV and AIDS - Second Annual Seminar, National Focal Points, European Project AIDS & Mobility*. Clarke K and Bröring G (eds) October 1999; *Athens Declaration,* November 1999
[102] http://www.nigz.nl/aidsmob/

infection and AIDS, living in the member states of the European Union, whatever their residency status. A recent Project report makes reference to each National Focal Point having drawn up a plan of action to provide a basis for future activities in their country to specifically improve migrants' access to treatments for HIV infection and AIDS.[103]

ii) Transnational AIDS/STD Prevention among migrant prostitutes in Europe Project (TAMPEP)

TAMPEP[104] commenced in 1993, with the aim of developing models of health promotion for women and transvestites/transsexuals (men to women) from Eastern Europe, Latin America, Africa and South-east Asia who were working in the prostitution industries of Western, Northern and Southern Europe. The main concern of the project is HIV/STD prevention, but the project notes that, in order to support safe behaviour they have needed to address health in general for the target populations, as well as the overall social position and the working conditions of the migrant sex workers.

In general, migrant sex workers in Europe have extremely limited access to health care services.[105] The specialized TAMPEP project had been effective in reaching migrant sex workers: from 1995 to 1997, the TAMPEP national teams had contacted more than 30,000 migrant sex workers in Italy, Austria, Germany and the Netherlands.[106]

About 30,000 persons work in prostitution in the Netherlands. Official authorities estimate that 50-60% of all sex workers originate from non-EU countries and are residing illegally in the Netherlands. TAMPEP notes that its outreach activities find that 80–90% of sex workers in the windows are migrants.

In 1997, there were between 200,000 and 400,000 women working in Germany in the sex industry: the percentage of migrant sex workers varied between 60 and 70 per cent in towns and border areas.

From 1994 to 1997, TAMPEP had noted an increase in both the numbers of female/ transsexual sex workers and in their originating countries: in 1997, 25 nationalities were recorded in the four participating countries. The sociocultural characteristics of the workers had also been broadening. In addition, by 1997, TAMPEP was noting an increased mobility within and between countries by migrant sex workers in Europe. The majority of women contacted by TAMPEP teams worked in at least two different European countries in any given year, with many working in three or more countries.[107]

TAMPEP has increasingly linked its own prevention work with an international network of service providers and basic projects in the countries of origin, transition and final destination, linking, for example, with EUROPAP, a project which targets all sex

[103] European Project AIDS & Mobility: *Access to New Treatments for Migrants Living with HIV and AIDS - Second Annual Seminar*, op. cit. p5
[104] Transnational AIDS/STD Prevention among migrant prostitutes in Europe Project (TAMPEP) *October 96 / September 97 Final Report*, 1997
[105] EUROPAP/ TAMPEP: *1996 - 1997 Final Report*, October 1997
[106] *TAMPEP Final Report*, op. cit., p1
[107] ibid, p3

workers in Europe. They have been developing as a centre of expertise for training, consultation and advice on migrant sex work for service providers and policy-makers (government and non-government) in all EU member countries, and to some extent more broadly.

TAMPEP has mediated some increased access to health and social services for migrant sex workers in the original four participating countries. However, the majority of migrant sex workers even in these countries have very little access to health and social services.[108] It should be noted that most EU countries provide HIV and STD testing (and some treatments) usually free of charge, and in many cases anonymously. Unfortunately, many migrant sex workers are unaware of this, or distrust government services.

3. North America

i) Whitman Walker Clinic, Washington, DC, USA

The Whitman Walker Clinic (WWC) in Washington, DC, is one of the largest AIDS service organizations in the United States: it provides services for people living with HIV and AIDS[109] in the United States irrespective of their immigration status.[110] Consequently, they provide care and support to possibly more undocumented than legally documented migrants. The clinic has a wide range of services available to persons living with HIV, ranging from anonymous testing and counselling to medical and dental care, legal services, case management services, mental health and addiction treatment services, and day treatment services. In addition, they have a food bank and housing services for clients who have been diagnosed with AIDS. All of the Clinic's services are available regardless of a client's income, insurance status or 'documented' status.[111]

[108] Access to specialized health care for (illegal) migrant sex workers is reasonably easy and inexpensive or free in most areas of The Netherlands. Germany allows non-insured people to have anonymous and free HIV tests, but they cannot obtain any kind of treatment or have preventive therapy. Official institutions (apparently also German sex worker groups) tend to be unwilling to adapt services to better meet the needs of migrants, and very few migrant sex workers use any health care service. For Austria, where free medical check-ups are only available for legal residents, a network providing inexpensive or free medical care for migrant sex workers has been started in Vienna and Linz. In Italy, officially, free-of-charge emergency outpatient treatment is available to anyone, including temporarily-resident foreigners - however, TAMPEP notes that in practice many regions do not provide these services (regions cite budget constraints), and migrant sex workers rarely use any health care service.

[109] Persons living with HIV/AIDS

[110] Personal communication, Glenn Clark, Director, Fleming-Morgan Access Center, Whitman-Walker Clinic, 17 September 1999

[111] At the point of intake, Clinic personnel assess a client's situation and need for services, including their eligibility for public benefits. Legal services, available in-house, can assist a client in applying for public benefits. Although undocumented immigrants are ineligible for many public benefits programmes in the United States, they are eligible for the AIDS Drug Assistance Program, which provides free HIV medications to low-income clients. All information gathered about a client is kept confidential. Language barriers are addressed by providing access to staff who speak the language, if available, or by providing an interpreter to ensure the client is actively involved in their service provision. For Latino/Latina clients, the Clinic has developed a Latino Services department. The Access Center, specifically, is funded by a private donor, which thus allows WWC leeway in how intake services are provided. The funding sources for other HIV services (which include federal, local and private funding) also allow the Clinic to provide services to clients regardless of their migrant status.

4. Asia

i) CARAM (Coordination of Action Research on AIDS and Migration)

CARAM, established in March 1997, is a regional network of NGOs from South and South-east Asia engaged in a major action research programme on Mobility and HIV/AIDS.[112] The organizations involved in CARAM as of mid 1999 included Tenaganita (Malaysia), CCDB (Bangladesh), Kalayaan (Philippines), CARE Thailand, CARE Vietnam, CARE Cambodia and UCM (Indonesia). It is likely that the network will soon expand to more countries of the region. The network is technically supported by the staff of Health Care and Culture of the Vrije Universiteit, the Netherlands.

The objectives of CARAM are:

- production of information on vulnerability and health status of migrant workers in general and HIV/AIDS especially
- advocacy work to improve the living conditions of migrants and to demonstrate how migration contributes to increased vulnerability to HIV infection
- development of grass-roots interventions in the field of health, especially STD/HIV/ AIDS education for migrants and the improvement of access to facilities
- development of action research models to do the above and to collect the data that are needed for CARAM's advocacy work
- protection of the human rights of migrants.

The partner organizations of CARAM are primarily responsible for the production of information and the development and stimulation of local/national interventions (ranging from provision of health services at the grassroots level to advocacy at local and national levels). CARAM-Asia leads in regional advocacy and international coordination and information exchange.

CARAM-Asia and its partner organizations try to ensure that migrants within the region are accessed at both point of origin and destination. For example, if the Ministry of Labour in Cambodia announced that a significant number of women will be going as housemaids to Malaysia, then CARAM-Cambodia would start developing pre-departure programmes, CARAM-Malaysia would develop interventions for Cambodian women on arrival, and CARAM-Asia would react at policy level concerning issues such as HIV testing for these women.[113]

Members of CARAM-Asia have noted that multiple-country and multiple-level mobility interventions and studies are rare. They advise, however, that "experience with participatory action research from the CARAM programme has shown that involvement of the people themselves in learning what the problems are, the collection of information that is needed, and the analysis, contributes greatly to the feasibility of interventions that result from the research. The nature of the research in the field of HIV/AIDS (sexual behaviour, hidden prejudices against foreigners, people with other sexual preferences, etc.) makes the cooperation of those involved very important. People that are stigmatized and fear discrimination (if not worse) are in no way likely to be willing to share information with people from outside".[114]

[112] CARAM-Asia: *Coordination of Action Research on AIDS and Migration. The vulnerability of migrants to HIV/AIDS*. June 1998
[113] ibid, p28
[114] Wolffers I, Fernandez I, Verghis S and Painter T. *A Model for Evaluating HIV/AIDS Interventions For Mobile Populations*, Paper presented at the Fifth International Congress on AIDS in Asia and the Pacific, Kuala Lumpur, 23 – 27 October 1999

CARAM-Asia has now developed a matrix framework for intervention involving the concepts of "vulnerability (leading to community interventions and empowerment), risk (related to a more personalised intervention and making individual choices) and human rights (related to advocacy work)" and "opportunities in time, place and conditions for implementation of interventions." The intervention framework also encompasses explicit attention to gender issues. The dimensions of time and place that are important include the pre-departure process, the migration itself, the initial period of adaptation, successful adaptation, return migration, and re-integration into the original community.[115]

ii) Australian multicultural AIDS projects

Within a context of considerable government/NGO attention to ethnic communities, particularly new arrivals, both national and state governments in Australia have funded a range of HIV/AIDS education projects targeting ethnic communities, especially those with large populations of people who speak English poorly or not at all.

A video (in 6 language versions plus English) on HIV/AIDS-related issues, produced for new arrivals by the New South Wales Multicultural AIDS Project, won the 1999 Australian Multicultural Marketing Award.

All national and state HIV/AIDS media campaigns have at least one component in multiple languages, and in most cases printed information is translated into more than 16 languages. In addition, there are specialized HIV and ethnic group health care workers in most parts of Australia, including specialized targeted sex worker and IDU projects.

Siren's Story is a booklet in Tagalog for Filipina sex workers in Australia. It contains information about how to work and manage money as well as health information and tips for negotiating safe sex. There are different versions of the booklet for sex workers from different countries.

While government-funded health care is officially only available to legal residents, sometimes unofficial arrangements are possible. Undocumented migrants with HIV/AIDS in Australia have been treated through the Sexual Health Centre network. Sexual Health Centres run confidential services and do not ask for identification, whereas most other health services have to ask for the national health insurance card which is only available to legal residents. This means that people with HIV/AIDS without legal residence in Australia can obtain outpatient care and treatment at relatively little or no personal cost, including antiretrovirals, other relevant drugs and health monitoring. The situation becomes more complicated if patients have to be admitted to hospital since they need to show a health insurance card, have private health insurance or pay for the care themselves.

Australia provides a (free access) national translating and interpretation service, 24 hours a day, seven days a week in over 100 languages.

[115] ibid, p8

VI. Implications for policy-makers

One of the overall problems in the area of migrant health, in particular in regard to STI/HIV and reproductive health, is that attention has for the most part been limited, patchy and sporadic.

This paper has argued for a more comprehensive, and global, approach, with clear leadership requirements from a number of international agencies. However, whatever the influence of an 'international' or 'global' agenda, the locus of decision-making will remain the nation state. The challenge will be to ensure that nation states understand that their self-interest requires attention to STI/HIV among all peoples of the world. In addition, policy-makers will need to consider the spectrum of decision-making and ensure that migrant health does not continue to fall off the agenda at most points along the spectrum.

As Parsons[116] has stated, "If we define decision-making as a process in which choices are made or a preferred option is selected, then the notion of decision involves a point or series of points in time and space when policy-makers allocate values. Decision-making in this sense extends throughout the policy cycle; for example:

- decisions about what to make into a 'problem'
- what information to choose
- choices about strategies to influence the policy agenda
- choices about what policy options to consider
- choices about what option to select
- choices about ends and means
- choices in how a policy is implemented
- choices about how policies may be evaluated.

At each of these points decision-making is taking place. Some of these decisions involve the allocation of values and the distribution of resources by the formulation of a policy, or through the ongoing conduct of a programme. Decision-making thus takes place in different arenas and at different levels. At one level, there is a decision by high policy actors to make 'national' health or economic policy, at another there are the decisions of other actors who are involved in 'health' policy at the level of a hospital or local service."

International agencies may be able to assist countries by promoting best practice policies and arrangements addressing all points on the decision-making continuum in relation to migrants' right to health, particularly in relation to HIV/AIDS/STD and reproductive health matters. In addition, the numerous research publications in the area need to be 'translated' so that policy- and decision-makers have better access to the research and the policy implications of the research.

[116] Parsons W: *Public Policy. An Introduction to the Theory and Practice of Policy Analysis*. Edward Elgar Publishing Ltd, UK, 1997, p245

It must be acknowledged by policy-makers and planners that equity of access to information and to health service delivery often requires a number of different and additional strategies to ensure that all parts of a population, especially the hard-to-reach such as illegal immigrants, have real access. Too often, in industrialized countries in particular, statements are made that health care access is available for all, without reference or attention to practical and psychological barriers for sub-populations such as females, people speaking a different language, people from different cultural backgrounds, people from rural areas or outlying regions, people with limited financial resources in generally affluent settings, or people ashamed of having contracted a sexually transmitted infection.

This paper has argued for a number of changes to improve migrants' health (particularly in regard to HIV/AIDS, other sexually transmitted infections and reproductive health), at global, national and local levels. In summary, these include:

- acknowledgment of the right to the highest attainable standard of physical and mental health. In relation to migrant populations, this might require attention to the right to affordable and accessible health services, the right to healthy working and living conditions, and the right to appropriate health education.
- attention to, and compliance by all countries with international treaties and agreements to which they are a party, and to relevant international customary law. It appears that many countries sign international treaties/ agreements but do not necessarily put in place the measures required for compliance with the letter and spirit of such agreements.
- general application of, and compliance with, the International Health Regulations.
- measures to ensure that major sending, transit and receiving countries have joint/ tripartite health access programmes in place to address all time and place points on the moving continuum for citizens/ migrant workers. Such points include pre-departure, the migration itself, the initial period of adaptation, successful adaptation, return migration, and re-integration into the original community.
- health care access programmes for travellers and migrant populations that move beyond emergency care, and address physical, mental and social well-being, particularly in relation to HIV/ AIDS/ STD and reproductive health.
- greater attention to prevention in health service policy and delivery for migrant/ mobile populations, including widespread development and implementation of community-level interventions.
- for migrants and for mobile populations within countries, measures to ensure good access to health-related HIV/ AIDS/ STD/ reproductive health prevention and care for all members of such populations. For example, appropriate health education may require the production of highly specific material in a range of languages.
- attention to the gender disparities often involved in migrant worker movements, both within countries and across borders, and to gender/ power relationships which frequently govern women's access to information and health care.
- understanding by major sending countries that contributions to the Gross National Product by migrant workers sending money back to their families may be balanced by pressure placed on health and social services, if migrant workers return to their home country ill or disabled.

VII. Conclusion

Migrants can be especially vulnerable to HIV/AIDS/STD, but are often excluded or simply missed in many prevention and care programmes.

The effects of globalization would seem to require governments, if only for self-interest, to ensure that this state of affairs does not continue. In addition, there is evidence of human rights and other ethical violations occurring that need to be urgently addressed at local, national and international levels.

Changing this state of affairs will require consideration of a range of socioeconomic and political factors.

Successful HIV/AIDS/STD prevention and care programmes for migrant populations tend to be those developed with and guided by migrant communities, and involving substantial community mobilization. Programmes must ensure access to care and be integrated with other local and national AIDS-related programmes. Peer educators often may play a key role, but flexibility and committed staff are essential to supervise and support peer educators.

It is particularly difficult for government agencies to address HIV/AIDS/STD issues as they concern undocumented migrants. However, non-government organizations in a number of countries and settings have shown that they can readily access and work effectively with people without legal status in the countries in which they are living.

Progress has been made in preventing the spread of HIV to and from migrants, and in ameliorating the impact of the disease upon HIV-infected migrants. Projects addressing other sexually transmitted infections and reproductive health for migrants and mobile populations are available in a number of countries and settings. The challenge now is to address more comprehensively the complex issues involved, in all countries and at all levels.

Recommendations

Guidelines and policy recommendations must be issued and implemented in regard to migrant health, especially concerning HIV/AIDS/STD and reproductive health. It is international organizations with either migration or health within their mandate that must take leadership in such policy recommendations, and as a matter of urgency. The IOM may assist this process by providing a clearinghouse support regarding status and progress of improvements in (migrant) health in major sending and receiving countries.

Global attention must be drawn to the health access needs of migrants, particularly in relation to HIV/AIDS/STD. Strategic action will need to be undertaken at global, regional, national and local levels. Policies, activities, and information exchange must be coordinated between countries where migrants originate, transit and settle. It is UN agencies, and relevant international organizations and international NGOs that should organise to ensure that this happens.

Countries that receive migrants need to adopt health policies and practices that will remove economic, administrative and linguistic barriers to their access to health. Such policies and practices should specifically encompass all types of migrant, including the most vulnerable, such as seasonal workers and undocumented migrants. Gender issues will need to be integrated within policies and programmes.

STD and reproductive health services for mobile/ migrant populations must be strengthened, in addition to and as part of HIV/AIDS prevention and care programmes.

Where appropriate, such programmes should address cross-border traffic and zones.

Prevention and care interventions addressing HIV/AIDS/STD and reproductive health should involve community mobilizers and facilitators. Members of the target community must be involved at all stages, from planning then delivering to evaluating health promotion and services delivery programmes.

Appendix 1 International instruments (and relevant clauses)

This appendix seeks to provide some of the key clauses in International instruments of relevance for this paper. The full texts may be found at http://www.unhchr.org

Charter of the United Nations (1945)

Art 2. The Organization and its members, in pursuit of the Purposes stated in Article 1, shall act in accordance with the following Principles.

1. The Organization is based on the principle of the sovereign equality of all its members.

4. All members shall refrain in their international relations from the threat or use of force against the territorial integrity or political independence of any state, or in any other manner inconsistent with the Purposes of the United Nations.

Art. 10. The General Assembly may discuss any questions or any matters within the scope of the present Charter or relating to the powers and functions of any organs provided for in the present Charter, and, except as provided in Article 12, may make recommendations to the Members of the United Nations or to the Security Council or to both on any such questions or matters.

Art. 55. With a view to the creation of conditions of stability and well being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

a) higher standards of living, full employment, and conditions of economic and social progress and development;

b) solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and

c) universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Art. 56. All Members pledge themselves to take joint and separate action in cooperation with the Organization for the achievement of the purposes set forth in Article 55.

World Health Organization Statute (1946)

Preamble: The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.

Universal Declaration of Human Rights (1948)

Art. 25.1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

International Covenant on Economic, Social and Cultural Rights (1966)

Art 12. 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:

a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

b) The improvement of all aspects of environmental and industrial hygiene;

c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

d) The creation of conditions which would assure access to all medical service and attention in the event of sickness.

Art. 2. 1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

International Covenant on Civil and Political Rights (1966)

Art. 6. Every human has the inherent right to live. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

Art. 7. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Art. 17. 1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.

2. Everyone has the right to protection of the law against such interference or attacks.

International Covenant on the Elimination of all Forms of Racial Discrimination (1965)

Art. 5. In compliance with the fundamental obligations laid down in Article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: (...)

(e) Economic, social and cultural rights, in particular: (...)

iv) The right to public health, medical care, social security and social services.

Bibliography

Acción Ciudadana Contra El SIDA – ACCSI (Citizen Action against AIDS). Cornieles C, Carrasco E and Koch R. *Magdalena's story: The pregnancy of a HIV+ adolescent who lives in the streets of Caracas.* 1999

Achmat Z, Barrett C, Cohen B et al. *HIV/AIDS and The Law: A Resource Manual*. Published by the AIDS Law Project and Lawyers for Human Rights, South Africa. May 1997

Allin NE. "The AIDS Pandemic: international travel and immigration restrictions and the World Health Organization's Response", *Virginia J Int Law* 1988, 28: 1043-1063

Appleyard R and Wilson A (eds.). "Migration and HIV/AIDS", *International Migration Quarterly Review*, Vol. 36 (4), 1998

Archiv für Sozialpolitik AIDS Archiv. "Restrictions of entry and residence for people with HIV/AIDS: a global survey". Frankfurt am Main, 1991

Berlinguer G. "Indivisibility and Globalization of Health" in *The Effects of Globalization on Health*, Report from a Symposium held at the Annual Meeting of the NGO Forum for Health, Geneva, May 1998

Bidjeh K, Zinsstag J and Wyss K. *Santé des Nomades au Tchad. Un projet de Recherche et d' Intervention*. Ministère de l'Elevage, Tchad, Ministère de la Santé Publique, Tchad, Centre de Support en Santé Internationale, Tchad, Institut Tropical Suisse, 1999

Bollini P and Siem H. "No real progress towards equity: Health of migrants and ethnic minorities on the eve of the year 2000". *Soc. Sci. Med*. Vol. 41, No. 6, pp819-828, 1995

CARAM-Asia. *Coordination of Action Research on AIDS and Migration. The vulnerability of migrants to HIV/AIDS*. June 1998

Christakis NA. "Responding to a Pandemic: International Interests in AIDS Control", in Graubard, SR (ed.) *Living with AIDS*, Cambridge, MA, MIT Press, 1990. pp329-351

Colvin M, Abdool Karim SS and Wilkinson D. "Migration and AIDS". *The Lancet* 1995; 346: 1304

Commission on Global Governance. *Our Global Neighbourhood: The Report of The Commission on Global Governance*. Oxford University Press, 1995

Decosas J and Adrien A. "Migration and HIV". *AIDS* 1997, 11 (suppl. A): 577-584

Decosas J, Kane F, Anarfi JK, Sodji KDR and Wagner HU. "Migration and AIDS" *The Lancet* 1995; 346: 826-28

Decosas J. *Labour Migration and HIV Epidemics in Africa*, presentation at the 12th World AIDS Conference, Geneva, Switzerland, July 1998

Doupe A. *AIDS and Human Rights: Time for an Empowered Response*, LLM Thesis, September 1997

Duckett M and Orkin AJ. "HIV/AIDS-related migration and travel policies and restrictions: a global study". *AIDS* 1989: 3(Suppl. 1); s231-252

Egger M, Minder CE and Smith GD. "Health inequalities and migrant workers in Switzerland", *Lancet* 816, Sept 29, 1990

European Project AIDS and Mobility. *AIDS and Mobility Annual Report 1998, Planned Activities 1999*. 1999

European Project AIDS and Mobility. *AIDS & STDs and Migrants, Ethnic Minorities and other Mobile Groups; the State of Affairs in Europe*, de Putter J (ed.). June 1998.

European Project AIDS & Mobility. *Access to New Treatments for Migrants Living with HIV and AIDS - conclusions and recommendations*. August 1999

European Project AIDS & Mobility. *Access to New Treatments for Migrants Living with HIV and AIDS - Second Annual Seminar, National Focal Points, European Project AIDS & Mobility*. Clarke K and Bröring G (Eds) October 1999

European Project AIDS & Mobility. *Athens Declaration*. November 1999

European Project AIDS & Mobility. *Bibliography*. February 1997

European Project AIDS and Mobility. *"Equal Opportunities in Public Health". A European Meeting on the vulnerability of socially disadvantaged groups in public health*, Bonn, September 1996

European Project AIDS and Mobility. *Exchange Meeting: HIV/AIDS Prevention and Care Programmes among Migrants*, Geneva, July 1998

European Project AIDS and Mobility. *AIDS and Mobility Annual Report 1999, Planned Activities 2000*. 2000

European Project AIDS & Mobility. *Literature and Materials*. February 2000

EUROPAP/ TAMPEP. *1996 - 1997 Final Report*, October 1997

European Network on Male Prostitution. *First Interim Report* 1998

Fernandez I. *Migration and HIV/AIDS Vulnerability in South East Asia*. Paper presented at the 12th World AIDS Conference, Geneva, July 1998

Fidler DP. "Globalization, International Law, and Emerging Infectious Diseases", *Emerging Infectious Diseases*, Vol. 2, No. 2, April-June 1996

Fluss S. *Some recent patterns and trends in communicable disease legislation in selected European countries*, presentation at the May 1996 meeting of the Biomed 2 Project on Communicable Diseases, Lifestyles and Personal Responsibility: Ethics and Rights.

Forrest DM. "Control of Imported Communicable Diseases: Preparation and Response". *Canadian Journal of Public Health*, Vol. 87, No. 6. November-December 1996, pp368-372

Friedrich D and Heckmann W (eds.). *AIDS in Europe - The Behavioural Aspect. Vol. 1: General Aspects.* 1995

Gellert GA. "International Migration and Control of Communicable Diseases", *Soc. Sci. Med*. Vol. 37, No. 12, 1993, pp1489-1499

Gilmore N. *HIV/AIDS Legislation: Blame and Responsibility. The Saga of HIV-infected Haitian Refugees at Guantanamo Bay, Cuba*, Presentation at (US) National Council for

International Health Workshop, June 1995. Revised text, November 1995

Gilmore N. *Human Rights Issues and Migration*, presentation at the 12th World AIDS Conference, Geneva, Switzerland, July 1998

Graubard, SR (Ed.) *Living with AIDS*, Cambridge, MA, MIT Press, 1990

Gruskin S, Mann J, and Tarantola D (eds.). *Health and Human Rights Journal*, Vol. 2; No. 4. Special Focus: HIV/AIDS and Human Rights. 1998

Haour-Knipe M and Rector R. *Crossing borders: migration, ethnicity and AIDS*. London, Taylor & Francis, 1996

Haour-Knipe M and Aggleton P, "Social enquiry and HIV/AIDS*", Critical Public Health*, Vol. 8, No. 4, 1998, pp257-271

Haour-Knipe M. *In conclusion*, presentation at the 12th World AIDS Conference, Geneva, Switzerland, July 1998

Hendriks A. "The right to freedom of movement and the (un) lawfulness of AIDS/HIV specific travel restrictions from a European perspective." *Nordic Journal of International Law* 59: Fasc. 2/3, 1990

Human Rights Internet. *Human Rights and HIV/AIDS: Effective Community Responses*. May 1998

ILO. *Migrant Workers, International Labour Conference, 87th Session 1999, Report III (Part 1B*). Geneva, 1999

International Council of AIDS Service Organizations: *NGO Summary of the International Guidelines on HIV/AIDS and Human Rights*, 1997

International Council of AIDS Service Organizations (ICASO). *An Advocate's Guide to the International Guidelines on HIV/AIDS and Human Rights*, October 1997

Kane F, Alary M, Ndoye I et al. "Temporary expatriation is related to HIV-1 infection in rural Senegal". *AIDS* 1993, 7:1261-1265

Laboratory Centre for Disease Control, Health Canada. *Countries with HIV-Related Entry Restrictions*. December 1996

Latin American and Caribbean Council of AIDS Service Organizations (LACCASO). *Migratory Routes from Haiti to Dominican Republic: Consequences for HIV/AIDS and the Human Rights of Infected People*, Paper prepared by Severino IL, de Moya EA, Scharboy V, Rowinsky P, Stephens R and Esquea R, April 1999

Loewenson R and Whiteside A. *Social and Economic Issues of HIV/AIDS in Southern Africa*. A Consultancy Report prepared for SAfAIDS, Harare, March 1997

Lomas J. "Social Capital and Health: Implications for Public Health and Epidemiology", *Soc. Sci. Med*. Vol. 47, No. 9, pp1181-1188, 1998

Lurie M, Garnett G, Abdool Karim S, Sturm W, Wilkinson D, and Williams B. *Research Protocol. Migration and the Spread of HIV and Other Sexually Transmitted Diseases in South Africa: Interlocking Urban and Rural Cohort Studies*. January 1998

Mann J, Tarantola DJM and Netter TW (eds.). *AIDS in the World: A Global Report*. Cambridge, MA, Harvard University Press, 1992.

Merchant Navy Welfare Board, UK. *Seafarers: EC Co-ordination of Information on HIV and STDs. Final Report 1998*

Mishra SI, Conner RF and Magana JR (eds.) *AIDS. Crossing Borders: The Spread of HIV Among Migrant Latinos*. Colorado, Westview Press, 1996

Montgomery J. "Recognizing a right to health" in Beddard R & Dilys DM (eds.). 1992. *Economic, social and cultural rights: Progress and achievement*. New York, St. Martin's Press, pp. 184-203

Network of Sex Work Projects (NSWP). *Making sex work safe*. London, 1997

New Zealand Ministry of Foreign Affairs and Trade. *NZODA Regional Health Programme Initiatives, 1997-1999*

Ngwena C. *AIDS and Right of Access to Treatment: The Scope and Limits*, Paper presented at the XIth International Conference on AIDS and STDs in Africa, Lusaka (Zambia), 12 -16 September 1999.

Office of the United Nations High Commissioner for Human Rights/ UNAIDS. *HIV/AIDS and Human Rights. International Guidelines*. United Nations, New York and Geneva, 1998

Ottawa Charter, WHO/HPR/HEP/95.1. Charter adopted at an International Conference on Health Promotion, November 1986

Overseas Development Institute Briefing Paper. *Global Governance: An Agenda for the Renewal of the United Nations?* 1999 (2) July

Parsons W. *Public Policy. An Introduction to the Theory and Practice of Policy Analysis*. Edward Elgar Publishing Ltd, UK, 1997

Piot P. "Sexually transmitted diseases in the 1990s. Global epidemiology and challenges for control". *Sex Transm Dis* 1994 Mar-Apr, 21 (2 Suppl.): S7-13

Secretariat of the Pacific Communities. *HIV/AIDS Among Seafarers in the Pacific Region: A Situational Analysis*. 1999

Secretariat of the Pacific Communities. Report on Seafarers Project. *PASA 18*, 1999

Singhanetra-Renard A. "Population movement and the AIDS epidemic in Thailand", Paper presented at the IUSSP Seminar on Sexual Subcultures and Migration in the Era of AIDS/STDs, Bangkok, Thailand, March 1994

Somerville MA and Orkin AJ. "Human rights, discrimination and AIDS: concepts and issues" *AIDS* 1989, 3 (suppl. 1): S283-S287

Somerville MA and Wilson S. "Crossing Boundaries: Travel, Immigration, Human rights and AIDS", *McGill Law Journal*, 1998, Vol. 43, pp782-835

Tan M. "Migration and Risk". *AIDS action*, Issue 40, July-September 1998

Tenaganita. *Solidariti Migran*. Issue No. 1, June 1998

Tomasevski K. "Health rights" in Eide A, Krause C & Rosas A. (eds.) 1995. *Economic, social and cultural rights: A textbook*. Dordrecht, Boston, London, Martinus Nijhoff Publishers, pp125-142

Transnational AIDS/STD Prevention among migrant prostitutes in Europe Project (TAMPEP). *1996 -1997 Final Report*, October 1997

UNAIDS. *The UNAIDS Report*. UNAIDS/99.29E, June 1999

UNAIDS. *Migration and HIV/AIDS*. Paper prepared for UNAIDS Programme Coordinating Board meeting, December 1998

UNAIDS. *Technical Update: The public health approach to STD control*. May 1998

UNAIDS. *Technical Update on Migration and HIV/AIDS*, UNAIDS, 2000

UNAIDS Press Release: *UN Officials in Lusaka Commit to Increased Action against AIDS in Africa*. Lusaka, 15 September 1999

UNAIDS. Fages V *Migration and AIDS in South Africa: A Public Health Issue*, UNAIDS Pretoria, March 1999 (unpublished)

UNAIDS. *Report of the Executive Director, UNAIDS Programme Coordinating Board*. UNAIDS/ PCB (8)/99.2, June 1999

UNFPA. Chung M. *Integrating Reproductive Health and STD/HIV Prevention Services: A Guide for Pacific Island Reproductive Health Programme Managers*. 1999

United Nations. Ayton-Shenker D. *The Challenge of Human Rights and Cultural Diversity*. United Nations Background Note. DPI/1627/HR March 1995

United Nations. *The Universal Declaration of Human Rights, 1948-1998*. United Nations Department of Public Information, June 1998

van Beelen N, Wolffers I and Brussa L (eds.). *Research for Sex Work*. June 1998

van den Berg, RG. *Migrants with HIV/AIDS and access to health care in Europe: human rights aspects*. European Project AIDS and Mobility. February 1999.

Wahdan MH. "Shortcomings in the Current Version of the International Health Regulations and Difficulties in their Implementation", *WHO Informal Consultation to review the International Response to Epidemics and Application of the International Health Regulations*, December 1995, EMC/IHR/GEN/95.4

WHO. *Primary Health Care. Report of the International Conference on Primary Health Care,* Alma Ata, USSR, 6-12 September 1978

WHO. *Background Paper: Long Term Travel Restrictions and HIV/AIDS*. WHO Global Programme on AIDS, October 1994

WHO. *Report of the Preparatory Meeting for a Consultation on Long Term Travel Restrictions and HIV/AIDS*. WHO Global Programme on AIDS, October 1994

WHO. *Removing Obstacles to Healthy Development: Report on Infectious Diseases*. World Health Organization, 1999 WHO/CDS/99.1

WHO. *The World Health Report 1999: Making a Difference*. World Health Organization, 1999

WHO. *World Health Opportunity: Developing Health, Reducing Poverty. Meeting Report*, May 1999

WHO. *Statement by Dr Gro Harlem Brundtland, Director-General, World Health Organization, ICPD + 5 Forum*, The Hague, 8-12 February 1999

WHO. *Tuberculosis in the Western Pacific*, WHO Regional Office for the Western Pacific, 1999

WHO. Press Release WHA/13 22 May 1999 *WHO to Address Trade and Pharmaceuticals*

WHO. Murray CJL and Lopez AD (eds.). *Health Dimensions of Sex and Reproduction: the Global Burden of Sexually Transmitted Diseases, HIV, Maternal Conditions, Perinatal Disorders, and Congenital Anomalies*. Global Burden of Disease and Injury Series, Harvard, 1999

WHO. *Fact Sheet No. 186: Young People and Sexually Transmitted Diseases*. December 1997

Wolffers I and Fernandez I. "Migration and AIDS" *The Lancet* 1995; 346: 1303

Wolffers I, Fernandez I, Verghis S and Painter T. *A Model for Evaluating HIV/AIDS Interventions For Mobile Populations*, Paper presented at the Fifth International Congress on AIDS in Asia and the Pacific, Kuala Lumpur, Malaysia 23 – 27 October 1999

World Bank. *Workers in an Integrating World: World Development Report 1995*. Oxford, Oxford University Press, 1995

World Bank. *Confronting AIDS: Public Priorities in a Global Epidemic*. Oxford, Oxford University Press, 1997

Ybanez RFC. "Breaking Borders: Migration and HIV/AIDS". *AIDS action*, Issue 40, July-September 1998

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.

Produced with environment-friendly materials

Although there is no agreed definition of what is a migrant, it is estimated that there are probably two billion people on the move globally each year. Migrants can be especially vulnerable to HIV/AIDS/STD, but are often excluded or simply missed in many prevention and care programmes. This paper outlines key existing laws, policies and best practices in relation to the rights of migrants to health, and associated care, treatment, support and prevention. It argues for a number of immediate changes to improve migrants' health and concludes with recommendations for the future development of policies to improve the health status of migrant populations.

Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

Joint United Nations Programme on HIV/AIDS (UNAIDS)
UNAIDS - 20 avenue Appia - 1211 Geneva 27 - Switzerland
Telephone: (+41 22) 791 46 51 - Fax: (+41 22) 791 41 87
E-mail: unaids@unaids.org - Internet: http://www.unaids.org

$10.00