



in focus

Civil Society Perspectives on the 2011 HIV/AIDS HLM
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MIGRANT WORKERS

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The 2011 Political Declaration on HIV/AIDS

In 2011, the United Nations General Assembly High Level Meeting on HIV/AIDS was held in New York where 193 member states adopted the 2011 Political Declaration on HIV/AIDS (the Political Declaration) through UN Resolution 65/277. This issue of InFocus unpacks the Political Declaration to see how the commitments made relate to the 61 million migrant workers from Asian countries, and identifies the barriers that currently exist in scaling up Universal Access to comprehensive HIV prevention, treatment, care and support for them.

The Political Declaration only mentions migrants specifically in paragraphs 60 and 84, and indirectly in 79. However, because migration does not increase the risk of HIV, but does increase vulnerability, migrants should be considered as a cross-cutting group throughout the whole Declaration and thereby referenced in many other paragraphs. For example, mention of “workers” or “employment” is an indirect reference to migrants because most of those who migrate do so for work. This means that migrant workers should be included in the commitment made to promote non-discriminatory access to employment (paragraph 77); and in the commitment to mitigate the impact of the epidemic on workers, their families, their dependants and workplaces, by taking into account the relevant guidance provided in ILO conventions and ILO Recommendation 200 (paragraph 85).

in a nutshell

Out of 105 paragraphs, migrants are mentioned twice (paras 60 and 84). However, numerous other paragraphs, especially paragraph 79, affect migrant workers' ability to access HIV prevention, treatment, care and support:

- Paragraphs 39 and 77 reaffirm that enabling legal and policy frameworks are needed in order to eliminate stigma and discrimination, with paragraph 84 naming migrants specifically, and paragraph 79 calling to eliminate HIV-related restrictions on entry, stay and residence.
- The commitment to halve sexual transmission by 2015 (para 62) through increased prevention (para 58) identifies migrants (para 60) as needing to be included under National AIDS Plans that have disaggregated data (para 46 and 61), evidence-based strategies supported by allocation of necessary budgets and condoms (para 54, 55, 59(d)) and strategies to address relevant gender inequality (para 21 and 28).
- The pledge to facilitate access to sexual and reproductive health services made in paragraphs 21, 25, 41, 53 and 59(k), means reaching migrants of all ages, sexes and genders, at all stages of migration.
- In paragraphs 66, 67, 69 and 73, the commitments made to accelerate timely initiation of treatment, promote adherence and provide socio-economic support, need to include migrants.
- The commitments to expand and promote voluntary and confidential HIV testing and counseling made in paragraphs 59(f), 61 and 80, require special strategies for migrants and the end of mandatory HIV testing.

unpacking key paragraphs

Human Rights, and Reducing HIV-Related Stigma and Discrimination (paras 39,77,79,84)

Paragraph 39 reaffirms that full realization of all human rights and fundamental freedoms is an essential element in the global response to the HIV epidemic, and a key component is combating stigma and discrimination.

HIV-related restrictions on entry, stay and residence are institutionalized stigma and discrimination, and act as the initial and most obdurate (or stubborn) barrier to providing HIV services to migrants. While paragraph 79 encourages Member States to take steps to eliminate these policies, the language falls short of a commitment.

Paragraph 84 commits to address, "according to national legislation," the vulnerabilities to HIV of migrants and mobile populations, and support their access to HIV services. While it is unclear what legislation this terse paragraph refers to specifically, changes to policies that make migrants' legal status tenuous and thus limit access to services, or policies that explicitly exclude migrants from protections against HIV related discrimination granted to nationals or that limit migrants' health insurance coverage, are most needed.

Supporting this commitment, in paragraph 77, Member States commit to intensify national efforts to create enabling frameworks to eliminate discrimination and promote access to healthcare. Such actions would uphold migrants' basic right

to health (as established in the ICESCR, Article 12d; and in the Convention on the Protection of the Rights of Migrant Workers, Article 43e); and echo the recommendations made at the 61st World Health Assembly on the Health of Migrants to promote: (1) migrant-sensitive health policies; and (2) equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race.

Prevention (paras 21,28,46,54,55,58,59(d),60,61,62)

Looking at more pragmatic aspects of the Declaration, paragraph 46 recognizes the need for better disaggregated data on HIV incidence and prevalence by age, sex, mode of transmission, and other relevant data; and paragraph 61 commits to ensuring that systems to collect and analyze this data are in place and strengthened. While there is a lack of data on migrants and HIV, any data collected needs to respect migrants' right to confidentiality, and should not impact their legal or work status.

Paragraph 59 commits to implementing comprehensive, evidence-based prevention approaches; and paragraph 60 names migrants as a group in particular need of HIV prevention. As migrants' exposure to HIV infection varies according to country context and individual behaviors, interventions need to focus on the specific nature and circumstances of transmission among migrants in each country; consider migrants' sub-cultures, languages, geographic location and type of work; and develop strategies that are able to reach them accordingly.

Unfortunately, migrants are included in very few origin or destination Asian countries' National AIDS Plans. When migrants are included, National Plans either lack strategies or do not adequately fund such strategies or both, undermining the commitments made in paragraphs 54 & 55. Similarly, in paragraph 59(d) there is a call to expand access to male and female condoms; however, even in countries where there is successful condom programming, migrants are commonly neglected. Without effective interventions and sufficient condom supplies for migrants, commitments under paragraphs 58 and 62 -- to make prevention the cornerstone of the response and reduce sexual transmission of HIV by 50 percent by 2015 -- will be missed.

Gender inequality is another factor that needs to be addressed to reach the commitment of paragraph 62. Paragraphs 21 and 28 indicate that women's vulnerability to HIV is increased by gender inequality, especially under conditions of married or cohabitating individuals. Spouses of migrants are particularly vulnerable to HIV infection, especially when the migrant has been deported for HIV.

“... migrant workers experience particular HIV risks and needs, which must be addressed in striving towards universal access to HIV prevention, treatment, care and support services...”

- ILO, IOM and UNAIDS Joint Policy Brief:
HIV and International Labour Migration (2008)

Sexual and Reproductive Health (paras. 21,25,41,53, 59(c), 59(k))

Paragraph 41 identifies access to proper sexual and reproductive health (SRH) information and services as an essential component of the HIV and AIDS response, while paragraphs 21 and 25 note that women and young people face numerous limitations in terms of access. This raises concern for Asian migrants where almost 20 percent are under the age of 25, and more than half are female in some countries.

Female Asian migrants receive very little practical information on HIV prevention or SRH before they go abroad, and may simply be encouraged to practice abstinence (para 59(c)). The inherent flaw here is that migrants are considered solely as laborers, and their SRH needs are ignored. Member States can remedy this by upholding the commitment in paragraph 59(k) to facilitate access to SRH services to migrants of all ages, sexes and genders, working in all occupations, at all stages of migration.

There are also policies that require migrant women to be tested for pregnancy and may result in either denial of entry or deportation. These practices violate their rights by going against General Recommendation 26 of the 42nd session of CEDAW (Convention on Elimination of all forms of Discrimination Against Women), and countering the pledge in paragraph 53 of the Declaration to ensure that women can exercise their right to have control over their SRH free of coercion, discrimination and violence.

Voluntary & Confidential HIV Testing & Counseling

(paras. 59(f),61,75,77,80)

Paragraphs 59(f) and 61 commit to the expansion and promotion of voluntary and confidential HIV testing and counseling (VCCT). They also commit to making VCCT more accessible and ensuring that it acts as a gateway to accessing prevention, treatment, care and support.

Contrary to this, a number of destination countries in Asia and the Middle East currently require Asian migrants to undergo mandatory HIV testing in order to receive and renew work permits and visas. Migrants who test positive for HIV (or TB) are either disallowed from entering the host country, or are immediately detained and deported (which also counters the call for expanded efforts to combat TB in paragraph 75).

While the commitment to “expand and promote VCCT” in paragraph 59(f) is a positive goal, in order to encourage migrants and their partners to undergo VCCT, the commitments to protect privacy and confidentiality in paragraphs 77 and 80 always need to be upheld, and special strategies are needed such as the use of rapid HIV-testing and peer counseling, accompanied by campaigns that promote testing (paragraph 59(g)).

Treatment, Care and Support (paras 66,67,69,73,77)

Migrant workers' access to treatment, care and support is also thwarted by HIV-related restrictions on entry and stay, and by the fact that very few host countries make affordable ART available to non-nationals. Beyond the fact that these two policies effectively preclude migrants from receiving treatment in host countries, rejection of a visa or being deported may also result in migrants missing the opportunity to initiate treatment in their home countries.

Since many migrants come from impoverished, rural areas where HIV services are unavailable, they may miss the opportunity to access treatment if not properly counseled before returning home. Thus, HIV-related restrictions on entry and stay also frustrate commitments in paragraphs 66 and 73 to accelerate timely initiation of treatment and overcome barriers in accessing adequate clinical facilities.

When migrants return home infected with HIV, they and their families need, as committed to in paragraphs 67, 69 and 77, access to both quality and affordable healthcare, socio-economic services and community support. Socio-economic support is especially important to maintaining adherence among migrants who initiate treatment at home, because without sufficient livelihood options or faced with debt, they are likely to migrate again to find work, regardless of their legal status or ability to maintain adherence.

“ I call for a change in laws that uphold stigma and discrimination – including restrictions on travel for people living with HIV. ”

Ban Ki-Moon, United Nations Secretary-General,
United Nations High Level Meeting on AIDS, June 2008

Making Use of the Political Declaration

- Eliminate HIV-related restrictions on entry, stay and residence and the accompanying practices of mandatory HIV testing for migrant workers.
- Ensure that all HIV testing for migrants follows the three C's (consent, counseling and confidentiality); is linked to treatment and support services; and never has a punitive outcome.
- Incorporate migrants into National AIDS Plans that use evidence-based strategies, are supported by disaggregated data, and provide adequate budgets for prevention and treatment programmes.
- Develop and implement multisectoral, bilateral and regional approaches in partnership with civil society to provide evidence-based HIV prevention and sexual and reproductive health information and services to migrants of all ages, sexes and genders, working in all occupations, all along the migration continuum.
- Uphold and abide by all relevant conventions and guidelines on the protection and promotion of migrants' rights and health by repealing discriminatory policies and practices, and by granting migrants equal access as nationals to health services and legal protections.

“Rather than screening international travellers (for HIV), resources must be applied to preventing HIV transmission among each population, based on information and education, and with the support of health and social services.”

- WHO statement on the screening of international travellers for HIV infection, WHO/GPA/INF/88.3 (1988)

End Notes

- i. United Nations, Department of Economic and Social Affairs, Population Division (2009). Trends in International Migrant Stock: The 2008 Revision (United Nations database, POP/DB/MIG/Stock/Rev.2008).
- ii. 61st World Health Assembly (61.17) Recommendations - Health of Migrants, Agenda Item 11.9, Eighth plenary meeting, A61/VR/8: 24 May, 2008.
- iii. “HIV & Migration, Regional Profile: Asia 2009,” Data Hub. http://www.aidsdatahub.org/dmdocuments/HIV_and_Migration_-_Regional.pdf
- iv. Ibid, Data Hub: 2009
- v. “HIV Vulnerabilities of Migrant Women: from Asia to the Arab States,” UNDP Regional Centre in Colombo: 2008.
- vi. “Adolescents, Youth and International Migration: Figures and Facts.” UNICEF: 2011. http://www.unicef.org/socialpolicy/files/GMG_-_Factsheet_UNICEF-FINAL.pdf
- vii. Ibid. ILO: 2011
- viii. Ibid. UNDP: 2008.
- ix. Ibid. UNDP: 2008.
- x. “State of Health of Migrants 2007 – Mandatory Testing,” CARAM Asia, Kuala Lumpur: 2007.
- xi. “Source, Transit, Destination and Back Again,” Raks Thai Foundation, Bangkok: 2007

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CARAM Asia is an open network of NGOs and CBOs that has Special Consultative Status with the Economic and Social Council of the United Nations. The CARAM Asia network engages in action research, advocacy, capacity building and coalition building with the aim of creating an enabling environment to empower Asian migrants and their communities to reduce all vulnerabilities including HIV and enhance their health rights globally.

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The Asia Pacific Council of AIDS Service Organizations (APCASO) is a civil society network of non-governmental (NGOs) and community-based organizations (CBOs) that provide HIV and AIDS services within the Asia Pacific region.

APCASO supports and promotes the role of CBOs and NGOs in their response to HIV and AIDS, particularly those representing communities most affected by the pandemic, namely people living with HIV, sex workers, people who use drugs, men who have sex with men, transgender people, migrants and mobile populations, young people and women.

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