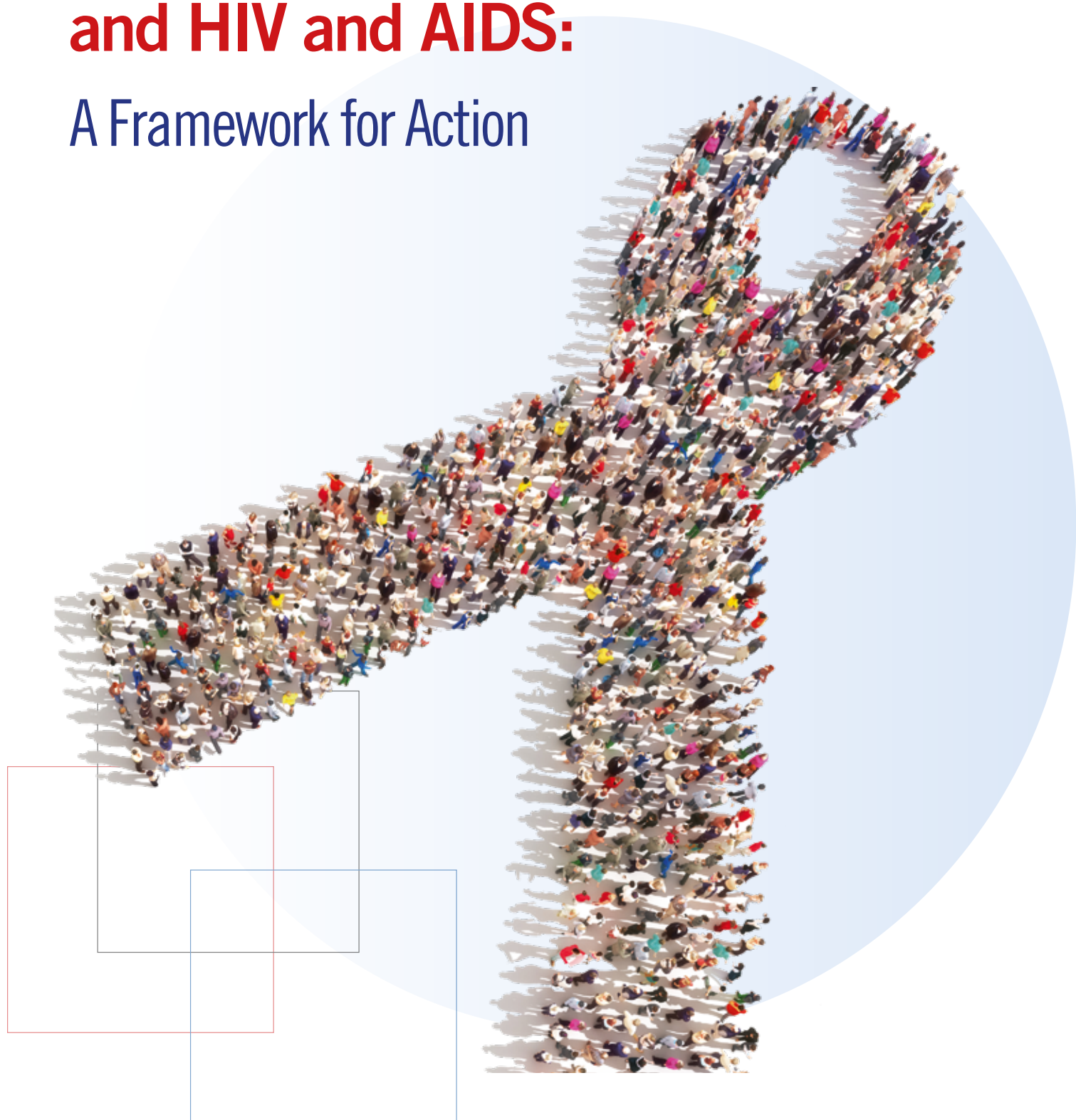




International  
Labour  
Office

# Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS:

## A Framework for Action



**Promoting a Rights-based Approach  
to Migration, Health, and HIV and AIDS:  
A Framework for Action**

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## Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ALAFSA	Apparel Lesotho Alliance to Fight AIDS
ART	Antiretroviral therapy
ARV	Antiretroviral
ASEAN	Association of South East Asian Nations
AU	Africa Union
BWI	Building and Wood Workers International
CARICOM	Caribbean Community
CDM	Centro de los Derechos del Migrante
CEACR	Committee of Experts on the Application of Conventions and Recommendations
CEDAW	Committee on the Elimination of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CMW	Committee on Migrant Workers
ECDPC	European Centre for Disease Prevention and Control
ECHR	European Court of Human Rights
ECOWAS	Economic Community of West African States
EU	European Union
FLMA	Fair Labour Migration Agenda
FSW	Female Sex Worker
GCC	Gulf Cooperation Council
HIV	Human Immunodeficiency Virus
HLD	High Level Dialogue
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICRMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
IDP	Internally Displaced People
IEC	Information Education and Communication

IGAD	Intergovernmental Authority on Development
ILO	International Labour Organization
IOM	International Organization for Migration
IRAPP	IGAD Regional HIV/AIDS Partnership Program
LAWA	Leadership for Advocacy for Women in Africa
LGBTI	Lesbian, Gay, Bisexual, Transgender or Intersex
MERCOSUR	Mercado Común del Sur
MFLM	Multilateral Framework on Labour Migration
MSF	Medecins Sans Frontières
MWTF	Migrant Workers Task Force
NGOs	Non-governmental Organizations
NRI	National Reporting System
OAS	Organization of American States
OCHA	Office for the Coordination of Humanitarian Affairs
OSH	Occupational Safety and Health
PANCAP	Pan Caribbean Partnership Against HIV and AIDS
PHAMIT	Prevention of HIV/AIDS Among Migrant Workers in Thailand Programme
PLHIV	People living with HIV
REWARD	Refugee Women in Agriculture for Rural Development
SAARC	South Asia Association of Regional Cooperation
SADC	Southern African Development Community
SADSAWU	South African Domestic Service and Allied Workers Unions
SDG	Sustainable Development Goal
SMEs	Small and Medium Enterprises
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organization
WOREC	Women Rehabilitation Centre



## Preface

More than three decades since the first case of HIV was diagnosed in 1982, the epidemic remains a significant obstacle to the realization of human rights in all regions. HIV-related stigma and discrimination lead to violations of fundamental human rights, including the right to decent work, the right to health, and fundamental privacy and confidentiality rights.

Migrant workers, especially women migrants, often encounter discrimination on multiple grounds, due to their status as migrants, coupled with other grounds, including race, sex, religion, ethnicity, real or perceived HIV status or other health conditions. Migrant workers from high HIV-prevalence regions may be perceived as “carriers of disease” who place a disproportionate burden on the health care system in the country of destination. These perceptions lead to high levels of discrimination against and marginalization of migrant workers.

In reality, most migrant workers are young and, at least at the beginning of their migration journey, are generally in good health. However, many migrant workers face a range of health risks linked to the migration process that ultimately make them vulnerable to illness.

While migration itself is not a risk factor for HIV or to negative health outcomes, specific factors linked to migration do increase migrants’ HIV and health vulnerabilities. These include: poor living and working conditions, social exclusion, labour exploitation, abuse and violence – which may include sexual assault. Migrants may be exposed to these risks during transit, after arriving in the host country, or both. Female migrants are particularly vulnerable to exploitation and violence, which correspondingly increases their exposure to HIV and other health risks.

In addition, migrant workers often underutilize health services in their host country due to lack of access to health insurance, poverty, fear of discrimination, language and cultural barriers, and fear of job loss and deportation, particularly for those migrant workers that are in the country without the appropriate authorization and documentation (those whose status is “irregular”). As a result, such workers may delay seeking medical attention until their health has significantly deteriorated.

At the core of this publication is the aim to highlight how deficits in the access to health, HIV services, as well as increased HIV-related risk factors, are intertwined with the complex conditions of migration and decent work gaps, which often exacerbate these risks and increase vulnerability for migrants in countries of origin, transit and destination.

These conditions can be changed through a human rights-based approach to migration governance. This includes ensuring access to adequate social protection; access to work and occupational health and safety; addressing specific gender inequalities and protecting the fundamental rights of women and men migrant workers.

It is hoped that this publication, by connecting different dimensions – encompassing human rights, migration governance, health and HIV – will provide building blocks of

a foundation for the protection of the rights of all migrant workers in relation to health and HIV. The proposed framework for action aims to assist governments, employers' and workers' organizations, as well as civil society actors to apply such principles and to achieve better health outcomes for all migrant workers.

SHAUNA OLNEY

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## Executive Summary

Migration is a permanent feature of contemporary life and can take many forms. People move from one place to another within their countries of residence and they also cross borders. People move for different reasons: as a consequence of the absence of decent work or as a means to securing a sustainable livelihood in their countries of origin; to seek or take up work; to reunite with their families or study; or they may move to escape persecution or hardship. The constant within all migratory flows is that they are made up of humans, and these humans have the same fundamental rights inherent to all individuals. This includes the right to health. In the context of the global response to contain the HIV epidemic, full enjoyment of the right to health should include appropriate and confidential testing, counselling, medical care and social support for all people living with HIV (PLHIV), including migrants.

This report provides an analysis of the underlying issues around health and HIV in the context of labour migration. An overview of contemporary migration, with a focus on labour migration, is provided as basis to frame the discussion.

In 2015, there were an estimated 244 million international migrants. Almost half of international migrants are women and girls, and in some countries women now outnumber men migrants. Major root causes of migration are identified, including the economic, political, social, environmental and demographic push and pull factors, with a discussion of their relevance to migrant health and HIV and AIDS. In particular, key migration policy issues are discussed, especially those related to health and HIV prevention, education and access to treatment. These include the risks and vulnerabilities faced by migrants in their working and living conditions, particularly in the context of law and policy issues surrounding legal recognition, human and labour rights protection, and immigration status. These issues are discussed with particular reference to economically active migrants.

The report emphasizes the health, HIV and AIDS policy issues and challenges in migration highlighting the link between HIV-related risk factors and the complex conditions of migration, which often exacerbate health risks and increase vulnerability for migrants in countries of origin, transit and destination. Many of these conditions and policy choices can be changed and improved, with highly beneficial consequences not only for the health of all migrants, but for public health generally, through the prevention of HIV. Furthermore, migrant workers, particularly those whose status is irregular, rarely have the same entitlements as nationals to insurance schemes that would facilitate access to health services.<sup>1</sup> The absence of adequate social protection; access to work and occupational health and safety; the legal status; specific gender concerns and risks associated with mobile work are identified as possible areas for intervention to reduce migrant workers' vulnerability to HIV and health deficits.

<sup>1</sup> ILO: *Labour Migration and HIV*, [www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_241234.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_241234.pdf) [accessed 21 September 2017].

The report also offers a law and policy backdrop for addressing migrants' health, as a basis for effective HIV and AIDS policy and programme responses in the context of migration. The contours of the legal, policy and strategic landscape are presented as it stands today, as a point of departure for a migration governance system that takes all migrants into appropriate consideration. Summaries of relevant international declarations that form part of the landscape are included, as are some key examples of jurisprudence on HIV and AIDS. Internationally agreed policy frameworks relevant to migration, health and HIV and AIDS are also discussed. The normative foundations include: various human rights instruments, particularly those that recognize the right to health and other related rights; migration governance instruments, particularly the ILO Conventions on employment and migrant workers and their rights; and other international instruments governing such matters as forced labour, non-discrimination, the rights of refugees and internally displaced persons; and human trafficking.

Based on the normative, policy and institutional instruments, the last part of the report outlines a concrete framework for action in key areas of law, policy and practice, in order to inform regional, national and local action to address health and HIV and AIDS issues among migrants. Ensuring the health protection of migrants requires advocacy in the legal and policy arenas, and also requires institutional and operational support by national governments in ways that empower concerned communities and their representatives, as well as civil society.

Extensive review of good practices and initiatives are proposed in each area discussed in the Framework for Action. These include a variety of programmes encompassing efforts directed at law, governance, and practical local actions, such as workplace or specific community applications.

Overall, the narrative points to areas of collaboration in the context of the Joint United Nations Programme on HIV and AIDS (UNAIDS), between the secretariat and the range of cosponsors, and the allocation of responsibilities in the context of addressing HIV and AIDS, health and migration, as well as modes of cooperation among national ministries and other institutions within government, together with other civil society partners at the national level.



## Introduction

According to the UNAIDS GAP Report (2014), there are about 1 billion people living outside their original places of birth or residence, including both international and internal migrants.<sup>2</sup>

The UN estimated a global total of 244 million international migrants in 2015, defined as persons living outside their country of birth or citizenship for one year or more, irrespective of the causes or the means of migration. Almost half - 48 per cent - of these migrants are women and girls.<sup>3</sup> ILO estimated that 150 million of the 232 million migrants counted in 2013 were economically active, meaning employed, self-employed or otherwise engaged in remunerative activity.

The global total number for international migrants is, however, an underestimation. On the one hand, the UN statistical definition for counting migrants does not include those travelling for short periods and not considered “resident” for at least a year, such as tourists, visitors and business persons. On the other hand, certain categories of persons working outside their countries of citizenship or birth are not counted in the global UN estimate because of the nature of their often short, occasional, cross-border or otherwise non-resident situation. They may be frontier workers, seasonal workers, seafarers, workers on offshore installations, itinerant workers, project-tied workers or workers undertaking specified forms of employment. These categories of migrant workers and members of their families are not accounted for in the current global migrant estimates. Migrant workers in short-term, temporary, itinerant or seasonal migratory situations, who travel to or among other countries and remain for short periods (for example to work planting or harvesting farm products) generally are not registered as resident in a destination country; many if not most retain residency in their home country or country of habitual residence.

This document focuses primarily on international migration. Its scope and content apply to the several distinct categories of migrant workers and members of their families referred to above. The report also refers to the term “mobile workers”, a commonly used synonym for itinerant, cross-border, or project-tied migrant workers such as international transport truck drivers, cross border traders (who may regularly travel circuits across several countries). While their numbers are not reflected in current global statistics on international migration, they comprise significant populations of concern with respect to the right to health, particularly for HIV prevention and treatment.

The challenges of migration and issues of migration governance have been a renewed focus of political attention since early 2015. Migration governance is not the only area in which challenges have arisen. Migration also represents significant challenges for public

<sup>2</sup> UNAIDS. 2014. *The Gap Report*. [http://www.unaids.org/sites/default/files/media\\_asset/UNAIDS\\_Gap\\_report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf) [accessed 21 September 2017].

<sup>3</sup> ILO: *Fair Migration, Setting and ILO Agenda*, International Labour Conference, 103rd Session, 2014.



health, not--as some political rhetoric asserts--because migrants pose a public health risk, but because the risks that the process of migration can impose on migrants may threaten their right to health and other health-related fundamental rights. These challenges are particularly acute in periods of economic and political crises, and especially those evoking migration consequences. In the context of health and migration, HIV and AIDS represent particularly important challenges due to the risks and vulnerabilities that migration entails for health, primarily caused by widespread difficulties in access to health prevention, health education and healthcare.

Migration, health and HIV feature explicitly and implicitly throughout the United Nations 2030 Agenda for Sustainable Development, adopted by the UN General Assembly in September 2015. Migrants are also highlighted across the New Urban Agenda adopted at Habitat III in Quito in October 2016: the Agenda emphasizes the importance of extending health care to all in cities and urban settlements worldwide, with specific attention to HIV and AIDS.

This document is intended to promote engagement with and to support the roles and work of the UNAIDS Joint Programme, including its eleven cosponsors, in furthering the UNAIDS Strategy 2016-2021: On the Fast Track to End AIDS, in the arena of migration. It also provides guidance towards ensuring coherency with the broader migration and health agenda. It focuses on key aspects of an integrated migration and health agenda:

- new and emerging trends and developments in labour migration, together with the HIV risks and vulnerabilities migrants face;
- gender-specific dimensions of migration and migrant work and their effect on policies and programmes addressing migrant workers and migrants' access to health and HIV-related services;
- the legal framework comprised of international human rights and international labour standards guiding regional and national responses to labour migration governance and its interaction with the right to health;
- the benefit to fair labour migration processes and practices of ensuring access to health services in general and HIV services in particular;
- the public health and occupational safety and health (OSH) imperatives of attending to health needs of migrants and migrant workers, including sustainably addressing HIV and AIDS;
- good practices in HIV and health programmes for migrants;
- and a framework for action to guide the development and implementation of policy and programme responses in relation to facilitating migration in conditions of safety, equality and dignity and ensuring access to health services for migrant populations, including HIV prevention, treatment, care and support services.

The Framework for Action includes recommendations on integrating HIV and health programmes for migrant workers in national and regional migration policies as well as in public health frameworks. It provides evidence-informed guidance on integrating access to HIV and health services into labour migration processes at all stages of migration; on the roles and responsibilities of national stakeholders, including government ministries, employers' and workers' organizations, public health actors, and other relevant actors,

emphasizing the importance of including migrant organizations in policy making and programme implementation on HIV and health issues in the context of migration.

This guidance is intended to complement relevant international labour standards, as well as the ILO Multilateral Framework on Labour Migration (MFLM) and the ILO Fair Labour Migration Agenda (FLMA), both of which are discussed in greater detail in Part Three. It is also relevant to the implementation of the Sustainable Development Goals on access to health, and productive employment and decent work for all (SDG 3 and 8).

This document is based on a detailed literature review that analyzed and drew upon more than 230 papers, articles, documents, and briefs, as well as on normative texts across contemporary institutional, academic and public health literature. The construction of this report entailed extensive analysis of existing data and a review of recent developments in law, policy and practice.





## Part 1. Global Migration and Mobility Today

Understanding migration and its health and HIV-related dimensions requires grasping the complexity of migration itself as a process, as well as the diversity of circumstances individual migrants and groups of migrants face. Different situations and distinct populations require differentiated policy approaches and responses. Moreover, the situation of working persons and non-working family members, as well as age, need to be taken into account in laws, policy and practice on migration, especially with regard to health and HIV and AIDS. The evidence from policy initiatives and research on migration and HIV indicates that differences in the situations of migration populations require specific, targeted approaches to ensure their effective access to HIV prevention, treatment, care and support. Furthermore, labour migration policies should take into account gender dimensions, that may have an impact on women's HIV vulnerability, providing women with equal opportunities to safe, fair and regular migration channels, pre-departure training and information about legislation and rights' protection in countries of destination; and ensuring a regular gender analysis of the legal and policy framework.

A short overview of contemporary migration and relevant governance issues around labour migration is provided below, in order to frame the discussion around HIV and health within a broader policy context.

### 1.1 Contemporary Migration and its Importance

Migration today is a feature of virtually every country and territory of the world. As the Secretary General of the United Nations has emphasized, the contemporary era is the age of mobility.<sup>4</sup> Nearly all States are places of origin, transit or destination for international migrants. Many countries also have significant levels of internal mobility, in which people move within the boundaries of a country.

The United Nations estimated 244 million foreign-born people residing in 2015 in countries other than where they were born or held original citizenship account for 3.3 per cent of the world population.<sup>5</sup> However, these figures may be significantly underestimated as they do not include important numbers of persons defined in international law as "migrant workers" who are in temporary, short-term, seasonal, frontier or itinerant working situations. The United Nations refers to an international migrant as "a person living in a country other than where they were born." However, for statistical purposes, the published count of international migrants is based on data collected from countries on those who are foreign-born and resident for at least one year.

<sup>4</sup> K. Ban: "Going Global for Good", in *The Washington Times*, 9 July 2007. <http://www.un.org/sg/articles/articleFull.asp?TID=66&Type=Op-Ed&h=0> [accessed 21 September 2017].

<sup>5</sup> United Nations, Department of Economic and Social Affairs, Population Division. 2015. *Trends in International Migrant Stock: The 2015 Revision*. <http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates15.shtml> [accessed 21 September 2017].

A defining characteristic of migration is its connection with labour. Migration is predominantly about labour and skills mobility in a globalized world. Migration is critical to sustaining the world of work in the twenty-first century. According to ILO estimates, more than 70 per cent of working age adults within the worldwide migrant population in 2013 were economically active.<sup>6</sup> This data indicates that migrants have higher labour force participation rates than non-migrants: 72.7 per cent in contrast with 63.9 per cent. Particularly striking is the difference between migrant and non-migrant women; 67 per cent of migrant women participate in the labour force, whereas only 50.8 per cent of non-migrant women worldwide do so.<sup>7</sup>

## 1.2 Drivers of Migration

Throughout history, warfare, natural disasters and environmental degradation have compelled people to leave their homes and homelands in search of temporary or permanent refuge. Lack of decent work, persistent human rights violations, and the complete absence of means of earning a livelihood have long been drivers of migration. People migrate to seek new opportunities for employment or career advancement, for training and education, or to join their families. Demand for high- and low-skilled foreign workers is growing in many countries, as a result of technological changes, changing labour needs, and aging work forces, increasing the pull factors for migration.

Sometimes these drivers prompt people to move to nearby localities; in other situations, people are compelled to travel across borders. A significant part of contemporary migration is the result of injustice, oppression and warfare, as reflected in the current high numbers of refugees and internally displaced persons.

At the same time, increasing international economic activity has led to greater cross-border mobility of workers in many sectors, including transport, trade and commerce, tourism and other industries. A growing number of workers do not change their place of residence, but circulate regularly within countries and across borders in the course of their work.

Current trends and available data indicate that migration will become more prevalent in many parts of the world in the next three decades.

## 1.3 Migration Governance and Key Policy Migration Issues

Considerable progress has been made in the formulation of a more comprehensive approach to migration governance<sup>8</sup> and in the creation of a global compact on migration linked to target 10.7 of the 2030 Agenda for Sustainable Development, in which Member States commit to cooperate internationally to facilitate safe, orderly and regular migration.<sup>9</sup>

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<sup>6</sup> ILO: *Global Estimates on migrant workers, Results and Methodology; Special focus on migrant domestic workers*. International Labour Office, Geneva, 2015. [http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms\\_436343.pdf](http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_436343.pdf) [accessed 21 September 2017] .

<sup>7</sup> Ibid.

<sup>8</sup> See *New York Declaration for Refugees and Migrants* adopted at 71st Session, United Nations General Assembly, 19 September 2016. [http://www.un.org/en/ga/search/view\\_doc.asp?symbol=A/RES/71/1](http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/71/1) [Accessed 21 September 2017].

<sup>9</sup> Id. at *Annex II, New York Declaration for Refugees and Migrants* p.21/24.

The two UN General Assembly High-level Dialogues on International Migration and Development, in 2006 and 2013, reinforced the importance of global cooperation and global approaches to migration governance. The 2013 High-level Dialogue achieved agreement on a Declaration “Making Migration Work” that reiterated a general consensus around several main normative and policy lines articulated in the formal policy frameworks mentioned above.<sup>10</sup> Application of the concepts elaborated in these relevant initiatives and documents assures the conditions and context for access by all migrants as well as their host and home communities to the highest attainable standards of health, and particularly to full HIV prevention and care.

However, where the focus is on immigration enforcement rather than a human rights approach to labour migration, this may have a negative impact on the governments’ capacity to address the underlying causes of HIV vulnerability and lack of access to health services among migrant workers.

Key policy migration issues to be considered, as possible barriers to ensuring equal access to health and HIV services for migrants, are highlighted below:

- Failure to recognize migrants as individuals equal before the law;
- Lack of recognition and protection of migrants’ human rights;
- Characterizing migrants as merely economic actors or merely “development actors”;
- Criminalization of migrants;
- Prevalence of sub-standard, abusive employment relations and conditions of work;
- Increasing xenophobic hostility and violence against migrants worldwide;
- Systematic/structural discrimination and exploitation of migrant women;
- Suppression of migrant organizations and participation, particularly as workers;
- Lack of health care, including explicit denial of access to care and of health-related rights;
- Challenges in access to social protection and social security for many migrants;
- Failure to respect migrants’ right to family unity.

<sup>10</sup> United Nations, General Assembly. *Declaration of the High-level Dialogue on International Migration and Development*, report of the Secretary-General, A/68/190 (October 2013). [http://www.un.org/en/ga/68/meetings/migration/pdf/migration\\_8points\\_en.pdf](http://www.un.org/en/ga/68/meetings/migration/pdf/migration_8points_en.pdf) [accessed 21 September 2017].





## Part 2. Health, HIV and AIDS Policy Issues and Challenges in Migration and Mobility

Migration in and of itself does not put people at risk of negative health outcomes. Rather, the circumstances in which people migrate, notably social determinants of health such as their living and working conditions, and particularly their migration status, can leave them more vulnerable to health risks and less able to cope with illness, including HIV-related illness. Migration is not per se a primary risk factor for disease or for propagation of HIV. Instead, it is the conditions of migration and the lack of appropriate policy responses that exacerbate health risks and increase vulnerability in places of origin, transit and destination. Many of these conditions and policy choices can be improved, and modifying them can have very beneficial consequences, including improved migrant health, reduction of HIV, and improved public health in the host country.

Issues of separation from or loss of family, home, community and social networks, as well as detachment from a familiar culture and traditions, together with the language barriers that many migrants face, are all factors that make migrants susceptible to negative health outcomes. Their situations may be further complicated by inadequate or non-existent access to health services generally, and to HIV prevention, support and treatment services in particular. Moreover, migrants, refugees and displaced populations may also encounter apathy or even hostility on the part of government authorities and host populations, which poses an additional obstacle to efforts to ensure prevention, treatment, care and support.

Several factors that can increase risks of negative health outcomes are analysed in more detail in this section:

- *separation from family, familiar and accessible local context, loss of 'landmarks';*
- *precarious and marginal living conditions;*
- *absence of access to health services, health education, treatment;*
- *discrimination, including discrimination based on sex, sexual orientation and gender identity, and xenophobia;*
- *social exclusion and cultural marginalization, in some cases cultural repression;*
- *language and social communications barriers;*
- *specific health and HIV-related stigmatization;*
- *precarious, temporary, restricted legal status/recognition for many migrants;*
- *particular risks and vulnerabilities for migrants in irregular or undocumented situations;*
- *precarious access to work, absence of formal work for some; and*
- *difficult, degrading or dangerous working conditions.*

Most adult migrants are engaged in the world of work. Employment, the workplace and conditions of work are major issues for migration governance, for health, and



particularly for HIV risks and responses. Key work and workplace issues noted below are also discussed:

- *absence of access to decent work – or to any work;*
- *discrimination in access to employment and occupation;*
- *conditions of work;*
- *occupational health and safety;*
- *employer policy and workplace attitudes; and*
- *labour inspection and OSH/public health monitoring and enforcement.*

Nearly half of all migrants today worldwide are women and girls, and most women migrants are economically active. Unfortunately they are often only in demand for jobs that gender stereotyping assigns as “women’s work” and which are often low-paid with little, if any, work-related protection. In addition to discrimination – based on gender stereotypes about women’s roles, responsibilities or capacities – women migrants often face multiple discrimination based on class, nationality, ethnicity and disability, among other factors. All this effectively limits most women to precarious, unprotected jobs with consequent economic, social, health and other risks and exclusions.

Migration for work has proven to be a positive experience for many women, who in migrating can learn new skills, become more economically empowered, and enjoy higher status within their own families and communities as a result of their economic contributions. Nevertheless, many female migrants face a high risk of sexual and gender-based exploitation and violence, both in the migration process and in destination countries. They are also especially susceptible to social exclusion depending on the nature of their work. For example, women in domestic work may be particularly isolated and restricted from communicating with those outside the employer’s family.

The interconnections among migration, health and HIV also create specific vulnerabilities for certain populations. Very limited knowledge about HIV transmission reduces prevention ability, as does having concurrent multiple partners, men having sex with men and engagement in commercial sex work. These specific vulnerabilities are discussed in more detail.

Difficult conditions of migration coupled with policies that do not contain any specific public health measures render migrants more susceptible to higher health risks, especially when they are combined with a lack of preventative health education, detection and treatment. As a result, health risks for migrant populations become exacerbated, as do those for host populations. Notable consequences of policy gaps or insufficiencies include diminished or no access to health care or to HIV preventative measures, including detection and treatment. Targeted approaches are needed, and different populations require tailored responses as a matter of priority.

## **2.1 General Factors Contributing to Risk and Vulnerability**

Research and policy responses to HIV have predominantly addressed the epidemic in terms of risk – the possibility or probability of infection and its consequences – caused by behavioural as well as social, cultural and other environmental factors or vulnerabilities,

with “vulnerability” being understood as the degree to which people are susceptible to harm (in this case exposure to HIV). A primary concern has been to identify factors over which the individual has control, and to distinguish them from the range of factors outside the control of the individual that reduce his or her ability to avoid the risk, including social, economic, political and cultural determinants.

Migration has been shown not to be a risk factor for the spread of HIV and AIDS. Instead, vulnerability for migrants to HIV results from the social and environmental conditions and patterns in which mobility takes place. As elaborated elsewhere in this publication, many migrants are among the least protected and least informed, have little or no access to prevention, diagnosis, counselling and treatment services, and are often constrained in circumstances facilitating or compelling risky behaviour.

Different categories of migrants and mobile populations are differently exposed to HIV, due to varying conditions of migration, as well as to a variety of situations in transit and destination countries. A skilled French worker migrating to Hong Kong will not face the same risk of contracting HIV as an unskilled Bengali migrant worker in a Gulf State, or a Tajik construction worker in Moscow. It is therefore essential to develop evidence-based HIV prevention, care and treatment policy measures and responses based on the specific risks faced by different groups of migrant workers. The extent to which migration is associated with an increase in HIV vulnerability depends on the various factors discussed below.

#### **Labour Migration and HIV Vulnerability**

HIV vulnerability is associated with various factors: prolonged or frequent absence from home; precarious financial status; difficult working and housing conditions; change in cultural norms; separation from family; low social support; substance abuse; mental health problems; lack of HIV testing; needle sharing; limited condom use; concurrent multiple partners; sex work; low HIV knowledge, and low perceived HIV risk.

Of these factors, those involving physical and mental health and sexual practices tend to have the greatest effect on HIV risk, although the social, cultural and other factors also are important. Scholarly findings regarding the role of social determinants in HIV risk confirm that the need for multilevel intervention strategies exists in all geographic regions.<sup>11</sup>

#### **2.1.1. The HIV Burden Among Migrants**

There is little coherent data on HIV prevalence and incidence rates among migrant populations. Due to this lack of sufficient data and analysis, no general observations on rates of HIV infection among migrants can be inferred. Nevertheless, the available data clearly shows a need for particular attention to provision of HIV prevention and healthcare services to migrants and a need for more research, as well as disaggregated prevalence or incidence data.

<sup>11</sup> S. Weine and A. Kashuba: “Labour Migration and HIV Risk: A Systematic Review of the Literature”, in *AIDS and Behaviour* (2012, Vol. 16, No. 6, August): 1605-1621.

The most substantial data available is on HIV prevalence among migrants in Europe. In contrast to other regions around the globe, in Western Europe, “ethnic minority” groups – a term usually encompassing immigrant and immigrant origin populations – were found to have a greater HIV prevalence in comparison to the overall population. A study by the Spanish Centre for Epidemiology revealed that between 2007 and 2012, 38 per cent of new HIV cases in Europe occurred in migrant populations.<sup>12</sup>

The European Centre for Disease Prevention and Control (ECDC) has indicated that the HIV incidence rate among migrants is “disproportionately” high; it made a similar observation regarding tuberculosis infections among migrants.<sup>13</sup> In its report, the ECDC highlights that any predictions on evolution of prevalence rates among migrant populations are difficult to make due to the heterogeneity and shifts of the composition of the migrant population in the European Union.<sup>14</sup>

A few specific regional studies on migrants in Asia indicate a higher HIV incidence rate in comparison to the local population. For example, a systematic review of rural to urban migration in China found that HIV prevalence was higher among the migrant population in comparison to the overall Chinese population.<sup>15</sup> In Myanmar, which is one of the hardest hit countries by HIV in Asia, HIV prevalence was estimated at 0.47 per cent of the population aged above 15 in 2013,<sup>16</sup> whereas a small case study found that 4.9 per cent to 10 per cent of the Myanmar migrant fishers in Southern Thailand were HIV positive.<sup>17</sup>

### 2.1.2 Absence of Family and Lack of Social Support

Separation from family or loss of family is a common experience for many migrants. Although some migrants are able to bring family with them, more often legal, logistical or financial constraints act as barriers to travel as a family, meaning the majority of migrants travel alone. This separation is associated with the more general loss of cultural landmarks, which occurs when migrants enter a different culture and face language barriers. Removed from their original environment, migrants may have little or no social support, making it difficult to communicate about the stress engendered by challenging living and working conditions, and being separated from a supportive home environment.

Being away from family, a regular partner and social networks can lead to migrants being more likely to engage in high-risk sexual behaviours involving multiple partners, including with sex workers. For example, a study in North Carolina found a correlation between the frequency of sex worker visits and the quality of social networks Mexican male migrants had in their new environment. It suggested that migrants’ likelihood of visiting commercial

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<sup>12</sup> V. Hernando et al: “HIV Infection in Migrant Populations in the European Union and European Economic Area in 2007-2012: An Epidemic on the Move”, in *Journal of Acquired Immune Deficiency Syndromes* (2015, Vol. 70, No.2, October): 204-211.

<sup>13</sup> European Centre for Disease Prevention and Control. 2014. *Assessing the Burden of Key Infectious Diseases Affecting Migrant Populations in the EU/EEA* (Stockholm, May 2014): 94.

<sup>14</sup> Ibid.

<sup>15</sup> Zhang, L. et al: “High HIV Prevalence and Risk of Infection among Rural- to Urban Migrants in Various Migration Stages in China: A systematic Review and Meta- Analysis”, in *Journal of the American Sexually Transmitted Diseases Association* (2013, Vol. 20, No.2, February): 136-147.

<sup>16</sup> UNAIDS. 2014. *Global AIDS Response Progress Report, Myanmar*: 4.

<sup>17</sup> AIDS Data Hub. 2009. *HIV and Migration – Country Profile 2009 – Myanmar*: 1-4.

sex workers varied according to the time spent in the host country, initially increasing with an altered financial situation, but decreasing over time with the acquisition of strong social bonds.<sup>18</sup>

Many migrants return periodically to their homes if their spouses and children do not accompany them. Those in temporary, seasonal and short-term arrangements may be able to return more often, whereas long-term contract workers in places where travel is restricted may only be allowed to return home once a year or once every two years.<sup>19</sup> Their spouses and regular partners may in turn be exposed to a higher risk of HIV, suggesting a need for targeted interventions for spouses remaining at home as well as the individuals who migrate. Additionally, research suggests that partners who are left behind tend to engage more in sexual relations outside the primary relationship than do those with non-migrant partners.<sup>20</sup>

### 2.1.3 Precarious Living and Working Conditions

The circumstances surrounding migration often put many migrants in precarious living and working conditions that increase their vulnerability to adverse health outcomes. Migrants frequently find themselves concentrated in marginal neighbourhoods with poor access to public transport, education and healthcare services.

Migrant workers tend to be concentrated in the so-called “3-D” jobs – dirty, dangerous and difficult — with little or no occupational and safety protection. Significant numbers of migrant workers live and work in geographically isolated areas, such as construction sites, mining facilities, or in rural agricultural areas, where health care facilities and services are limited, inaccessible or non-existent.

Many migrant workers are employed in jobs the “locals” are unable or unwilling to take. These jobs are often characterized by exploitative and hazardous working situations. Many migrants work in the mining and construction sectors, which have high rates of occupational accidents, injuries and deaths. The mining sector in certain countries is a particularly risky environment in terms of HIV exposure and infection.<sup>21</sup>

Domestic workers may be highly vulnerable to HIV. Frequently their work is not well paid, and they may be subject to abuse by their employers. This abuse can range from excessive working hours to delays in payment, but can also encompass sexual harassment and sexual violence, including rape. This is particularly an issue for migrant women engaged in domestic work. This violence may include non-consensual and unprotected sex, meaning exposure to HIV can be elevated. Migrant domestic workers fleeing abusive working conditions or employers can be pushed into informal and irregular economic activity,

<sup>18</sup> E. A. Parrado, and C. Flippens, “Community attachment neighbourhood context and sex worker use among Hispanic migrants in Durham, North Carolina, United States”, In *Social Sciences & Medicine* (2010, Vol. 70, No. 7, April): 1059-1069.

<sup>19</sup> As reported to the author by migrant workers in interviews in Qatar, May 2015.

<sup>20</sup> L. Corno and D. De Walque: “Mines, migration and HIV and AIDS in Southern Africa” in *Journal of African Economies* (2012, Vol. 21, No.3, June): 465-498; Q. R. Qin et al: “Risk of sexual HIV transmission among wives left behind and wives of non-migrant men in rural areas of China”, in *Journal of the Association of Nurses in AIDS Care* (2009, Vol. 20, No.4, July-August): 308-315.

<sup>21</sup> ILO: *Handbook on HIV and AIDS for Labour Inspectors*. Geneva: International Labour Office, 2014.

including sex work, which significantly heightens their HIV vulnerability.<sup>22</sup> These patterns may be particularly serious for domestic workers in countries subject to the “kafala” system, including Gulf Cooperation Council (GCC) member countries as well as Jordan and Lebanon,<sup>23</sup> in which any labour dispute with an employer can lead to deportation or criminal prosecution and severe punishment if the migrant worker is accused of ‘moral wrongdoing’.<sup>24</sup>

In South Africa, some employers have reportedly pressured their domestic workers into having HIV tests. Some of the domestic workers tested and found to be HIV-positive were fired without any HIV counselling.<sup>25</sup> In this context, migrant domestic workers are put in high-risk situations because they may not be aware of the means of transmission of the virus. They may end up with no counselling or treatment if found to be HIV-positive, and they face high levels of stigma and community exclusion.

Migrants may avoid seeking medical care and treatment due to factors deriving from these precarious conditions including costs incurred, inability to take time off work or problems accessing transportation.

#### 2.1.4 Restricted Legal Status and Limited Access to Health Care

Precarious living and working conditions affect migrants in irregular or undocumented situations even more acutely than other migrants. (The challenges migrants in irregular situations face are discussed in greater detail in sections 2.2.1 and 2.4.5). Without legal status, they tend to accept jobs with dangerous working conditions or work in the informal economy, where low wages and an absence of occupational safety and health protections are common. Migrants in irregular situations often live in substandard conditions for multiple reasons, including a lack of formal employment that generates consistent income, or a reluctance to raise concerns about housing conditions due to fear of deportation.

Without legal status, migrants living in such conditions also often face considerable difficulty in accessing healthcare.<sup>26</sup> Even those in authorized situations may be afraid to access healthcare and testing services out of fear of being deported in case of an HIV positive test result. A study in Northern Sweden pointed to the persistence of a “deportation myth” among lawfully admitted immigrants reluctant to seek medical care for fear of being tested positive for HIV.<sup>27</sup>

This makes it difficult or impossible for migrants to get clinical or preventive care, including treatment for HIV or AIDS. Meanwhile, private clinics, which charge very high fees, are unaffordable for many migrants. Migrants who test positive for HIV are not

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<sup>22</sup> P. Mahdavi: “Gender, labour and the law: the nexus of domestic work, trafficking and the informal economy in the United Arab Emirates”, in *Global Networks* (2013, Vol. 13, No. 4, October): 425-440.

<sup>23</sup> Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates (UAE). [www.ilo.org/dyn/migpractice/docs/132/PB2.pdf](http://www.ilo.org/dyn/migpractice/docs/132/PB2.pdf) [accessed 21 September 2017].

<sup>24</sup> Ibid.

<sup>25</sup> “South Africa: Is there a virus in the house?”, in *IRIN News*, 15 July 2008.

<sup>26</sup> S. Weine and A. Mirzoev: “Unprotected Tajik male migrant workers in Moscow at risk for HIV and AIDS”, in *Journal of Immigration and Minority Health* (2008, Vol.10, No. 5, October): 461-468.

<sup>27</sup> K. Nkulu, K. et al: “Fear of deportation may limit legal immigrants’ access to HIV/AIDS related care: a survey of Swedish language school students in northern Sweden”, in *Journal of Immigration and Minority Health* (2012, Vol. 14, No.1, February): 39-47.

necessarily provided a full diagnosis and needed treatment, especially in the countries where deportation on the basis of positive status occurs.<sup>28</sup>

An additional complicating factor to HIV vulnerability is the challenge of care continuity. Migrants in precarious work and living situations may frequently be forced to leave or change jobs or residences on short notice. Those who are receiving medical treatment can then face interruptions to antiretroviral therapy (ART) or other care.

### 2.1.5 Low HIV Awareness and Limited Ability to Protect Themselves from Infection

Many migrant workers lack adequate knowledge about HIV and AIDS, and often lack understanding of the different means of transmission of the virus, as well as of prevention and treatment methods. Some mistakenly believe that AIDS is a disease only homosexuals or drug addicts can contract, and therefore perceive themselves as free of risk, despite their risky sexual behaviour. Others have reported believing that HIV could be transmitted by mosquito bites or by sharing food with an HIV positive person, and were convinced that antibiotics were enough to cure the disease.<sup>29</sup> The findings from a recent study conducted among fishing communities in Uganda suggest that 89 per cent of men and 88 per cent of women were familiar with the most common means of HIV prevention, that is, using condoms, limiting sex to one partner who is not infected and abstaining from sex. However, the level of comprehensive HIV knowledge among the respondents was only moderate, standing at 45.8 per cent among women and 48.8 per cent among men.<sup>30</sup>

A lack of understanding of HIV often leads to low levels of condom use in migrant communities. Even when they are available, condoms may not be used because there are negative connotations associated with them and because they may be considered by some as an obstacle to sexual pleasure.<sup>31</sup> In Kenya, reported use of condoms among migrant female sex workers is relatively low. Only about half of female sex workers used condoms every time they had sex with a client in the past month. More than three quarters of respondents who did not use a condom during the most recent sexual encounter indicated that the reason they did not was because the client objected to it.<sup>32</sup> Migrants, particularly if they are in irregular situations, may also have difficulty acquiring condoms.<sup>33</sup>

<sup>28</sup> A. Qureshi: "Structural violence and the state: HIV and labour migration from Pakistan to the Persian Gulf", in *Anthropology & Medicine* (2013, Vol. 20, No. 3, August): 209-220; Human Rights Watch. 2009. *Discrimination, Denial, and Deportation- Human Rights Abuses Affecting Migrants Living with HIV*: 1-28.

<sup>29</sup> J. Huang, et al: "Female streetwalkers' perspectives on migration and HIV/STI risks in a changing economic and social environment: a qualitative study in Shanghai, China" in *Culture, Health & Sexuality* (2015, Vol. 17, No.6, January): 763-776.

<sup>30</sup> International Organization for Migration (IOM). 2013. *HIV Knowledge, Attitudes and Practices and Population Size Estimation of Fisher folk in Six Districts in Uganda*. [https://issuu.com/iomuganda/docs/kap\\_fisheries\\_report](https://issuu.com/iomuganda/docs/kap_fisheries_report) [accessed 21 September 2017].

<sup>31</sup> Ibid.

<sup>32</sup> International Organization for Migration. 2011. *Integrated biological and behavioural surveillance survey among migrant female sex workers in Nairobi*. [http://kenya.iom.int/sites/default/files/2010\\_Integrated\\_Biological\\_and\\_Behavioural\\_Surveillance\\_IBBS\\_Survey\\_among\\_Migrant\\_Female\\_Sex\\_Workers\\_in\\_Nairobi\\_Kenya.pdf](http://kenya.iom.int/sites/default/files/2010_Integrated_Biological_and_Behavioural_Surveillance_IBBS_Survey_among_Migrant_Female_Sex_Workers_in_Nairobi_Kenya.pdf) [accessed 21 September 2017].

<sup>33</sup> S. Weine and A. Mirzoev: "Unprotected Tajik male migrant workers in Moscow at risk for HIV and AIDS", in *Journal of Immigration and Minority Health* (2008, Vol.10, No. 5, October): 461-468.



### 2.1.6 Language and Cultural Barriers

Language and cultural barriers often contribute to inadequate access to HIV prevention information, confidential voluntary testing opportunities and treatment and support services.<sup>34</sup> Being unable to speak and understand the local language poses challenges for basic daily activities, including use of social and healthcare services associated with HIV prevention, treatment, care and support. Migrant workers and their families might be unfamiliar with the local health system and might have difficulties in communicating their concerns to healthcare providers. They might also face uncooperative attitudes from local health personnel that are exacerbated by miscommunication due to the language barrier.

Behaviour that can enhance risks of HIV infection or avoidance of testing and treatment may be shaped by harmful traditional stereotypes, practices and gender norms, especially regarding marriage, fidelity, condom use and masculinity. Mobility generally has an impact on these norms, and the extent to which they may hinder or reinforce behaviour that elevates HIV risk. In many migration situations, cultural norms and constraints on behaviour differ between origin and destination countries. These differences can result in migrants feeling free from home community constraints on behaviour regarding such issues as extramarital relations and same sex relations. Additionally, research has shown that strong religious convictions and beliefs from home country environments commonly contribute to migrants being reluctant to seek HIV testing and to implement prevention.<sup>35</sup> In some countries of origin, AIDS is portrayed as a disease that afflicts only men having sex with men or drug addicts. This belief leads to higher risk behaviour and HIV vulnerability among those who believe themselves to be at little risk because they neither engage in same sex relations nor use drugs. As a result, they believe they do not need to practice safe sex or seek HIV testing.<sup>36</sup>

### 2.1.7 Xenophobia, Discrimination and Stigma

Migrants' status as non-nationals often leaves them less protected under the national law. Additionally, because they are less familiar with the local language and with the legal and social support systems in the new country, and in many cases are visible minorities, they are particularly at risk of discrimination. Other differences from local populations, such as race, ethnicity or religion, are also often factors in the discrimination migrants are subjected to.

Discrimination on the basis of race, ethnicity, national extraction and social origin is prohibited in international law and the national legislation of most contemporary States. Discrimination on the basis of nationality is also explicitly prohibited under international law, including in the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. However, widespread racist and xenophobic hostility directed against migrants, refugees, immigrants and immigrant-origin populations, particularly those whose appearances and backgrounds are visibly different from the 'norm' of the host society, are reported worldwide. These represent

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<sup>34</sup> ILO: Meeting Report 3, *Technical workshop on population mobility, migration and HIV and AIDS*, Geneva 18 March 2002. [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_116970.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_116970.pdf) [accessed 21 September 2017].

<sup>35</sup> V. Massari et al: "Gender, socio-economic stats, migration origin and neighbourhood of residence are barriers to HIV testing in the Paris metropolitan area" in *AIDS Care* (2011, Vol. 23, No. 12, December): 1609-1618.

<sup>36</sup> Ibid.

especially virulent manifestations of discrimination. The negative effects of xenophobia and racism – which manifest through political and popular discourse as well as through physical violence, including murder – cannot be underestimated. Not only have such incidents occurred in every region of the world, evidence suggests they are increasing in intensity. Frequent attacks against migrants by individuals or groups, police round-ups, mass detention and even killings of migrants take place with alarming regularity.

Reports from Africa, Asia, Europe, the Middle East and elsewhere have indicated that in some situations of domestic unrest and civil conflict, foreigners have been explicitly targeted, sometimes with deadly hostility. However, discrimination, racism and xenophobic hostility against migrants and other ‘foreigners’ are increasing even where overt civil unrest and conflict are absent. This fact is aggravated when governments fail to respond vigorously to quell these xenophobic acts and also to discourage and prevent them from occurring in the first place. When governments fail to respond appropriately, and do not prosecute perpetrators, or even either tacitly or overtly condone their actions, it is not only migrants who suffer violations of their human rights. Social cohesion and economic stability in the host country also suffer. This situation is further aggravated by discourse and action by some governments that engage in public brutality and violent repression against migrants. Xenophobia and discrimination are all too common experiences for many migrants, and represent a serious violation of their basic human, including labour, rights.

Discrimination and conditions in which exclusion of migrants or hostility and violence against them thrive lead to direct and indirect negative health consequences, which can be severe. These range from high levels of stress, to psychological problems, to physical illness, as well as injury resulting from direct violence.

Policies requiring mandatory testing of migrants for HIV reinforce misconceptions and stereotypes about migrants and mobile workers as carriers of disease. At best, mandatory testing is ineffective in preventing transmission. At worst, mandatory testing distracts attention from effective prevention programmes and contributes to the spread of HIV by discrediting voluntary testing and prompting avoidance of social and health services,<sup>37</sup> especially in the context of irregular migration.

Stigma within migrant origin and destination societies also hinders efforts to prevent HIV infection.<sup>38</sup> Migrants testing positive for HIV can be marginalized both within the country in which they work and their origin community. HIV is considered a shameful disease in some cultures, and the HIV positive individuals’ initial reactions to the test results, which may include shock and denial, can be exacerbated by the social ostracism that follows.<sup>39</sup> Due to cultural taboos and the stigma associated with the disease, HIV-positive individuals are often reluctant to disclose their status, even to their spouse or partner, leading to a heightened risk of further transmission of the virus as well as an increased risk that the spouse or other partners will not get tested or treatment, or take preventative measures against additional transmission.

<sup>37</sup> A. Qureshi: “Structural violence and the state: HIV and labour migration from Pakistan to the Persian Gulf”, in *Anthropology & Medicine* (2013, Vol. 20, No. 3, August): 209-220.

<sup>38</sup> Y. Yang: “Stigma against HIV and AIDS among female sex workers and general migrant women in eastern China” in *BMC Women’s Health* (2015, Vol. 15, No. 2, January): 2-9.

<sup>39</sup> A. Qureshi: “Structural violence and the state: HIV and labour migration from Pakistan to the Persian Gulf”, in *Anthropology & Medicine* (2013, Vol. 20, No. 3, August): 209-220.



## 2.1.8 Specific Population Groups and Practices at Particular Risk

### Multiple concurrent partners

Mobility impacts sexuality, it changes and often enhances financial assets and it offers a widened cultural perspective. In doing so, migration often provides greater opportunities for sexual encounters than are available or acceptable in communities of origin, which may be small and tightly knit, as well as subject to more restrictive behavioural codes.

Having multiple concurrent partners is a behaviour that can be facilitated by mobility and it plays a role in increased HIV risk when it includes limited or no use of condoms. Outside of the norms and constraints of their original social environment, migrants can be more likely to engage in sex with multiple partners. Research indicates that in some situations, spouses or partners who are left behind are also found to have higher numbers of partners than those in relationships with non-migrants. However, in some cases, spouses left behind face increased risk of exposure to HIV due to migrant or mobile worker partners who engage in unprotected extramarital sexual relations.

In some countries, such as Malawi, migration is considered a rite of passage for young men through which maturity and masculinity are acquired.<sup>40</sup> Economic success upon return provides an entry point for instigating partnerships with women. In this context, having multiple partners is not considered immoral, but a status symbol and marker of success. A study on Mexican male migrants identified a phenomenon researchers termed homosociality in which the pursuit of pleasure among migrant men is understood to involve multiple partnering.<sup>41</sup>

### Men who have sex with men

Few studies report specific data on migrant men having sex with men, but this group does constitute a sub-population with a higher risk of contracting HIV. Migrants can be solicited by both female and male sex workers. Men having sex with men may have higher vulnerability in their sexual practices because anal sex is more risky for HIV transmission than vaginal sex.<sup>42</sup> A study on Mexican migrants in California reported that male migrants having sex with men averaged significantly more sexual partners than the other male migrants over the previous two months, which indicated higher risks from having multiple partners.<sup>43</sup>

### Alcohol and substance use

Separation from familiar surroundings and support systems provided by family and community can lead to increased alcohol and drug use for migrants. Such substances

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<sup>40</sup> W. Chirwa: "Migrant labour, sexual networking and multi-partnered sex in Malawi" in *Health Transition Review* (1997, Vol. 7, Suppl. 3): 5-15.

<sup>41</sup> J. Hirsch: "Desire across borders: markets, migration, and marital HIV risks in rural Mexico" in *Culture, Health & Sexuality* (2015, Vol.17, Suppl.1, April): 20-33.

<sup>42</sup> R. Pebody: "HIV Transmission Risk during Anal Sex 18 Times Higher than during Vaginal Sex", in *Aidsmap (website)*, <http://www.aidsmap.com/HIV-transmission-risk-during-anal-sex-18-times-higher-than-during-vaginal-sex/page/1446187/> [accessed 21 September 2017].

<sup>43</sup> J. Denner et al: "Predictors of HIV Transmission Among Migrant and Marginally Housed Latinos", in *AIDS and Behaviour* (2005, Vol. 9, No. 2, June ): 201-210.

are known to elevate risky sexual behaviours in all populations, including migrant workers. Under the influence of drugs and alcohol, judgment can be impaired and HIV transmission prevention measures, such as condom use, can be ignored. A study conducted in the Russian Federation on migrant workers discovered that male migrant workers with higher alcohol and drug use attested to higher engagement in risky sexual practices.<sup>44</sup>

### Sex Workers

Sex workers – defined as consenting female, male and transgender adults, as well as young people over the age of 18 years, who regularly or occasionally receive money or goods in exchange for sexual services – are considered among the highest risk groups for HIV. Although there are significant variations between regions and countries, HIV prevalence among sex workers in low-income and middle-income countries is estimated to be roughly 12 per cent.<sup>45</sup> Regardless of their social background or different circumstances, sex workers share exposure to a common set of risky practices that render them vulnerable to HIV, including having sex with multiple partners and inconstant condom use. Indeed, some customers offer more money or use intimidation or violence to have unprotected sex.

Sex workers face a high level of discrimination and marginalization. In many countries, their activity is criminalized, making it extremely difficult for them to report sexual violence or other forms of abuse, which exacerbates HIV vulnerability. These obstacles, combined with persistent stigma, limit sex workers' ability to protect themselves against HIV infection and to access healthcare and other social services, including voluntary testing, counselling and treatment. They may be afraid – or even prevented by their managers or by public or private health care “gatekeepers” – from reporting abuse or to access services on the basis of their work or occupation.

Migration and sex work are interconnected in certain circumstances. A significant number of sex workers are migrants. Migrants may be the clients of sex workers. Sex work may also be the unintended result of migration. In certain specific circumstances, research indicates that migrants – especially those in irregular situations – may turn to sex work as an alternative when no other means of earning income is available to them. A study in the United Arab Emirates found that migrant women employed in low-wage jobs or exploitative domestic work tend to be pushed into sex work to escape abusive employers and to survive economically.<sup>46</sup> Migrant sex workers face risks both as migrants and as sex workers. Research among sex workers in Shanghai showed that internal migrant sex workers were less informed about the risks of transmission of HIV and had a lower usage of condoms.<sup>47</sup> Internal migrant sex workers were also reported earning a lower income than the local sex workers, which further exacerbated their HIV vulnerability by hindering their ability to access healthcare services.<sup>48</sup>

<sup>44</sup> Y. Amirkhaniyan, et al: “Male labour migrants in Russia: HIV risk behaviour levels, contextual factors, and prevention needs”, in *Journal of Immigration and Minority Health* (2011, Vol. 13, No. 5, June): 919-928.

<sup>45</sup> S. Barat et al: “Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis” in *The Lancet* (2012, Vol. 12, No.7, July): 538-549.

<sup>46</sup> P. Mahdavi: “Gender, labour and the law: the nexus of domestic work, trafficking and the informal economy in the United Arab Emirates”, in *Global Networks* (2013, Vol. 13, No. 4, October): 425-440.

<sup>47</sup> Q.R. Qin et al: “Risk of sexual HIV transmission among wives left behind and wives of non-migrant men in rural areas of China”, in *Journal of the Association of Nurses in AIDS Care* (2009, Vol. 20, No. 4 July-August): 308-315.

<sup>48</sup> Ibid.

## 2.2 Challenges in Accessing Social Protection

The right to social protection is a basic human right, enshrined in numerous international instruments. (For a discussion of social protection instruments, including ILO's Social Protection Floors Recommendation, 2012 (No. 202), see Part Three).

Although migrants make many contributions to economies and societies in countries of origin and destination, they are routinely excluded from even the most basic coverage by social protection instruments and schemes. This exclusion is experienced by migrants whose status is regular as well as irregular, but is particularly acute among undocumented migrant workers. Upon leaving their countries of origin, migrant workers risk losing entitlements to social security benefits in their country of origin due to their absence, and may at the same time encounter restrictive conditions under the social security system of the host country. This is despite the important contributions they make to social security schemes, either in their home countries or countries of destination.

Low-skilled migrant workers face particularly acute social security concerns, which include coverage, portability, minimum qualifying conditions, impediments to access to rights, administrative obstacles, and coordination between countries of employment and origin.<sup>49</sup> Low-skilled migrant workers, especially those in an irregular situation, are often excluded or restricted from coverage by national social security schemes in countries of destination, as entitlements are usually linked to nationality, residency, or immigration status.<sup>50</sup> For example, migrant domestic workers in the GCC countries do not enjoy pension or maternity benefits, leaving pregnant or retired migrant workers with little financial protection, and without access to medical care. Moreover, social security schemes may also have long residency requirements, making it difficult for migrants to claim their benefits when engaged in temporary or informal work. High-skilled migrant workers also suffer from low portability of social security. Even when they are entitled to social security benefits in their countries of destination, they often lose what they have accumulated in their countries of origin.

Inadequate or no access to social protection exacerbates health risks and vulnerabilities by leaving migrants with little or no means to obtain essential health services. Lack of social protection undermines or denies access to minimum income for those in need to support basic nutrition and housing essential to maintain healthy living conditions. This is often the case for women who are not economically active, as well as children, migrants with disabilities, and migrants who retire from employment, whether they remain in countries of employment or return to origin countries.

### 2.2.1 Access to Health Care for Undocumented Migrants

Access to healthcare for undocumented migrants is problematic in all regions around the globe, despite the right to health being guaranteed under international law. Considerable data on the healthcare situation of undocumented migrants can be found regarding Europe and the United States while some research has also been undertaken on the situation in certain countries in Asia.

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<sup>49</sup> Migrant Forum in Asia, Policy Brief No. 7. 2013. *Social Protection for low-Skilled Migrant Workers and their Families*, (September 2013).

<sup>50</sup> Ibid.

In Europe, Article 35 of the European Union Charter of Fundamental Rights establishes that “everyone has the right to access preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices.” Furthermore, Article 13 of the Council of Europe Resolution 1509 (2006) on the Human Rights of Irregular Migrants establishes “minimum rights” and more specifically states, in paragraph two, that “emergency health care should be available to irregular migrants and states should seek to provide more holistic health care, taking into account, in particular, the specific needs of groups such as children, disabled persons, pregnant women and the elderly.”

All European Union Member States allow for access to health care for undocumented migrants but some states, such as Germany, only grant them access to emergency care.<sup>51</sup> However, Germany also provides an example of how even emergency care can become inaccessible for undocumented migrants. An undocumented migrant who cannot cover his or her healthcare costs is obliged to seek financial assistance from the German social services, which, in turn, are obliged to report undocumented migrants to the authorities.<sup>52</sup> Nonetheless, undocumented migrants can access free testing for sexually transmitted infections and tuberculosis, and in some cases “outpatient treatment” is provided by local Public Health Authorities.<sup>53</sup> The United Kingdom changed its policy on the provision of antiretrovirals to include all people in the UK regardless of immigration status.<sup>54</sup> Good practice examples of ensuring access to healthcare for children of undocumented migrants, include Greece, where free access is granted, and Spain where migrant children have the same access to healthcare as nationals; whereas in the UK undocumented migrant children are not granted any specific protection.<sup>55</sup>

In addition to facing legal barriers, undocumented migrants often lack sufficient financial resources to cover healthcare services.<sup>56</sup> It is especially problematic in cases where states oblige undocumented migrants to cover all their healthcare costs, as is the practice in Sweden.<sup>57</sup> In the United States, healthcare services received by undocumented migrants are often not covered by any insurance.<sup>58</sup> Undocumented migrants remain the largest uninsured group in the country and poverty levels among the group are accelerating.<sup>59</sup>

<sup>51</sup> P. Chauvin et al.: *Access to Healthcare for Undocumented Migrants in 11 European Countries (Médecins du Monde European Observatory on Access to Healthcare, September 2009)*: 35.

<sup>52</sup> Ibid.

<sup>53</sup> M. Mylius and A. Frewer: “Access to Healthcare for Undocumented Migrants with Communicable Diseases in Germany: A Quantitative Study”, in *European Journal of Public Health* (2015, Vol. 25, No.4, August): 583.

<sup>54</sup> Government of UK, Department of Health. 2012. *HIV treatment for overseas visitors in England from 1 October 2012*. <https://www.gov.uk/government/publications/hiv-treatment-for-overseas-visitors-in-england-from-1-october-2012> [accessed 21 September 2017].

<sup>55</sup> Ibid.

<sup>56</sup> A. E. Stanciole and M. Huber: “Access to Health Care for Migrants, Ethnic Minorities and Asylum Seekers in Europe,” *European Center* (2009): 1-8.

<sup>57</sup> P. Chauvin et al.: *Access to Healthcare for Undocumented Migrants in 11 European Countries (Médecins du Monde European Observatory on Access to Healthcare, September 2009)*: 1-157.

<sup>58</sup> S. P. Wallace et al.: *Undocumented Immigrants and Health Care Reform*, (UCLA Center for Health Policy Research, April 2012): 1-51.

<sup>59</sup> American Nursing Association (ANA). 2010. *Issue Brief on Nursing Beyond Borders: Access to Health Care for Documented and Undocumented Immigrants Living in the US*: 1-10.

In Asia, restrictive measures exist that impede healthcare access for undocumented migrants as well as the general migrant population. In Hong Kong, for example, undocumented migrants have the right to access emergency care but health authorities are legally obliged to report them to the authorities.<sup>60</sup> One study concluded that, in the overall ASEAN community, healthcare access for undocumented migrants is marginal to non-existent.<sup>61</sup> Thailand's legislation allows access to the government Compulsory Migrant Health Insurance scheme for undocumented migrants, although implementation on the ground has been difficult due to fear of identification by enforcement agencies and as a result, undocumented migrants are hesitant to make use of it.<sup>62</sup>

Restrictions on access to healthcare for undocumented migrants can cause an additional set of problems. In some places, it is common practice for migrants in an irregular situation to use identification or health care cards belonging to individuals who have legal status in the country in order to get healthcare treatment. This creates not only administrative complications, which can lead to access being even more difficult to achieve, it can also create real medical risks because treatments designed for one individual may be inappropriate or even harmful for another.<sup>63</sup>

Regarding enhancing access to healthcare for irregular migrants, Medicine Sans Frontiers (MSF) projects highlighted a number of 'good practice' initiatives to reach migrants with healthcare services: mobile clinics, cultural mediators, collaboration with local migrant-friendly NGO's, and advocacy.<sup>64</sup> Case study research carried out under the auspices of the ASEF Public Health Network covering a number of European and Asian countries demonstrated that NGOs play a major role in covering costs for healthcare provision to undocumented migrants and thus, in effect aid formal healthcare systems in 'saving money'.<sup>65</sup> The ASEF report recommends that governments work closely with NGOs as they provide a key link in "providing medical services" to migrants, particularly those in irregular or undocumented situations.<sup>66</sup>

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<sup>60</sup> U. Trummer and S. Novak-Zezula: *Migrants and Healthcare- Social and Economic Approaches*, (ASEF Public Health Network. 2014): 1-122.

<sup>61</sup> United National Development Programme. 2015. *The Right to Health, Right to Health for Low- Skilled Labour Migrants in ASEAN Countries* (Bangkok, 2015): 30.

<sup>62</sup> C. Khoon: "Universal Health Care? (Un)documented Migrants in Southeast Asia" in *Health and Human Rights Journal*, November 2015. <http://www.hhrjournal.org/2015/11/universal-health-care-undocumented-migrants-in-southeast-asia/> [accessed 21 September 2017].

<sup>63</sup> United National Development Programme. 2015. *The Right to Health, Right to Health for Low- Skilled Labour Migrants in ASEAN Countries* (Bangkok, 2015): 31.

<sup>64</sup> K. Pottie et al.: "Access to Healthcare for the most Vulnerable Migrants: a Humanitarian Crisis", in *Conflict and Health* (2015, Vol. 9, No. 16, March): 3.

<sup>65</sup> U. Trummer and S. Novak-Zezula: *Migrants and Healthcare- Social and Economic Approaches*, (ASEF Public Health Network. 2014): 85.

<sup>66</sup> U. Trummer and S. Novak-Zezula: *Migrants and Healthcare- Social and Economic Approaches*, (ASEF Public Health Network. 2014): 1-122

## 2.3 Access to Work and Occupational Safety and Health (OSH)

HIV and AIDS have affected millions of workers and their families by leading to loss of life and livelihoods and by imposing significant burdens on employers.<sup>67</sup> The workplace is one of the most effective settings in which to address HIV and AIDS, and is therefore a critical venue in which to reach those living with and affected by HIV.<sup>68</sup> In the current context of global migration, in which a large majority of migrants worldwide are employed or otherwise engaged in economic activity,<sup>69</sup> ensuring proper protection in the workplace, as well as access to HIV prevention and treatment in and through the world of work, is a crucial component of global action against HIV and AIDS.

### 2.3.1 Challenges in Accessing Employment and Decent Work

Access to employment and decent work is not only a right, it is essential to maintain adherence to HIV treatment.<sup>70</sup> The ILO report released on World AIDS Day 2013, *The Impact of Employment on HIV Treatment Adherence*, showed that employment has a positive impact on treatment adherence by 39 per cent because it provides food security and financial security.

By contrast, unemployment may increase the risk of depression, which can in turn increase the risk of unhealthy behaviours and contribute to homelessness or even imprisonment, which have been shown to be factors for non-adherence to treatment.<sup>71</sup> Unemployment can also lead to substance abuse and commercial sex work, which can increase the risk of infection for individuals. As a result, ensuring decent work and access to employment is a key factor to prevent and treat HIV or AIDS.

However, migrants often do not have access to decent work, or, sometimes, to any work. During economic downturns or crises, migrant labour is often used as a cyclical buffer, meaning these workers are frequently the last to be hired and the first to be fired. The general unemployment rate among foreign-born workers increased significantly during the recent economic crisis in Europe. In Sweden for example, 21.6 per cent of non-EU or third-country nationals were unemployed between 2009 and 2010, compared to 12.2 per cent of persons born in Europe and 7 per cent of Swedish nationals.<sup>72</sup> In Germany, 17 per cent of foreigners were unemployed in 2009, compared to 7.8 per cent of German nationals.<sup>73</sup> This is partly due to the fact that migrants are often treated as scapegoats during a crisis, and suffer from xenophobic and discriminatory behaviour by nationals. It

<sup>67</sup> ILO: *Handbook on HIV and AIDS for Labour Inspectors*. International Labour Office, (Geneva 2014): 9.

<sup>68</sup> ILO: HIV and AIDS Recommendation 2010 (No. 200), para. 3 (j); ILO: *International Labour Migration: A Rights Based Approach* (Geneva, ILO, 2010).

<sup>69</sup> ILO: *Global Estimates on migrant workers, Results and Methodology; Special focus on migrant domestic workers*. (Geneva, ILO, 2015).

<sup>70</sup> ILO: *Message from ILO Director-General Guy Ryder on the occasion of World AIDS Day, 29 November 2013*. [http://www.ilo.org/global/about-the-ilo/who-we-are/ilo-director-general/statements-and-speeches/WCMS\\_230906/lang--en/index.htm](http://www.ilo.org/global/about-the-ilo/who-we-are/ilo-director-general/statements-and-speeches/WCMS_230906/lang--en/index.htm) [accessed 21 September 2017].

<sup>71</sup> ILO: *The Impact of Employment on HIV Treatment Adherence*, (Geneva, ILO, 2013): 24-27.

<sup>72</sup> M. Benito: *Labour Migration and the Systems of Social Protection: Country Report Sweden* (Czech Republic, Multikulturni Centrum, 2011): 10.

<sup>73</sup> B. Jungius: *Crisis of Migrant Employment in Germany: Country Report Germany* (Czech Republic, Multikulturni Centrum, 2011): 6.



is also because migrants are statistically more likely to concentrate in more economically volatile employment sectors such as construction, tourism and the hospitality sector. Compared to that of other populations, migrants' employment situation is less secure.

Moreover, migrants also face more obstacles than other populations when it comes to access to decent work. These obstacles can result from xenophobic behaviour by employers and local populations, undocumented status, failure to recognize foreign qualifications, and discrimination. The gap in harmonization and recognition of educational qualifications means that many migrants with proper training experience difficulties in obtaining decent work or middle-skilled work. This forces them to seek low-skilled jobs or drives them to take informal jobs that are low-paid and demanding, in which workers have higher exposure of injury and infection and little access to social protection or to HIV prevention and treatment.

### 2.3.2 Discrimination in Employment

Discrimination in employment and occupation is defined by the ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111) as “any distinction, exclusion or preference made on the basis of race, color, sex, religion, political opinion, national extraction or social origin which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation,” unless based on inherent requirements of the job.<sup>74</sup> The Convention also foresees the addition of additional grounds of discrimination, “after consultation with representative employers' and workers' organizations ... and with other appropriate bodies.”<sup>75</sup> Migrant workers are particularly at risk of discrimination because they are non-nationals and often of a different ethnicity, race or religion from the native or dominant population of the countries to which they migrate.<sup>76</sup>

Migrant workers tend to be perceived and treated as exploitable, and are seen as expendable, cheap, docile, flexible labour. These conditions contribute to the risk that migrant workers will be subject to differential and discriminatory treatment. Such treatment may entail being underpaid, provided with inadequate or no workplace safety and health protections, and hired and dismissed with no notice, justification, or legal recourse.

Discrimination against migrant workers involves several legal and practical concerns including discrimination based on immigration status or nationality, multiple discrimination against women, including based on gender, and discrimination in application of labour standards and social protection. Discrimination may also result in violence and harassment, increasing migrant workers' vulnerability to HIV. Discrimination on any of these grounds or their combination could lead to higher rates of unemployment and poor conditions of work, which increases the risk of HIV infection and lowers adherence to treatment. Discrimination in application of labour standards and social protection may also lead to lack of access to prevention and treatment measures available for non-migrants. Gender discrimination limits job opportunities for women, who are often denied equal access to jobs and receive lower wages than men for work of equal value.

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<sup>74</sup> ILO: Discrimination (Employment and Occupation) Convention, 1958 (No. 111), Art. 1(1)(a) and Art. 1(2).

<sup>75</sup> Ibid. Art. 1(1)(b).

<sup>76</sup> ILO: *General Survey on the Fundamental Conventions concerning Rights at Work in Light of the ILO Declaration on Social Justice for a Fair Globalization 2008*, International Labour Conference, 101st Session, Geneva, 2012.

### 2.3.3 Mandatory HIV Testing as Part of the Hiring Process

The practice of mandatory HIV testing in the hiring process is of considerable concern. When employers demand that migrant workers take HIV tests in order to obtain a job or to remain on the job where such testing and HIV status have no bearing on ability to work, it violates the rights of the migrant. Some employers try to justify testing by claiming that the worker's health needs can be better addressed if HIV status is known; however, in the majority of cases, no elevated level of access and treatment is granted after HIV status is determined.<sup>77</sup> A second argument is that testing promotes overall public health if those infected seek treatment. While it is true that public health is improved when individuals living with HIV seek treatment, the fault in this second argument is the assumption that forced testing will lead to individuals' seeking of treatment, which evidence shows it does not.<sup>78</sup>

In a study carried out by the ILO Sub-regional Office for East Asia and the IOM, ILO and IOM affirmed that: (1) "mandatory HIV testing for employment represents a serious human rights violation," and (2) "mandatory HIV testing for employment is not an effective public health response."<sup>79</sup>

### 2.3.4 Conditions of Work

Once they are employed, migrants often face conditions of work that are worse than those of non-migrants. As a result of various factors, including lack of recognition of qualifications and also discrimination, migrants are more likely to take up non-standard jobs in poorly regulated sectors or activities. Employment in the informal economy, temporary work, and employment in "3D" jobs (dirty, dangerous, and difficult) are all susceptible to poor conditions of work.

Migrant workers often engage in informal work characterized by a complete absence of workplace protection and the presence of exploitation or abuse. Informal employment takes place in many professions, but is prevalent in agriculture (particularly seasonal work), construction, mining and logging, domestic housekeeping, care work, and sex work. In South Africa for example, the construction sector is largely made up of migrant workers, including rural to urban migrants and migrants from other parts of Africa.<sup>80</sup> The Cologne Institute for Economic Research estimates that 95 per cent of all domestic workers in Germany are working in irregular situations in about four million German households.<sup>81</sup> Moreover, migrants are more likely to be engaged in temporary employment. Even before the recent economic crisis, the share of foreign-born workers in temporary work in many European countries exceeded that of the native-born by at least 50 per cent.<sup>82</sup>

<sup>77</sup> ILO Subregional Office for East Asia and IOM, *Mandatory HIV Testing for Employment of Migrant Workers in Eight Countries of South-East Asia: From Discrimination to Dialogue*, (Bangkok, 2009): 11.

<sup>78</sup> Id. at 12.

<sup>79</sup> Ibidem.

<sup>80</sup> P. Bowen et al.: "Guidelines for Effective Workplace HIV and AIDS Intervention Management by Construction Firms" in *Construction Management and Economics* (2014, Vol. 32, No. 4, March): 363.

<sup>81</sup> B. Jungius: *Crisis of Migrant Employment in Germany: Country Report Germany* (Czech Republic, Multikulturni Centrum, 2011): 8.

<sup>82</sup> J. P. Martin (ed): "Migration in the Post-Crisis World", in *International Migration Outlook 2011* (Paris: Organization for Economic Cooperation and Development, 2011): 12.



Low social protection combined with low wages reinforces a class of “working poor,” whose income is frequently not enough to raise them above the national poverty line. For example, before 2008, three out of five farmworker families in the United States had annual incomes that fell below federal poverty levels, and 75 per cent earned less than US\$10,000 per year.<sup>83</sup> Low wages generally condemn workers and their families to poor living conditions and poor nutrition, which further undermine their health in addition to compounding the impact of HIV and AIDS. Furthermore, with low wages, the cost of living with HIV can be prohibitive. The costs for purchasing medications to treat opportunistic infections alone can be unaffordable for many migrants. Despite free access to antiretroviral therapy (ART) in some countries, low-income people living with HIV and their households have a difficult time covering expenses such as co-payments on insurance, payments for hospital or clinic visits, payments for transportation to and from hospital, and payments for medicines other than antiretroviral therapy.<sup>84</sup>

### 2.3.5 Occupational Safety and Health (OSH)

The ILO Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200), discussed in Part Three, places a strong focus on occupational safety and health issues. It provides that “workers should benefit from programmes to prevent specific risks of occupational transmission of HIV and related transmissible diseases” and that workers in occupations that are particularly exposed to the risk of HIV transmission need to be protected.<sup>85</sup> Several economic sectors with higher HIV prevalence for migrant workers than among the general population have been identified: transportation, construction, mining and logging, ports and seafarers, export processing zones, agriculture, health care, hospitality, hotels and tourism, and the entertainment industry.<sup>86</sup> In many countries, large numbers of migrants are employed in these sectors.

The special characteristics of some work sectors may result in higher risk of HIV infection. For example, informal housing and overcrowding, exposure of workers to dust that contains silica (in the case of TB), and a concentration of working-age single men, as well as proximity of sex workers, are all common in the mining industry. These are high risk factors for development of TB as well as being conducive to transmission of HIV. Research suggests that such situations increase the risk of TB and HIV co-infection.<sup>87</sup> Nevertheless, this does not determine the high HIV prevalence. Adequate occupational safety and health policy responses from employers and the government can not only address the risk factors of HIV infection in the workplace, they can improve access to treatment and reduce discrimination and stigma. For example, addressing the discriminatory treatment in the sex industry could facilitate sex workers’ access to health information and services, and their willingness to seek health care related to HIV and AIDS.<sup>88</sup> For migrant sex

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<sup>83</sup> M. Anthony et al.: “Health Needs of Migrant and Seasonal Farmworkers”, in *Journal of Community Health Nursing* (2008, Vol. 25, No. 3 July-September): 154.

<sup>84</sup> ILO: *Access to and Effects of Social Protection on Workers Living with HIV and their Households* (Geneva, ILO 2014): 8.

<sup>85</sup> ILO: HIV and AIDS Recommendation 2010 (No. 200), para. 3 (g) and (k).

<sup>86</sup> ILO: *Handbook on HIV and AIDS for Labour Inspectors*, International Labour Office, (Geneva 2014): 5.

<sup>87</sup> International Council on Mining & Metals. 2008. *Good Practice Guidance on HIV and AIDS, Tuberculosis and Malaria*: 10, <https://www.icmm.com/website/publications/pdfs/314.pdf> [accessed 21 September 2017].

<sup>88</sup> Global Network of Sex Works Projects. 2014. *Good Practice in Sex Worker-Led HIV Programming: Global Report*, 2014: 2. <http://www.nswp.org/sites/nswp.org/files/Global%20Report%20English.pdf> [accessed 21 September 2017].

workers, policies need to also address their linguistic constraints and, for many, lack of legal documentation, which can drive them further underground, undermine safe sexual behaviour, and disrupt information networks.<sup>89</sup>

Inadequate or discriminatory occupational safety and health policies, on the other hand, increase the risk of HIV transmission by leaving unaddressed conditions of substandard or overcrowded housing, unsafe working conditions and environments, an absence of preventative health and safety training, and practices that tolerate discrimination and stigma. For example, a 2008 Portuguese Supreme Court of Justice judgment ruled that an HIV-positive cook could not continue his professional activity due to his HIV status.<sup>90</sup> Not only was this decision not in line with scientific knowledge about HIV transmission, it imposes discriminatory measures on people living with HIV.

### 2.3.6 Labour Inspection

The risk factors for HIV are closely connected to the concerns of labour inspection. Many workplace situations and working environments may increase the risk of HIV infection for workers, such as long working hours, difficult or exploitative working conditions, and exposure to contaminated blood or blood products.<sup>91</sup> These situations are common in sectors largely composed of migrant workers such as agriculture, mining and logging, and sex work. These sectors are precisely those reported to have a higher HIV prevalence than the general population,<sup>92</sup> and require labour inspection to prevent or reduce the risk of occupational transmission of HIV. Moreover, labour inspection could play a crucial role in ensuring observance of the principle of equality of opportunity and treatment in employment for all persons. It could also promote a working environment without discrimination and stigma,<sup>93</sup> as its main function is “to protect the rights and interests of all workers”.<sup>94</sup>

Labour inspection also faces many challenges in relation to HIV. There are gaps in national legislation: by the end of 2012, only 61 per cent of countries were reported to have anti-discrimination legislation protecting people living with or affected by HIV.<sup>95</sup> Even where protective legislation exists, it may not explicitly apply to the employment context.<sup>96</sup> While effective labour inspection can play a key role in ensuring that migrant workers are not subject to discrimination and abuse with respect to conditions of work, including wages, and issues relating to occupational safety and health, countries have reported labour inspectors’ difficulties in identifying cases of discrimination which apply to multiple grounds (nationality, race, gender etc.) and to different areas (pay, safety and health, working conditions).<sup>97</sup>

<sup>89</sup> Ibid.

<sup>90</sup> A. Pereira: “HIV and AIDS and Discrimination in the Workplace: The Cook and the Surgeon Living with HIV”, in *European Journal of Health Law* (2010, Vol. 17, No. 2, March): 144.

<sup>91</sup> ILO: *Handbook on HIV and AIDS for Labour Inspectors* (Geneva, ILO, 2014): 11.

<sup>92</sup> Id. at 5.

<sup>93</sup> Id. at 11.

<sup>94</sup> ILO: *General Survey on Promoting Fair Migration 2016*, International Labour Conference, 105th Session, Geneva 2016. para. 482: 153.

<sup>95</sup> Id. at 12.

<sup>96</sup> Ibid.

<sup>97</sup> ILO: *General Survey on the fundamental Conventions concerning rights at work in light of the ILO, Declaration on Social Justice for a Fair Globalization 2008*, International Labour Conference, 101st Session, Geneva 2012. para. 875: 363.

Another specific challenge in the context of labour migration is potential misunderstandings that may arise between labour inspectors and migrant workers due to differing political and cultural references. As migrants often come from different political contexts and socio-cultural backgrounds, they may have difficulty with questions addressing HIV, AIDS, and other sexually transmitted infections that implicitly or explicitly refer to sexuality and private life. There may also be a lack of understanding of the inspector's function and a fear that if the person's HIV status is disclosed, it will be revealed to the employer and the worker will be dismissed.<sup>98</sup>

## 2.4 Legal Status and Travel Restrictions

Migrants, irrespective of their immigration status, are entitled to all human rights that every individual enjoys, such as the right to the highest attainable standard of physical and mental health, the right to leave any country, including their own, and the right to be free from arbitrary detention.<sup>99</sup>

### 2.4.1 Migration and Health Policy Linkages

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.<sup>100</sup> This includes all migrants with or without valid immigration status. Migrants, due to the circumstances present before the departure, during travel, at the destination and while returning to the place of origin, face increased levels of vulnerability to health risks including HIV.<sup>101</sup> Moreover, different groups of migrants face different degrees of risk. Those migrants originating from areas of poverty or displaced by conflict or natural disaster, and those with limited skills all have greater health risks.<sup>102</sup> Only by implementing health care policies without discrimination, stigmatization, or inequality can these risks be addressed and the health of migrants be protected.

As the 2010 Global Consultation on Migrant Health emphasized, current health policies are not addressing the problem of migrant health and population health in a unified manner. While population health policies and principles are based on fundamental concepts of universal access to preventive or therapeutic clinical health and medical services, migration health policies tend to focus on immigrants separately rather than considering migration health beyond nationality and residence.<sup>103</sup>

In addition, conflicting pressures created by policies and regulations in areas such as national security, registration, profiling, labour and criminalization of migration have hindered the core human rights aspect of migrant health, often conditioning health care on nationality or

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<sup>98</sup> ILO: *Handbook on HIV and AIDS for Labour Inspectors* (Geneva, ILO, 2014):14.

<sup>99</sup> United Nations General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, Vol. 999: 171, Art. 9 (1) and 12 (2); UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, Art. 12.

<sup>100</sup> United Nations General Assembly, *International Convention on Economic, Social and Cultural Rights*, Art. 12.

<sup>101</sup> IOM, WHO, and OHCHR. 2013. *International Migration, Health and Human Rights*, International Organization for Migration (Geneva, 2013): 29.

<sup>102</sup> WHO and IOM. 2014. *Tuberculosis Prevention and Care for Migrants* [http://www.who.int/tb/publications/WHOIOM\\_TB\\_migration.pdf](http://www.who.int/tb/publications/WHOIOM_TB_migration.pdf) [accessed 21 September 2017].

<sup>103</sup> IOM, WHO, and the Ministry of Health and Social Policy of Spain. 2010. *Health of Migrants-the Way Forward*, World Health Organization (Geneva 2010): 43.

residence status instead of making it available to all as directed by human rights standards. National migration health care policies need to be based on a firm foundation of legal norms found in international labor standards, human rights law, and other international norms.

#### 2.4.2 Entry, Stay and Travel/Mobility Restrictions

Article 12 of the International Covenant on Civil and Political Rights stipulates that “1) Everyone lawfully within the territory of a State, within that territory, has the right to liberty of movement and freedom to choose his residence; 2) Everyone shall be free to leave any country, including his own; 3) The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant; 4) No one shall be arbitrarily deprived of the right to enter his own country.”<sup>104</sup> While the Covenant allows States to limit entry on their territory on public health grounds, according to the International Health Regulations, the only disease for which an international travel vaccination certificate is required is yellow fever.<sup>105</sup>

Evidence has amply demonstrated that HIV-related restrictions on entry and stay in countries – often referred to as “travel restrictions” – have little impact on its transmission regionally and globally. HIV is not airborne and cannot be transmitted by casual physical contact of any kind. It is only transmitted through body fluids, including blood, semen, vaginal secretions, and breast milk, through unprotected sexual intercourse, mother-to-child transmission, and contact with blood and blood products.<sup>106</sup> As a result, mobility in and of itself cannot spread HIV and mobility restrictions therefore have no impact on preventing its transmission. Policy makers need to focus instead on public education about HIV and AIDS, such as promoting protected sexual intercourse and warning against the use of shared needles, as well as facilitating more accessible provision of HIV prevention, treatment, care and support services.

From efforts to address the spread of epidemics across borders, evidence shows that restrictions on access to, entry and stay in countries have limited effect, even for airborne viruses such as Pandemic Influenza A (H1N1). International travel restrictions may provide a delay in the spread of an epidemic such as Ebola and H1N1 for a very limited time (one or two weeks), but the accompanying economic and social costs could be considerable.<sup>107</sup>

<sup>104</sup> United National General Assembly, *International Covenant on Civil and Political Rights*. <http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx> [accessed 21 September 2017].

The General Comment No. 15 (1986) of the Human Rights Committee on the position of aliens under the Covenant, further states: “[i]n certain circumstances an alien may enjoy the protection of the Covenant even in relation to entry or residence, for example, when considerations of non-discrimination, prohibition of inhuman treatment and respect for family life arise” <http://www.ohchr.org/documents/publications/noncitizensen.pdf> [accessed 21 September 2017].

<sup>105</sup> WHO. 2005. *International Health Regulations*: the International Health Regulations are the only constraining global legal instrument dealing with measures to limit cross-border transmission of communicable diseases. The Regulations are undergoing far-reaching revision: see: <http://www.who.int/csr/ihr/>; See also *HIV/AIDS and human rights, International Guidelines* (op cit., 1998), § 105, and *Statement on HIV/AIDS-related travel restrictions* (UNAIDS & IOM, 2004).

<sup>106</sup> ILO, *Handbook on HIV and AIDS for Labour Inspectors*, International Labour Office, (Geneva, 2014): 6.

<sup>107</sup> C. Poletto et al.: “Assessing the Impact of Travel Restrictions on International Spread of the 2014 West African Ebola Epidemic” in *Eurosurveillance* (2014, Vol. 19, No. 42, October); P. Bajardi et al.: “Human Mobility Networks, Travel Restrictions, and the Global Spread of 2009 H1N1 Pandemic” in *PLoS ONE* (2011, Vol. 6, No. 1, January); J. M. Epstein et al.: “Controlling Pandemic Flu: The Value of International Air Travel Restrictions”, in *PLoS ONE* (2007, Vol. 2, No. 5, May).

Comparing the cost of limiting the mobility of persons and goods with the limited effect it would have, indicates that travel restrictions are largely counter-productive in the face of an epidemic and are unlikely to be an effective option in future epidemic events.

Nonetheless, in past years a large number of countries have imposed restrictions on arrival, entry and stay on the basis of HIV status, and, in some cases, on the basis of other diseases such as tuberculosis (TB). “Travel restrictions” is in fact a misnomer: most of these measures were specific legal restrictions or immigration criteria barring the entry of people living with HIV and providing for expulsion of non-nationals found to be HIV-positive. In a positive development, the number of countries which impose restrictions on entry and stay of HIV positive persons decreased by 24 per cent in 2015 alone, largely due to the implementation of the 2011 UN Agreement on Eliminating HIV- Related Travel Restrictions.<sup>108</sup>

States attempt to justify implementation of entry and stay restrictions on HIV positive persons on two main grounds: public health concerns and public expenditure.<sup>109</sup> However, international recommendations note that restrictions must still comply with international law standards.

### 2.4.3 Deportation Due to HIV Status

As case studies reveal, deportation of migrant workers due to HIV positive status remains a common practice in certain countries, including Gulf Cooperation Council (GCC) countries as well as South Korea,<sup>110</sup> Malaysia and Singapore.<sup>111</sup> Data on the exact number of deportations of migrant workers with HIV positive status is not accessible. Countries in which such deportations occur typically do not make such data public, and do not generally inform the governments or health services of the countries to which HIV-positive migrants are deported. For example, in the case of deportation of HIV-positive Pakistani migrant workers, GCC countries do not pass on data on deportation to the Pakistani diplomatic missions.<sup>112</sup>

International jurisprudence on deportation of migrants regarding HIV status is still minimal and inconsistent.<sup>113</sup> In the Case of *N. v. The United Kingdom*, a Ugandan asylum seeker appealed to the European Court of Human Rights (ECHR) claiming that upon deportation from the UK, she would not be able to access sufficient antiretroviral therapy in her country of origin. She argued, therefore, that deportation would be in clear violation of Article 3 on prohibition of torture and Article 8 on the right to respect for private and family life of the

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<sup>108</sup> UNAIDS. 2015. *Eliminating HIV-Related Travel Restrictions*, <https://results.unaids.org/priority/ubraf-outcome/eliminating-hiv-related-travel-restrictions> [accessed 21 September 2017].

<sup>109</sup> UNAIDS and IOM. 2004. *UNAIDS/IOM Statement on HIV and AIDS- Related Travel Restrictions* (June 2004): 1-14.

<sup>110</sup> Human Rights Watch, Deutsche Aids Hilfe e.V., EATG, African HIV Policy Network. “Returned to Risk. Deportation of HIV- Positive Migrants.” (Human Rights Watch, New York, 2009); Human Rights Watch, “Discrimination, Denial, and Deportation- Human Rights Abuses Affecting Migrants Living with HIV,” (June 2009): 1-28; UNAIDS. 2014. *The Gap Report*: 1-16.

<sup>111</sup> ILO Subregional Office for East Asia and IOM. 2009. *Mandatory HIV Testing for Employment of Migrant Workers in Eight Countries of South- East Asia: From Discrimination to Social Dialogue* (Bangkok, 2009): 34, 41.

<sup>112</sup> A. Qureshi: “Structural violence and the state: HIV and labour migration from Pakistan to the Persian Gulf”, in *Anthropology & Medicine* (2013, Vol. 20, No. 3, August).

<sup>113</sup> C. Izambert: “Europe: Securing Legal Protection Against Expulsion for HIV- Positive Migrants”, in *HIV/AIDS Policy and Law Review* (2010, Vol.15 No. 1, October): 57-58.

European Convention on Human Rights. The Court ruled that ill treatment falls within the scope of Article 3 only in cases of “minimum level of severity that is relative and dependent on all the circumstances of the case, including the duration of treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim.”<sup>114</sup> The Court held that states may apply Art 3. “where harm derives from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country”<sup>115</sup> and concluded that the UK may deport non-nationals who receive treatment in the UK, even if no sufficient treatment in the country of destination is guaranteed.<sup>116</sup>

In another case, however, *D. v. the United Kingdom*, the ECHR ruled against the deportation of an HIV-positive person.<sup>117</sup> The Court ruled that expulsion of the HIV positive foreigner was against Article 3 of the European Convention on Human Rights.<sup>118</sup>

It has been argued that the ruling in *N. v. the United Kingdom* was motivated by concern to discourage health tourism to Europe.<sup>119</sup> However, data from France, which introduced a system allowing for obtaining residence on medical grounds, has shown that the number of people accessing this benefit remains low.<sup>120</sup>

Research shows that in several countries where deportation of migrants who may be or are HIV positive has taken place, the grounds for deportation were due to irregular or unauthorized immigration status, not to health status. For example, one study reported that in the US, when undocumented migrants seek medical care, health authorities do in some cases pass on the information about their irregular status to immigration authorities, although this is prohibited by national legislation.<sup>121</sup> By contrast, the United States is also among the few countries that have granted asylum to HIV-positive migrants on the basis that they would have faced likely persecution in the country of origin<sup>122</sup> and in 2010 the HIV travel ban was lifted.

Deportation due to HIV-positive status can also severely impact the social environment to which migrants return if it is not coordinated with health authorities in the country of return, and if no treatment in that country of origin is established. Studies show that upon return, deported HIV-positive migrants represent a high-risk factor for passing on the virus to their spouse and other possible partners. In Pakistan, for example, data from 2010

<sup>114</sup> ESCR-Net, “Case of *N. v. The United Kingdom*,” <https://www.eschr-net.org/caselaw/2012/case-n-v-united-kingdom> [accessed 21 September 2017].

<sup>115</sup> *Ibid.*

<sup>116</sup> *Ibid.*

<sup>117</sup> European Court of Human Rights, Case of *D. v. the United Kingdom*, Application no. 146/1996/767/964), Judgment, Strasbourg (May 2, 1997).

<sup>118</sup> A. Devillard: “The Principle of Non-Discrimination and Entry, Stay and Expulsion of Foreigners Living with HIV/AIDS” in *International Journal on Multicultural Societies* (2009, Vol. 11, No 2, June): 91-105.

<sup>119</sup> C. Izambert: “Europe: Securing Legal Protection Against Expulsion for HIV- Positive Migrants” in *HIV/AIDS Policy and Law Review* (2010, Vol. 15, No. 1, October): 57-58.

<sup>120</sup> *Ibid.*

<sup>121</sup> Human Rights Watch. 2009. *Discrimination, Denial, and Deportation- Human Rights Abuses Affecting Migrants Living with HIV* (June 2009): 1-28.

<sup>122</sup> K. Wiltenburg Todrys: “Returned to Risk. Deportation of HIV- Positive Migrants”, *Health and Human Rights Division at Human Rights Watch* (New York, 2009).



on patients in HIV clinics in the country revealed that all patients were either returned migrant workers themselves or spouses of migrant workers.<sup>123</sup>

Women migrants deported on HIV grounds face particular stigmatization and in some cases exclusion from their communities upon return to their country of origin.<sup>124</sup> Migrants are put in vulnerable situations, especially in cases of deportation from GCC countries, where no pre or post counseling is conducted if an individual tests positive.<sup>125</sup>

#### 2.4.4 Migrants with Restricted Entitlements

In some cases, migrants may have restrictions in their entitlements to rights and protection. These restrictions apply to a range of migrant jobs, including those that are temporary, seasonal, and short-term in nature, and are present in many countries, including developed countries. These migrants often face considerable obstacles in enjoying the right to health and access to health services. They often experience precarious and dangerous working conditions, absence of occupational safety and health protection, and violations of human rights as a direct consequence of insufficient protection under the law. These precarious conditions exacerbate health risks and vulnerability to HIV and other diseases.

##### The Kafala System

The *kafala* (sponsorship) system of work permits common among the GCC countries represents a generalized migration status regime with significant restrictions. Under the *kafala* system, a migrant worker's immigration status is legally bound to an individual employer or sponsor (*kafeel*) for the contract period. The migrant worker cannot enter the country, transfer employment, or leave the country without permission from the *kafeel*. Moreover, the *kafeel* often exerts further control on migrant workers by confiscating their passports and travel documents.<sup>126</sup> Under this system, the legal status, entitlements to human and labour rights, and social protection for migrant workers are directly linked to a specific employer and the employment contract, leaving them extremely vulnerable to a number of decent work deficits. In Qatar, for example, migrant domestic workers are not governed by national labour law, and are therefore not legally protected against physical, mental and sexual abuse, precarious working conditions, delay in the payment of wages, and workplace injuries.<sup>127</sup> Those migrant workers who suffer from sexual harassment or sexual abuses from their employers often have a hard time accessing justice or legal protection. They fear loss of employment and, as a consequence, loss of legal status. These circumstances leave them more vulnerable to HIV infection.

<sup>123</sup> A. Qureshi: "Structural violence and the state: HIV and labour migration from Pakistan to the Persian Gulf", in *Anthropology & Medicine* (2013, Vol. 20, No. 3, August).

<sup>124</sup> UNDP Regional Center Colombo. 2008. *HIV Vulnerabilities of Migrant Women: from Asia to the Arab States* (Colombo, October 2008): 1-108.

<sup>125</sup> CARAM Asia. 2007. *State of Health of Migrants 2007- Mandatory Testing*: 1- 243.

<sup>126</sup> Migrant Forum in Asia, Policy Brief No. 2: Reform of the Kafala (Sponsorship) System: 1. <http://www.ilo.org/dyn/migpractice/docs/132/PB2.pdf> [accessed 21 September 2017].

<sup>127</sup> United Nations General Assembly, *Report of the Special Rapporteur on the human rights of migrants, Addendum, Mission to Qatar, Twenty-Sixth Session of the Human Rights Council, A/HRC/26/35/Add.1, Para 48, (23 April 2014).*

While restricted migration status often results in higher HIV vulnerabilities for migrant contract workers, for domestic workers, and for temporary, seasonal, and short-term migrant workers, it can also have an impact on access to health services and HIV prevention and treatment for other categories of migrants, including students and highly-skilled migrants. In Canada, for example, public health insurance only covers Canadian nationals and permanent residents and does not cover non-permanent immigrants including visitors, students and people on work visas. While some provinces offer provincial health care programmes to students and workers, others require the purchase of private health insurance, which could increase the financial burden on immigrants, especially those in need of HIV-related treatment.<sup>128</sup> The cost of antiretroviral drugs can also impose huge financial burdens where students, workers and visitors are not eligible for provincial coverage and will need to obtain drugs through private insurance, or pay for them out of their own pocket.<sup>129</sup>

#### 2.4.5 Non-documented Migrants/ Migrants in an Irregular Situation

In Article 5(b) the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, the terms “non-documented” and “in an irregular situation” are used to describe migrants without authorization to stay in their country of destination. They may have been unsuccessful in the asylum procedure, have overstayed their visa, or have entered irregularly.<sup>130</sup> Accurate estimates of numbers of migrants in irregular status are difficult to obtain. However, the ILO has estimated that globally, the total proportion of migrants in irregular situations may be 15 to 20 per cent of the total number of migrants. Estimates for specific countries and regions vary considerably, with some sources citing higher proportions in certain countries.<sup>131</sup> Rigorous research across the European Union estimated that migrants in irregular situations numbered between 1.9 to 3.8 million, 6 to 12% of total migrant population, in the EU-27 in 2008, and the total number had declined between 2002 and 2008.<sup>132</sup> Policy makers and employers should be aware that these migrants, despite their immigration status, are still protected under international law and basic human rights standards.

Migrants in irregular situations are extremely vulnerable to HIV because they are often perceived as easily exploitable and thus subjected to abusive conditions. The absence of legal status heightens exploitability and may be seen as lowering the costs of migrant

<sup>128</sup> Canada Immigration Newsletter. 2014. *International Students: Securing Health Insurance in Canada*, <http://www.cic-news.com/2014/03/international-students-securing-health-insurance-canada-033252.html>.

<sup>129</sup> “Managing Your Health: a guide for people living with HIV,” in *Canada’s Source for HIV and Hepatitis C Information (CATIE)*: Chapter 17 Immigrants, refugees and non-status people with HIV: <http://www.catie.ca/en/practical-guides/managing-your-health/17> [accessed 21 September 2017].

<sup>130</sup> Platform for International Cooperation on Undocumented Migrants, “Who are Undocumented Migrants,” <http://picum.org/en/our-work/who-are-undocumented-migrants/>.

<sup>131</sup> ILO: *International Labour Standards on Migrant Workers* in ILO (website), <http://www.ilo.org/global/standards/subjects-covered-by-international-labour-standards/migrant-workers/lang--en/index.htm> [accessed 22 September 2017].

<sup>132</sup> CLANDESTINO: Research Project. 2009. *Comparative Policy Brief: Size of Irregular Migration to the EU: 4*. [http://irregular-migration.net/fileadmin/irregular-migration/dateien/4\\_Background\\_Information/4.2.Policy\\_Briefs\\_EN/ComparativePolicyBrief\\_SizeOfIrregularMigration\\_Clandestino\\_Nov09\\_2.pdf](http://irregular-migration.net/fileadmin/irregular-migration/dateien/4_Background_Information/4.2.Policy_Briefs_EN/ComparativePolicyBrief_SizeOfIrregularMigration_Clandestino_Nov09_2.pdf) [accessed 22 September 2017].



labour, in some cases arguably allowing marginally competitive activity to remain in business.<sup>133</sup>

In the context of HIV and AIDS, migrants in irregular status are far less able than others to obtain the social and health services they need. They are often unable to obtain health insurance and sometimes are explicitly denied health care even in emergency situations, which makes HIV treatment extremely difficult to access. The additional fear of contact with authorities, along with language and cultural difficulties, discourages them from approaching health services at all. Attempts in some countries to tie provision of health education and health services to legal status compounds this lack of access, and drives potential risks and problems further ‘underground,’ with negative consequences for public health generally.<sup>134</sup>

#### 2.4.6 Detention

Any detention of or restrictions on the freedom of movement of people living with HIV is in violation of the fundamental rights to liberty and security of the person, as well as the right to freedom of movement, if it is carried out solely on the basis of a person’s actual or suspected HIV status. There is no public health justification for restrictions of these rights due to a person’s HIV status alone. Moreover, such restrictions would be discriminatory.

Detention is commonly used for migrants in an irregular situation, including asylum seekers and children. In certain countries, it may also be used for migrants or migrant workers who have tested positive for HIV and as a consequence subject to and awaiting deportation.

On the basis of human rights instruments and other international law, United Nations organizations, intergovernmental organizations, and civil society organizations dealing with migration, health and HIV recommend repealing laws and regulations that establish mandatory HIV screening of migrants, including refugees and asylum-seekers, the lifting of restrictions on their movement as well as doing away with coercive measures such as isolation, detention and quarantine as means to address their HIV status.<sup>135</sup>

### 2.5 Gender Responsive Approaches

Addressing gender inequalities is central to effective HIV and AIDS responses. Indeed, gender inequalities and gender-based stereotyping and harmful traditional practices and norms are some of the key elements driving the HIV epidemic, particularly in high HIV prevalence countries. The ILO HIV and AIDS Recommendation, 2010 (No. 200) recognizes the gender dimensions of the epidemic, including employment discrimination and gender-based violence at work. The Preamble of Recommendation No. 200 notes

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<sup>133</sup> R. Cholewinski and P.Taran: “Migration, Governance and Human Rights: Contemporary Dilemmas in the Era of Globalization”, in *Refugee Survey Quarterly* (2009, Vol. 28, No. 4, January): 10.

<sup>134</sup> OHCHR. 2015. *Behind Closed Doors: protecting and promoting the human rights of migrant domestic workers in an irregular situation* (New York and Geneva).

<sup>135</sup> OHCHR and UNAIDS. 2006. *International Guidelines on HIV and AIDS and Human Rights* (Geneva, 2006); United Nations General Assembly, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/7/11* (May 2013), and case law such as by the UN Committee on the Elimination of Racial Discrimination, *LG. v. Republic of Korea No.51/2012* (June 2015).

that: “HIV affects both men and women, although women and girls are at greater risk and more vulnerable to HIV infection and are disproportionately affected by the HIV pandemic compared to men as a result of gender inequality, and that women’s empowerment is therefore a key factor in the global response to HIV and AIDS”.<sup>136</sup>

### 2.5.1 Gender-specific Aspects of Labour Migration

In many countries, the demand for labour is growing in specific sectors such as services—including domestic work, healthcare, elder care and childcare, characterized by a higher number of migrant workers, and of female migrants, in particular.<sup>137</sup> For example, female migrants now comprise 52 per cent of international migrants in Europe. There were more than one hundred countries in 2013 in which women comprised more than half of all migrants.<sup>138</sup> However some legal channels of migration in some regions, particularly the Gulf and South Asia, still remain dominated by job offers in typically male-dominated sectors. In comparison with past decades, migrant women today tend to be more economically active rather than being dependent on their spouses or partners.

Demand for migrant workers in destination countries is defined by the labour market in these countries. Opportunities are available precisely because certain jobs considered to be “low-skilled” are viewed as “suitable” for women, which explains the feminization trend in international labour migration. These jobs are found particularly in sectors with a high prevalence of irregular or undeclared work, including domestic work, agriculture, and sex work, which are also workplaces with high risk factors for HIV.<sup>139</sup> The nature of these jobs contributes to the prevalence of discrimination in labour markets in countries of destination.<sup>140</sup> As a result, women migrants often suffer discrimination on multiple and intersecting grounds, including on the basis of gender, class, nationality – and often race or ethnicity as well.<sup>141</sup>

Gender-selective migration policies and regulation for admission and entry often intensify existing inequalities between male and female migrants. For example, the right to entry does not necessarily mean the right to work for women in certain Western European countries. In such cases, female migrants may thus be left with no option but irregular migration, which further exposes them to various forms of abuse.<sup>142</sup>

A UNDP report on Asian migrant women in the Arab States<sup>143</sup> found that poor access to information and limited preparedness enhance women’s vulnerability to exploitation,

<sup>136</sup> ILO, *Handbook on HIV and AIDS for Labour Inspectors*, International Labour Office, (Geneva, 2014).

<sup>137</sup> L. Beneria et al.: “Gender and International Migration: Globalization, Development, and Governance”, in *Feminist Economics* (2012, Vol. 18, No. 2, August): 1-33.

<sup>138</sup> United Nations Department of Economic and Social Affairs (UNDESA). 2013. *Population Facts: The number of international migrants worldwide reaches 232 million*, United Nations (New York 2013).

<sup>139</sup> C. Del Rio and O. Alonso-Villar: “Occupational Segregation of Immigrant Women in Spain” in *Feminist Economics* (2012, Vol. 18, No. 2, August): 91-123.

<sup>140</sup> P. Taran: “Clashing Worlds: Imperative for a Rights-Based Approach to Labour Migration in the Age of Globalization.” In V. Chetail (ed.): *Globalization, Migration and Human Rights: International Law under Review* (2007).

<sup>141</sup> D. Piazzalunga: “Is there a double-negative effect? Gender and ethnic wage differentials in Italy”, in *LABOUR* (2015, Vol. 29, No. 3, April): 243-269.

<sup>142</sup> Ibid.

<sup>143</sup> UNDP. 2008. *HIV vulnerabilities faced by women migrant: from Asia to the Arab States*, Regional HIV & Development Programme for Asia and the Pacific. 2008.

violence and HIV. Abusive working conditions dangerously trap women into poverty and HIV vulnerability. This is especially true for those who have ended up in irregular situations or those with low levels of education. Heavy workloads and extremely low wages or failure to pay wages are the most common issues faced by migrant domestic workers (as well as other migrant women workers) in these countries. Those escaping such conditions are considered to be in “illegal” immigration status by host countries, since their migration status is usually directly tied to their employment and employer. Those who do escape are exposed to greater risk of abuse and may also be faced with deportation. Deportation is not a viable outcome for the many women whose families in the country of origin depend on their earnings, and as a result may feel pushed into sex work as a means to survive. Migrant women as a whole, as well as women left behind while their spouse is away, may be compelled to take part in unprotected sex in exchange for money, shelter or even food because they have no other economic means of supporting their families.

On the other hand, numerous migrant worker associations are led by women, doing an effective job of providing information and education to their peers in a range of contexts, empowering other female migrants, advocating for their rights and protecting them.

### **2.5.2 Stereotyped Gender Roles Among Migrant Communities and HIV-Related Vulnerabilities**

Stereotyped gender roles common to many migrant populations constitute risk factors for HIV transmission. Unequal status and power relations within marriage reduces women’s ability to protect themselves from HIV infection by negotiating condom use or refusing to have sex, especially unprotected sex. Women can face violence for requesting condom use, and they can feel ashamed to carry condoms when this is perceived to signify promiscuity. In a study of wives left behind by migrant workers in Tajikistan, women who were committed to strongly traditional gender roles refused to use condoms despite having some basic knowledge of HIV transmission, and felt ashamed to discuss the issue.<sup>144</sup> Heavy stigma associated with HIV, combined with these traditional gender norms can also act as an additional barrier for women to access health services. In sub-Saharan countries, fear of their husbands’ reactions—which could range from violence to rejection and abandonment—have been commonly reported among women as constituting barriers to HIV testing, services, and disclosure of status.<sup>145</sup> Gender-based violence, especially rape and sexual abuse, is another crucial issue that heightens women’s vulnerability to HIV.<sup>146</sup>

In certain regions such as Central America, the HIV prevalence rates reported are significantly higher for men than for women.<sup>147</sup> However, other sources suggest that in East and Southern Africa, in addition to increased HIV and health vulnerabilities, women’s health outcomes tend to be worse than men’s in terms of safety, employment and access to social services. Mobility particularly increases women’s vulnerability to exploitation, HIV

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<sup>144</sup> A. Golobof et al.: “The roles of labour migrant’s wives in HIV and AIDS risk and prevention in Tajikistan”, in *AIDS Care* (2011, Vol. 23, No. 1, January): 91-97.

<sup>145</sup> ILO, *Handbook on HIV and AIDS for Labour Inspectors*, International Labour Office, (Geneva, 2014).

<sup>146</sup> L. Gilbert et al.: “Intimate Partner Violence and HIV Risks among Migrant Women in Central Asia”, in *AIDS and Clinical Research* (2015, Vol. 6, No. 3, February).

<sup>147</sup> ILO, *Handbook on HIV and AIDS for Labour Inspectors*, International Labour Office, (Geneva, 2014).

and gender-based violence.<sup>148</sup> Gender-stereotyping and related behaviours and attitudes increase HIV-related vulnerability for men primarily by fostering risk-taking behaviours in order to “prove” one’s masculinity. Demonstrating virility can include alcohol and drug abuse, which heightens HIV vulnerability, as well as having unprotected sex with multiple partners. A study focusing on return patterns of male migrant workers in rural Mexico found that paternity, and therefore pregnancy, was an important element of male “legitimization” and impregnating the female partner was a method for the absent spouse to assert sexual control over her.<sup>149</sup> In order to maximize the chance of paternity, the men refuse condom use, which turns marital sex into a high-risk activity for HIV infection should the male partner be HIV-positive. Gender-stereotyping and rigid definitions of masculinity also influence men’s access to HIV information and prevention, as well as their perception of HIV risk. A report from UNAIDS explained men’s consistently lower rates of HIV testing as compared with women as due to common norms of masculinity, which discourage men from seeking help and admitting illness.<sup>150</sup>

## 2.6 Young Migrants and HIV Risk

Today, young people make up a significant portion of the global migrant population.<sup>151</sup> In 2013, over 15 per cent of migrants were between the ages of 15 and 24.<sup>152</sup> Available data suggests that youth between the ages of 15 and 35 make up as much as 48 per cent of those individuals ‘on the move’ at any given moment.<sup>153</sup> The proportion is even higher among refugee populations.<sup>154</sup> In 2014, over 50 per cent of the refugee population was under the age of 18.<sup>155</sup> The increasing number of young migrants illustrates the need for cooperation between states to address this aspect of migration.

According to data from UNAIDS, there were 4 million young people between the ages of 15 and 24 who were living with HIV at the end of 2013.<sup>156</sup> Nearly all of the new infections among this group occurred in low- or middle-income countries. An increase in AIDS-related deaths in young people increased by a dramatic 50 per cent during the period 2005 to 2012; reflecting a pronounced contrast with the overall population, in which AIDS-related

<sup>148</sup> International Organization for Migration. 2014. *Regional synthesis of patterns and determinants of migrant health and associated vulnerabilities in urban settings of East and Southern Africa* (Pretoria 2014).

<sup>149</sup> D.H. Rosete: “Male Honour and the Ruralisation of HIV and AIDS in Michoacán. A case of Indigenous Return Migration in Mexico”, in *International Migration* (2012, Vol. 50, No 5, October):142–152.

<sup>150</sup> UNAIDS. 2012. *Report on the Global AIDS Epidemic 2012*. (Geneva).

<sup>151</sup> J. Cortina and P. Taran: “Youth and International Migration: Role and Relevance of Social Protection”, Chapter 3, in UNICEF/Global Migration Group: *Migration and Youth: Challenges and Opportunities*. (Online book 2014): 13. <http://www.globalmigrationgroup.org/migrationandyouth> [accessed 22 September 2017].

<sup>152</sup> UNICEF/Global Migration Group. 2014. *Migration and Youth: Challenges and Opportunities* (Online Book 2014) <http://www.globalmigrationgroup.org/migrationandyouth> [accessed 22 September 2017].

<sup>153</sup> ILO: *Mainstreaming HIV and AIDS in Youth Employment*, International Labor Office (Geneva, 2014) [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_239495.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_239495.pdf).

<sup>154</sup> UNICEF/Global Migration Group. 2014. *Migration and Youth: Challenges and Opportunities*, Chapter 5 – *The Refugee Dimension: Adolescents’ and Youths’ Right to Seek and Access Asylum and Protection* (Online Book, 2014): 2. <http://www.globalmigrationgroup.org/migrationandyouth> [accessed 22 September 2017].

<sup>155</sup> International Monetary Fund (IMF). 2015. *International Migration: Recent Trends, Economic Impacts, and Policy Implications – Staff Background Paper for G20 Surveillance Note* (November, 2015): 7.

<sup>156</sup> UNAIDS. 2014. *Report on the Global AIDS Epidemic 2014*. (Geneva): 17.

deaths dropped by 30 per cent during the same period.<sup>157</sup> The difference can largely be explained by risky sexual behavior, often more prevalent in teens and young adults, as well as by a general lack of understanding about HIV and how it is transmitted.<sup>158</sup> When young migrants are separated from their families, the absence of a family environment can increase psychological and physical vulnerability, which can in turn heighten the risk of engaging in behaviors that elevate exposure to HIV infection.<sup>159</sup> This is especially worrisome because many young migrants are still developing physically and mentally.<sup>160</sup>

Young migrants in undocumented situations are especially vulnerable to violence, abuse and exploitation throughout the whole migratory cycle, which puts them at higher risk of HIV infections.<sup>161</sup> Furthermore, young migrants are often confronted with lack of access to basic social protection and social security benefits in the country of destination, which constitutes a clear violation of a child's right to health care under the Convention on the Rights of the Child (discussed in Part Three)<sup>162</sup> and was highlighted in the General Comment No.3 (2003) by the same Committee.

Lack of access to social protection is not the only problem. Even where care is available, other factors can impede access to care. As case studies in India have revealed, religious and cultural restrictions, and also stigmatization often cause individuals to avoid seeking care.<sup>163</sup>

Besides being at risk of HIV infection themselves, young migrants can also be indirectly affected by HIV when family members become ill or die. The resulting disruptions include young people being sent away to work to help with health care costs or, in the case of a young person losing both parents, to support themselves. In South Africa, for example, such situations are common as families struggle to cope with HIV-related illness and death.<sup>164</sup> The growing population of young migrants, as well as the heightened vulnerability of this group to health risks in general, stresses the need for greater attention to as well as further study on the topic. As the Committee on the Rights of the Child has highlighted, children have been insufficiently viewed as individuals in their own right, and this tendency has resulted in inadequate policy design for taking their needs into account.<sup>165</sup>

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<sup>157</sup> UNAIDS, Programme Coordinating Board. 2013. *Thematic Segment: HIV, Adolescents and Youth- Background Note* (December 2013): 4, 6.

<sup>158</sup> ILO: *Mainstreaming HIV and AIDS in Youth Employment*, International Labor Office (Geneva, 2014) [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_239495.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_239495.pdf).

<sup>159</sup> UNICEF/Global Migration Group. 2014. *Migration and Youth: Challenges and Opportunities*, Chapter 12- *Health, Youth Migration and Development* (Online Book, 2014): 3, <http://www.globalmigrationgroup.org/migrationandyouth>.

<sup>160</sup> UNICEF/Global Migration Group. 2014. *Migration and Youth: Challenges and Opportunities* (Online book, 2014)

<sup>161</sup> UNICEF/Global Migration Group. 2014. *Migration and Youth: Challenges and Opportunities*, Chapter 12- *Health Youth Migration and Development* (Online book, 2014): 5 <http://www.globalmigrationgroup.org/migrationandyouth>.

<sup>162</sup> J. Cortina and P. Taran: "Youth and International Migration: Role and Relevance of Social Protection", Chapter 3, in UNICEF/Global Migration Group: *Migration and Youth: Challenges and Opportunities*. (Online book 2014): 13 <http://www.globalmigrationgroup.org/migrationandyouth> [accessed 22 September 2017].

<sup>163</sup> M. Dhapola et al.: "Migration, Youth and HIV Risk: A Study of Young Men in Rural Jharkhand", in *Economic and Political Weekly* (2007, Vol. 42, No. 4, December): 40-47.

<sup>164</sup> L. Young and N. Ansell: "Fluid Households, Complex Families: The Impacts of Children's Migration as a Response to HIV and AIDS in Southern Africa", in *The Professional Geographer* (2003, Vol. 55, No. 4, January): 464-476.

<sup>165</sup> Committee on the Rights of the Child. 2012. *Day of General Discussion- The Rights of All Children in the Context of International Migration*, Background Paper (August 2012): 3.



## 2.7 Mobile Workers' HIV-Related Vulnerabilities

Some migrants experience particularly mobile working and living situations that in turn pose particular challenges for the realization of their right to health and health-related rights, notably with respect to HIV and AIDS. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) identifies several categories of migrant workers with specific features of mobility in the nature and functions of their work.<sup>166</sup> They include:

- “*frontier workers*”, who retain their habitual residence in a neighbouring State to which they normally return every day or at least once a week;
- “*seasonal workers*”, whose work by its character is dependent on seasonal conditions and is performed only during part of the year;
- “*seafarers*”, including fishermen, refers to a migrant worker employed on board a vessel registered in a State of which he or she is not a national; and
- “*itinerant workers*”, “who, having his or her habitual residence in one State, has to travel to another State or States for short periods, owing to the nature of his or her occupation.”

The ICRMW also recognizes other categories of migrant workers on offshore installations, in project-tied employment or in specified employment situations in a State of which they are not nationals, and workers who are employed “for restricted and defined periods of time” or engaged “in work whose nature is transitory or brief.”

Increasing international trade, commerce, and flows of goods and services in a globalized world continue to expand the numbers of migrant workers. The land, sea and air transportation of goods and people is a huge and growing international business, employing millions of persons. Small-scale commerce and trading both within and across borders is widespread, with hundreds of thousands of people involved in commercial activity in regular regional circuits, such as across Andean, Southern African and West African countries. Specialists in industrial, telecommunications and infrastructure maintenance and repair represent another growing category of mobile workers who move for their work. Fishing fleets based in some countries rely on crews from other countries. Sex workers too are highly mobile due to stigma and discrimination, as well as the illegality and repression of sex work in many settings.

A common feature among migrant workers in mobile situations is that they regularly travel for frequent and extended periods away from their primary fixed place of residence. However, many retain formal residence in their country of origin or permanent residence in one country, while working in one or more other countries. Many mobile migrant workers are not tied to a fixed workplace or a stable residential place away from their primary home. While travelling, they commonly experience loneliness and usually have easy access to sex workers or other potential sexual partners at stopovers where they congregate. Concurrent multiple partnerships are thus easily formed, and condoms are not always used. Substance abuse among mobile workers is another key HIV risk factor, especially given its impact on sexuality. Where injectable drug use is common, HIV risk

<sup>166</sup> United Nations General Assembly, International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Resolution 45/158 (18 December 1990), Article 2.

is elevated further. Mobile migrant workers are, however, far from a homogenous group. Different subgroups—divided by professions or income levels—can have different HIV vulnerabilities.

For some groups of mobile migrant workers, the overall length of time spent away from home has been correlated with higher vulnerability. Data from a study on migrant market vendors in Kazakhstan indicated that the longer the duration of a migrant's most recent trip, the greater the probability of that individual having had multiple sexual partners. Frequency of absence is also a decisive factor, as more frequent mobility was correlated with multiple sexual partners and also with unprotected sex with steady partners.<sup>167</sup> In addition, long and frequent periods of travel constitute a barrier to accessing health care services. HIV-positive mobile workers also face difficulties in acquiring the treatment they need and long working trips can cause treatment to be interrupted.

Despite these specific vulnerability factors, many States do not recognize mobile migrant workers as a key group vulnerable to HIV and have not integrated them into HIV-related strategic plans. While considerable research has been conducted on sex workers and their HIV vulnerability, little data exists on their clients, of whom mobile migrant workers are a part.

### Migration of Health Workers

Another migration-related concern in relation to the HIV epidemic is the high level of emigration of skilled health personnel from some developing countries, including those where HIV is prevalent. Without enough skilled health care providers, governments cannot fulfill their obligations to provide access to health care, and the risk of negative public health outcomes goes up.

The migration of skilled health workers poses a major challenge not only when it results in a general loss of trained health care providers, but also when it leads to an imbalance in how health care workers are distributed between urban and rural areas, or public and private facilities. Services may become entirely unavailable due to such loss or imbalance, or professionals may have to deliver services that are outside of their scope of practice. It also represents a substantial loss of investment in education and specialized training of health personnel, and replacement of emigrant health personnel may be impossible, at least in the immediate term. In addition to a “brain drain” of skilled workers and the loss of human capital, emigration of trained medical and health professionals presents particular problems in the context of the HIV epidemic given the large human resource requirements to sustain an adequate response to the epidemic.

According to the World Health Organization, there is a shortage of 2.4 million health professionals worldwide, plus an additional 2 million more support workers, such as paramedics. Furthermore, the 60 million health workers globally are unequally distributed across regions and countries. Scarcity is most evident in the countries where the need is most urgent—in the poorest countries with the highest rates of HIV.<sup>168</sup> Migration, together with inadequate health systems, low wages and poor working conditions, is a key factor in the low numbers of health workers in many countries. In 2012, 37 per cent

<sup>167</sup> N. El-Bassel et al.: “Implications of Mobility Patterns and HIV Risks for HIV Prevention among Migrant Market Vendors in Kazakhstan” in *American Journal of Public Health* (2011, Vol.101, No.6, June): 1075-1081.

<sup>168</sup> WHO. 2014. *Migration of Health Workers WHO Code of Practice and the Global Economic Crisis*. World Health Organization (Geneva 2014).

of the doctors in the United Kingdom were foreign-born, as were more than 20 per cent of nurses. Around 13,000 Mexican medical professionals were reported to be working in the United States, as well as a significant number of Haitian nurses.<sup>169</sup> These numbers attest to the reliance of developed countries on international migrants to fill health workforce positions, due notably to rising life expectancy and expanding elderly populations. The past decades have witnessed an extension in the international migration of health workers through increasingly complex patterns, in which emerging countries like India or Indonesia are particularly affected.<sup>170</sup>

<sup>169</sup> Ibid.

<sup>170</sup> M. Nair, P. Webster: "Health professionals' migration in emerging market economies: patterns, causes and possible solutions", in *Journal of Public Health* (2012, Vol. 35, No.1, March): 157-165.







## Part 3. The Normative and Policy Framework for Good Governance of Migration, Health and HIV

### 3.1 Normative Foundations: International Human Rights Instruments and International Labour Standards

Human rights are rights inherent to all human beings. They are *universal* in that they apply to everyone, everywhere. Human rights encompass civil, cultural, economic, political and social rights, and are *indivisible*, meaning these different sets of rights are interdependent and cannot be separated out.<sup>171</sup> Human rights are also *inalienable*, and thus cannot be taken away, regardless of immigration status or HIV status.

Human rights principles have been codified in a number of human rights instruments and have been increasingly accepted over the last century. The fundamental rights enshrined in these instruments are affirmed in the Universal Declaration of Human Rights of 1948, which has acquired the status of customary international law. In addition, international labour standards establish specific rights and protections in the context of the world of work.

Respect for the basic human rights of all persons offers an essential and equitable basis for addressing and resolving the tensions that may arise when groups with different interests interact. Effective protection of the human rights of migrant populations contributes to lowering the risk of HIV transmission and improving access to HIV services. If the rights of persons with HIV to live in dignity without discrimination or stigmatization are respected, they will neither be afraid to learn their status, nor to disclose it, which in turn facilitates prevention efforts.<sup>172</sup> Stigma and discrimination not only place a heavier burden on persons living with or affected by HIV, they also impede HIV prevention efforts. Respect for the human rights of people living with HIV is a basis for ensuring universal access to HIV prevention, treatment, care and support.

The international instruments referred to below establish both general and specific principles that provide a foundation for the development of effective national legal and policy frameworks to regulate migration from a rights-based perspective while ensuring health protection and services.

<sup>171</sup> Vienna Declaration and Programme of Action, Adopted by the World Conference on Human Rights in Vienna on 25 June 1993, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx>.

<sup>172</sup> UNAIDS. 2006. *International Guidelines on HIV and AIDS and Human Rights, 2006 Consolidated Version*. (Geneva 2006).

### 3.1.1 Instruments that Recognize Non-Discrimination, the Right to Health and Health-Related Rights

International human rights instruments provide clearly articulated and widely accepted legal concepts that govern legislative and practical responses in the areas of health, labour and migration. The key human rights principles and international labour standards, which provide the basis for addressing health as well as an effective response to HIV and AIDS with respect to migrants and migration, are reflected in the instruments described below.

#### *United Nations Framework*

**The Universal Declaration of Human Rights (UDHR) (1948)** The bedrock international human rights instrument, the UDHR was adopted in 1948 and together with the two international covenants on civil and political rights (ICCPR), and economic, social and cultural rights (ICESCR), forms the International Bill of Rights. The UDHR provides that “All human beings are born free and equal in dignity and rights” (Article 1). It guarantees equal rights to all individuals (based on the principle of non-discrimination in Article 2, and equal protection before the law and equal treatment of the law in Article 7)), and sets out the right to health, including medical care and necessary social services (Article 25). It expresses the right to work and to just and favourable remuneration, as well as freedom of association and the right to form and join trade unions (Articles 20 and 23). Also important in the migration context are its guarantees of freedom of movement within the borders of each State and the right to leave any country and return to their country, and the right to seek and enjoy asylum from persecution (Articles 13 and 14).

**International Covenant on Civil and Political Rights (ICCPR) (1966)** Article 26 provides for equal treatment before the law and equal protection of the law for all persons, based on the principle of non-discrimination. The Covenant also guarantees the right to liberty and security of the person and the right to procedural fairness in legal proceedings (Article 9), and to freedom of association (Article 22). The monitoring body for the ICCPR is the Human Rights Committee. The Human Rights Committee has also confirmed that the right to equal protection before the law prohibits discrimination in all areas regulated or protected by the public authorities, including legislation applicable to travel, conditions of entry, and procedures for immigration and asylum.<sup>173</sup>

**International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966)** The ICESCR reiterates non-discrimination as a fundamental overarching human right.

Article 12 of the ICESCR provides the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This should include the availability and accessibility of HIV prevention, treatment, care and support for children and adults.<sup>174</sup> The principle of non-discrimination requires further that access to health facilities, goods and services, be equally available to nationals and non-nationals, including migrants in irregular

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<sup>173</sup> Office of the High Commissioner for Human Rights (OHCHR). 2006. *The Rights of Non-Citizens* (New York and Geneva 2006): 8, see also General Comment No. 15 (1986) of the Human Rights Committee on the position of aliens under the Covenant.

<sup>174</sup> OHCHR and UNAIDS. 2006. *International Guidelines on HIV/AIDS and Human Rights*: 6; see also Committee on Economic, Social and Cultural Rights, General Comment 14 (2000) on the right to the highest attainable standard of health, para. 16.

status.<sup>175</sup> The UN Committee on Economic, Social and Cultural Rights underlined this in very explicit terms in its General Comment No. 14 of 2000 discussed in section 3.2.2 below. Moreover, Article 2 of the ICESCR—which includes the non-discrimination principle noted above—calls on Member States to take steps, including through international cooperation, for the progressive realization of human rights. This is particularly vital in efforts to halt the HIV epidemic. In this context, UNAIDS is currently promoting the Fast-Track strategy to outpace the epidemic by 2030,<sup>176</sup> as well as implementing zero discrimination for any person living with HIV.

This protection has been upheld and reinforced by national courts, including decisions specifically addressing the issue of the foreigners' rights to access HIV-related services, including treatment. For example, on 26 August 2015, the Botswana Court of Appeal dismissed an appeal against a decision of the High Court, affirming the Government's legal obligation to provide foreign prisoners with antiretroviral therapy at government expense.<sup>177</sup>

**International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (1965)** Article 1 of ICERD defines “racial discrimination” to include “any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin...”. Article 5 prohibits racial discrimination, and reiterates the right to equal treatment before tribunals and all other organs administering justice and the security of persons; the right to freedom of movement within the border of the State; the right to leave any country, and to return to one's country; the right to freedom of association, to work, to free choice of employment, to just and favourable conditions of work and just and favourable remuneration; and the right to public health, medical care, social security and social services. The ICERD treaty body, the Committee on the Elimination of Racial Discrimination (CERD), considers xenophobia to be a form of racism and racial discrimination prohibited by the Convention. The CERD General Recommendation 30 on Discrimination against Non-Citizens is discussed below in section 3.2.2

**Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979)** The Convention aims to ensure and protect women's human rights. It protects civil, political, economic and social rights, including reproductive rights. Its monitoring body is the Committee on the Elimination of Discrimination against Women. This Committee has reinforced the understanding that all of the rights and protections laid out in CEDAW apply fully to all migrant women and girls. General Recommendation No. 26 on Women Migrant Workers by this treaty monitoring body is highlighted in section 3.2.2

**Convention on the Rights of the Child (1989)** The Convention on the Rights of the Child is the most comprehensively ratified treaty among the international human rights

<sup>175</sup> P. Pace: “Migration and the Right to Health: a Review of International Law”, in *International Migration Law Series* No. 19, IOM, (Geneva, 2009) [http://publications.iom.int/system/files/pdf/iml\\_19.pdf](http://publications.iom.int/system/files/pdf/iml_19.pdf). States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and irregular immigrants, to preventive, curative and palliative health services (...). See CESCR General Comment No. 14 of the Committee on Economic, Social and Cultural Rights, 2000; and CERD General Recommendation 30 on Discrimination Against Non-Citizens, 2004.

<sup>176</sup> More information is available at: [http://www.unaids.org/sites/default/files/media\\_asset/JC2686\\_WAD2014report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf).

<sup>177</sup> Southern Africa Litigation Centre. 2015. *News Release: Victory for HIV-positive Foreign Prisoners in Botswana Court of Appeal* (26 August 2015), <http://www.southernafricalitigationcentre.org/2015/08/26/press-release-victory-for-hiv-positive-foreign-prisoners-in-botswana-court-of-appeal/> [accessed 22 September 2017].

instruments, a process that unfolded quickly in comparison with ratification of other treaties. This signals the widespread recognition of the importance of guaranteeing human rights for children. The full spectrum of civil, political, economic, social and cultural rights is enshrined in the Convention, including the right to health. The Committee on the Rights of the Child (CRC) is the monitoring body for the Convention.<sup>178</sup>

**International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW) (1990)** The ICRMW is the most comprehensive international treaty dealing specifically with migrant workers. It guarantees equality of treatment with nationals of the State of employment in relation to certain aspects (Article 43); this equality of treatment also applies to the families of migrant workers for many of these aspects, including access to social and health services (Article 45). The Convention specifically states that the rights migrant workers enjoy to be treated “not less favourably” than nationals with respect to remuneration, and other conditions of work, including safety and health, may not be taken away based on “any irregularity” in the migrant’s “stay or employment.” Such irregularity does not relieve employers from their legal or contractual obligations.<sup>179</sup> (For additional discussion of the ICRMW, see section 3.1.2.)

**Convention on the Rights of Persons with Disabilities (CRPD) (2006)** The CRPD is an international human rights treaty that protects the rights and dignity of persons with disabilities. In particular, it ensures the rights of people with disabilities to participate and be included in all spheres of life. It provides for the right to the enjoyment of the highest attainable standard of health without discrimination, the right to access health services, including sexual and reproductive health, and habilitation and rehabilitation services.<sup>180</sup>

It needs to be noted that the UN Commission on Human Rights – today’s Human Rights Council – has interpreted the term “other status” in non-discrimination provisions in international human rights texts as “*encompassing health status, including HIV/AIDS*”.<sup>181</sup> This enables national courts to address HIV-related discrimination even when HIV and AIDS are not explicitly covered under national legislation.<sup>182</sup>

<sup>178</sup> In 2016, the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW) and the Committee on the Rights of the Child (CRC) have decided to elaborate a Joint General Comment on the human rights of children in the context of international migration. See also: CRC, 2012 Report on the Rights of All Children in the context of International Migration: <http://www2.ohchr.org/english/bodies/crc/docs/discussion2012/ReportDGDChildrenAndMigration2012.pdf> [accessed 22 September 2017].

<sup>179</sup> United Nations General Assembly, International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Resolution 45/158 (18 December 1990), Article 25.

<sup>180</sup> United Nations General Assembly, Convention on the Rights of Persons with Disabilities, Resolution 61/106 (24 January 2007), Articles 25 and 26; see also UNAIDS. 2017. Disability and HIV (Geneva 2017) [http://www.unaids.org/sites/default/files/media\\_asset/JC2905\\_disability-and-HIV\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf) [accessed 22 September 2017].

<sup>181</sup> United Nation Commission on Human Rights. 1995. *The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)*, Resolution 1995/44 (March 1995) paragraph 1; See also Resolutions 1996/43 of 19 April 1996; 1999/49 of 27 April 1999; 2001/51 of 24 April 2001; 2003/47 of 23 April 2003; 2005/84 of 21 April 2005.

<sup>182</sup> ILO: *HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals* International Labour Organization (Geneva, 2013): 21-22.

### ***International Labour Standards***

Since 1919, the ILO as a tripartite organization has developed and maintained a comprehensive set of international labour standards, which take the form of Conventions, Recommendations and Protocols, establishing fundamental rights and aimed at promoting and ensuring opportunities for women and men to obtain decent and productive work in conditions of freedom, equity, security and dignity. These standards cover all aspects of the employment relationship and address specific groups of workers, such as migrant workers, as well as specific themes, such as occupational safety and health. Unless otherwise stated, international labour standards are applicable to all workers, including migrant workers. Recognized as fundamental Conventions and thus part of the human rights framework, ILO Conventions on non-discrimination, freedom of association, child labour and forced labour provide important rights for all migrant workers. Labour standards also provide for occupational safety and health, labour inspection, social security, maternity protection, and other areas, a number of which have a bearing on vulnerability to HIV.

**ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111)** The Convention requires ratifying States to declare and pursue a national policy, designed to promote equality of opportunity and treatment in respect of employment and occupation, with a view to eliminating any discrimination in respect thereof.<sup>183</sup> This policy should cover all workers, including migrant workers. The Convention sets out a range of grounds of discrimination that are to be addressed, namely race, colour, sex, religion, political opinion, national extraction and social origin, but also foresees the addition of other grounds “after consultation with representative employers’ and workers’ organisations ... and with other appropriate bodies.”<sup>184</sup> A number of member States have included “nationality” or “citizenship” as prohibited grounds of discrimination in this context, as well as real or perceived HIV status.<sup>185</sup> The ILO Committee of Experts on the Application of Convention and Recommendation (Committee of Experts) has noted that migration policies and their implementation should not result in discrimination based on race, colour or national extraction.<sup>186</sup> It has also commented positively on the adoption of national laws and policies providing for HIV status as a prohibited ground of discrimination, as well as on the creation of national AIDS authorities or the adoption of national policies or strategies on HIV and AIDS.<sup>187</sup> In the specific context of labour migration, the Committee of Experts has also examined the issue of HIV-related discrimination under the Migration for Employment Convention (Revised), 1949 (No. 97) (discussed further in section 3.1.2), concluding that the refusal of entry or repatriation of a migrant worker on the ground that the worker was HIV-positive would “constitute an unacceptable form of discrimination and is contrary to the Convention.”<sup>188</sup>

<sup>183</sup> Article 2.

<sup>184</sup> Article 1(1)(a) and (b).

<sup>185</sup> ILO: Giving globalization a human face: General Survey on the fundamental Conventions concerning rights at work, Geneva 2012.

<sup>186</sup> Id.

<sup>187</sup> ILO: *HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals*, International Labour Organization (Geneva, 2013): 36.

<sup>188</sup> Id. at 37.

**ILO HIV and AIDS Recommendation, 2010 (No. 200)** ILO Recommendation No. 200 is the only international standard specifically providing human rights and labour protections with respect to HIV and AIDS in the context of the world of work. It builds on the successful development and implementation of the ILO *Code of Practice on HIV and AIDS and the World of Work, (2001)*, a set of guidelines developed by a tripartite group of experts (discussed in section 3.3.1).<sup>189</sup>

Recommendation No. 200 is intended to increase the attention paid to HIV and AIDS at the international, national and workplace levels across all economic sectors, including in the informal economy, and to promote increased engagement and coordinated action among key stakeholders in responding to the epidemic in and through the world of work. Its principal objectives are to promote universal access to HIV prevention, treatment, care and support for workers, their families and dependants, and to protect the fundamental rights of those living with or affected by HIV.

Recommendation No. 200 calls on member States “to adopt national policies and programmes on HIV and AIDS and the world of work and on occupational safety and health ... and integrate their policies and programmes on HIV and AIDS and the world of work in development plans and poverty reduction strategies.”<sup>190</sup> In the national response to HIV and AIDS in the world of work, a range of general principles are to be applied, including that “the response to HIV and AIDS should be recognized as contributing to the realization of human rights and fundamental freedoms and gender equality for all” and “no workers should be required to undertake an HIV test or disclose their HIV status.”<sup>191</sup> With respect to prevention programmes, these should include “measures to encourage workers to know their own status through voluntary counselling and testing.” It also invites member States to implement its provisions through national laws and regulations, collective agreements, national and workplace policies and programmes of action; and sectoral strategies, with particular attention to sectors where those covered by the Recommendation are most at risk.<sup>192</sup>

The principle of non-discrimination is one of the cornerstones of the Recommendation. This fundamental principle should be applied both in law and practice, and covers both direct and indirect forms of discrimination.<sup>193</sup> The Recommendation provides that:

“there should be no discrimination against or stigmatization of workers, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk of or more vulnerable to HIV infection.”<sup>194</sup>

This prohibition covers all aspects of the employment relationship, including access to employment or to specific occupations, forced disclosure or violations of confidentiality of HIV status, mandatory HIV testing or screening for employment purposes, access to

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<sup>189</sup> Id. at 39.

<sup>190</sup> Para. 4.

<sup>191</sup> Para. 3.

<sup>192</sup> Para. 37.

<sup>193</sup> Id. at Para. 1(e), 3(c),9-14, 20 and 39.

<sup>194</sup> Id. at Para. 3(c).



employment-related benefits, and unfair dismissal.<sup>195</sup> The ILO supervisory bodies have noted that the Recommendation provides protection against discrimination based on stereotyping including because the persons concerned belong to regions of the world or segments of the population perceived to be at greater risk or vulnerable to HIV infection, including men who have sex with men, injecting drug users and sex workers, and state clearly that protection should cover migrant workers.<sup>196</sup>

Recommendation No. 200 applies to all workers and workplaces. Its provisions also apply to migrant workers. It contains a number of specific references to migrant workers, providing that migrant workers should not be subjected to compulsory HIV testing, nor should they be required to disclose HIV-related information or be excluded from migrating based on their real or perceived HIV status at any stage of the migration process.<sup>197</sup> It also provides that training, safety instructions and HIV and AIDS guidance in the workplace should be provided in clear and accessible forms for all workers, including migrant workers.<sup>198</sup> It further calls for international cooperation among countries of origin, of transit, and of destination to ensure migrants' access to HIV prevention, treatment, care and support.<sup>199</sup>

**ILO Social Security (Minimum Standards) Convention, 1952 (No. 102),<sup>200</sup> the ILO Equality of Treatment (Social Security) Convention, 1962 (No. 118),<sup>201</sup> and the ILO Recommendation concerning National Floors of Social Protection, (No. 202).<sup>202</sup>** These two Conventions and the Recommendation govern the right to social protection<sup>203</sup>. In particular, the ILO *Social Protection Floors Recommendation, 2012 (No. 202)* stipulates that member States should “establish as quickly as possible and maintain their social protection floors comprising basic social security guarantees. The guarantees should ensure at a minimum that, over the life cycle, all in need have access to essential health care and to basic income security which together secure effective access to goods and services defined as necessary at the national level.”<sup>204</sup> Such guarantees should comprise at least “(a) access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality; (b) basic income security for children, at least at a nationally defined minimum level, providing access to nutrition,

<sup>195</sup> ILO: *HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals*, International Labour Organization (Geneva, 2013): 44.

<sup>196</sup> ILO: *General Survey on the fundamental Conventions concerning rights at work in light of the ILO Declaration on Social Justice for a Fair Globalisation*, International Labour Conference, 101st Session, Geneva, 2012. Paras. 810-812 and footnote 1048; ILO, HIV and AIDS Recommendation, 2010 (No. 200), Paras. 3 (c), 14 (b), (d), (e), and (f).

<sup>197</sup> Id. at Paras. 25, 27-28.

<sup>198</sup> Para. 40.

<sup>199</sup> Id. at Para. 47.

<sup>200</sup> ILO: *Social Security (Minimum Standards) Convention, 1952 (No. 102)*, adopted 28 June 1952, entry into force: 27 Apr 1955.

<sup>201</sup> ILO: *Equality of Treatment (Social Security) Convention, 1962 (No. 118)*, adopted 28 June 1962, entry into force 25 April 1964.

<sup>202</sup> ILO: *Social Protection Floors Recommendation, 2012 (No. 202)*, adopted 14 June 2012.

<sup>203</sup> *The right to social protection is also recognized as a basic human right in international human rights instruments including in Articles 22 and 25 of the Universal Declaration of Human Rights, Article 9 of the International Covenant on Economic, Social and Cultural Rights, as well as in other legal instruments, namely Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination, and Articles 25, 27, 28, and 43 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.*

<sup>204</sup> ILO: *Social Protection Floors Recommendation, 2012 (No. 202)*, para. 4.



education, care and any other necessary goods and services; (c) basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and (d) basic income security, at least at a nationally defined minimum level, for older persons.” Furthermore, such guarantees should be provided “to at least all residents and children, as defined in national laws and regulations”<sup>205</sup> Furthermore, such guarantees should be provided to all residents and children, as defined in national laws and regulations and subject to existing international obligations.<sup>206</sup> Therefore, migrants and their families should have access to these basic social security guarantees in the State where they reside, as well as in their home country.<sup>207</sup>

To protect migrants’ rights to social protection, the Equality of Treatment (Social Security) Convention, 1962 (No. 118) calls for mutual multilateral or bilateral agreements to give effect to inclusion of migrants in social protection systems in countries of employment and for portability of migrant contributions and earned benefits to their home countries.<sup>208</sup>

### 3.1.2 Instruments on Protection of Migrant Workers’ Rights

Three international instruments can be seen as comprising an “international charter” for the protection of international migrant workers. These instruments establish a normative framework for the protection of migrant workers, addressing their access to health services and treatment and calling for inter-state cooperation in this regard. These three instruments are:

- *ILO Migration for Employment Convention (Revised)*, 1949 (No. 97)
- *ILO Migrant Workers (Supplementary Provisions) Convention*, 1975 (No. 143)
- *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)*

The two ILO Conventions also apply to “refugees and displaced persons, where they are employed as workers outside their own countries”.<sup>209</sup>

#### A Rights-Based Approach to Migration

The rule of law and respect for widely recognized notions of human rights are the essential foundation for democratic societies and social cohesion. Respect for the human rights of all persons in society is an essential, accountable and equitable basis for addressing and resolving differences, tensions and potential conflicts that interaction among different persons and groups with different interests produces, particularly in the context of migration.

<sup>205</sup> Id. at para. 5.

<sup>206</sup> Id. at para. 6.

<sup>207</sup> ILO: “Social protection for migrant workers” in ILO (website): <http://www.ilo.org/global/topics/labour-migration/policy-areas/social-protection/lang--en/index.htm>.

<sup>208</sup> ILO: *Equality of Treatment (Social Security) Convention*, 1962 (No. 118), Article 8. See also Articles 5 and 7. [http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100\\_INSTRUMENT\\_ID:312263](http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312263).

<sup>209</sup> ILO: General Survey on Promoting Fair Migration 2016, International Labour Conference, 105th Session, Geneva 2016, para 113: 37.

The ILO's tripartite constituents pioneered the development of international instruments pertaining to migrant workers and articulating their rights at work and to social protection in its Conventions on Migration for Employment, 1949 (No. 97) and the Migrant Workers (Supplementary Provisions), 1975 (No. 143). Furthermore, all ILO labour standards apply to all migrant workers unless otherwise specified.

A long and slow trend extending application of basic human rights principles elaborated in the 1948 Universal Declaration of Human Rights to migrants culminated in the adoption by the UN General Assembly of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) on 18 December 1990. Recognition of migrants' human rights has become markedly more visible and "mainstream" over the last two decades. Today, migrant workers' rights are evoked at nearly all migration-related conferences and forums, while to date, 88 countries have ratified one or more of the three international instruments directly pertaining to rights of migrant workers and members of their families.

ILO Convention No. 97 on Migration for Employment applies to the whole labour migration continuum from entry to return and calls for measures regulating the conditions in which labour migration should occur. Of particular significance is the articulation of the principle of equal treatment of migrant workers in a regular situation with national workers regarding working conditions, trade union membership and enjoyment of the benefits of collective bargaining, accommodation, social security, employment taxes and legal proceedings relating to matters outlined in the Convention.<sup>210</sup>

ILO Convention No. 143, the Migrant Workers (Supplementary Provisions) Convention, complements Convention 97. It calls on States to take measures to prevent and address migration in abusive conditions.<sup>211</sup> It also focuses on ensuring that all migrant workers, regardless of their status, enjoy basic human rights, as well as certain rights arising out of past employment, including with respect to remuneration, social security and other benefits.<sup>212</sup> Certain other rights are limited to those in a regular situation. States are also to "declare and pursue a national policy designed to promote and to guarantee ... equality of opportunity and treatment in respect of employment and occupation, of social security, of trade union and cultural rights and of individual and collective freedoms for person who as migrant workers or as members of their families are lawfully within its territory."<sup>213</sup>

*The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990) (ICRMW)* establishes that migrant workers are more than labour or economic entities. They are social entities with families. It reinforces the principles enshrined in the ILO Conventions providing for equality of treatment between migrant workers and nationals in a range of areas, including remuneration and other conditions of work, including safety and health, as well as social security.<sup>214</sup> These conventions address gaps in protection for migrant workers and members of their families, including those in informal employment, by providing a foundation for the development

<sup>210</sup> Article 6(1).

<sup>211</sup> Part I.

<sup>212</sup> Articles 1 and 9.

<sup>213</sup> Article 10.

<sup>214</sup> Articles 25 and 27.

and implementation of national policies of host countries, transit countries and countries of origin.

The ICRMW includes specific provisions for equal treatment of migrant workers with nationals with respect to social and health services.<sup>215</sup> It also provides for emergency medical care to all migrants, irrespective of their status. Article 28 states: “Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.”

However, this provision should not be read restrictively. Article 81(1) of the ICRMW ensures that nothing in the Convention should affect more favourable rights or freedoms granted to migrant workers and members of their families by virtue of the law or practice of a State or any bilateral or multilateral treaty in force for that State Party. The International Covenant on Economic, Social and Cultural Rights (ICESCR) in effect recognize a more favourable right to health and health related rights for all, particularly in light of General Comment No. 14, discussed above.<sup>216</sup> The Committee on Migrant Workers (CMW), the treaty body for the ICRMW, has addressed this expanded view of migrant workers’ health rights in its elucidation of Article 28’s parameters, indicating that read together with other international instruments (including the ICESCR), broader obligations may be created. The CMW states that access to urgent medical care must be ensured to all migrant workers on the basis of equality of treatment with nationals and thus on a non-discriminatory basis... States parties should prohibit the charging of excessive fees from migrant workers in an irregular situation... States parties should ensure that migrant workers and members of their families are provided with information on the medical care provided and information about their health rights.”<sup>217</sup>

### 3.1.3 Other ILO Instruments and Supervisory Processes

#### Other International Labour Standards

The ILO has also developed specific instruments aimed at ensuring and protecting the rights of domestic workers, including migrant domestic workers: the Domestic Workers Convention, 2011 (No.189) and the Domestic Workers Recommendation, 2011 (No. 201). The Convention requires the respect, promotion and realization of fundamental principles and rights at work in respect of domestic workers, and also sets out the right of domestic workers to a safe and healthy working environment.<sup>218</sup> Paragraph 3(c) of the Domestic Workers Recommendation makes specific reference to the protection of domestic workers from mandatory HIV testing practices, providing that: “In taking measures for the elimination of discrimination in respect of employment and occupation, Members should, consistent with international labour standards, among other things: [...] ensure that no

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<sup>215</sup> Article 43(c).

<sup>216</sup> P. Pace: “Migration and the Right to Health: a Review of International Law”, in *International Migration Law Series* No. 19, IOM, (Geneva, 2009). [http://publications.iom.int/system/files/pdf/iml\\_19.pdf](http://publications.iom.int/system/files/pdf/iml_19.pdf).

<sup>217</sup> Committee on Migrant Workers, General Comment No. 2.

<sup>218</sup> Articles 3 and 13.

domestic worker is required to undertake HIV and pregnancy testing, or to disclose HIV or pregnancy status.”

### ILO General Survey 2016 on the ILO Migration Instruments

Each year, the ILO Committee of Experts on the Application of Conventions and Recommendations (the Committee of Experts) publishes a General Survey focusing on specific aspect of the ILO instruments. The 2016 General Survey canvasses a range of issues, including violations of the basic human rights of migrant workers, highlighting the vulnerability of those in an irregular situation to such violations.<sup>219</sup> In this context, the Committee of Expert has noted that certain countries of destination “have excluded migrant workers from entering countries on the basis of medical examinations including HIV and AIDS testing”, while also welcoming the adoption in other countries of specific HIV and AIDS legislation prohibiting HIV testing of workers “implicitly including migrant workers.<sup>220</sup> In this instance, the Committee of Experts refers to both the HIV and AIDS Recommendation, 2010 (No. 200), and to the Domestic Workers Recommendation, 2011 (No. 201), regarding the need to ensure that “no domestic worker is required to undertake HIV or pregnancy testing, or to disclose HIV or pregnancy status”.<sup>221</sup>

As recalled by the Committee of Experts, “refusal of entry or repatriation on the grounds that the worker concerned is suffering from an infection or illness of any kind which has no effect on the task for which the worker has been recruited, constitutes an unacceptable form of discrimination”<sup>222</sup>

#### 3.1.4 Instruments on Refugees and Asylum Seekers

Article 14(1) of the Universal Declaration of Human Rights affirms that: “*Everyone has the right to seek and to enjoy in other countries asylum from persecution*”. The 1951 UN Convention relating to the Status of Refugees and its 1967 Protocol defines who is a refugee, sets out the rights of refugees, and outlines the legal obligations of Member States ratifying the Convention. The rights of refugees and asylum seekers are also safeguarded in the range of human rights instruments referenced throughout this document.

The right to be protected against “refoulement” (expulsion or return) is the cornerstone of international refugee law. Such principle of “non-refoulement”, enshrined in Article 33 (1) of the 1951 Convention, prohibits Member States from returning a refugee to a country “where his life, or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion”. This principle now constitutes a norm of customary international law, and must be respected for all individuals, including all migrants, regardless of their status.<sup>223</sup>

<sup>219</sup> ILO: *General Survey on Promoting Fair Migration*, International Labour Conference, 105th Session, Geneva, 2016, paras 275-280. [http://ilo.org/wcmsp5/groups/public/---ed\\_norm/---relconf/documents/meetingdocument/wcms\\_453898.pdf](http://ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_453898.pdf).

<sup>220</sup> Id. at paras. 250 and 253.

<sup>221</sup> Id. at para 252.

<sup>222</sup> Id. at paras. 254: 83.

<sup>223</sup> IOM. 2014. *International Migration Law Information Note on the Principle of Non-Refoulement*, (April 2014): 1-3. <http://www.iom.int/files/live/sites/iom/files/What-We-Do/docs/IML-Information-Note-on-the-Principle-of-non-refoulement.pdf>.

The United Nations High Commissioner for Refugees (UNHCR) has issued a guidance clarifying that the HIV status is not a ground for any exception to this principle. In addition, HIV status cannot be considered as a legitimate reason for denying an asylum seeker access to asylum procedures and protection. Moreover, an asylum-seeker who has a well-founded fear of persecution because of his or her HIV status may fall within the refugee definition according to the 1951 Convention.<sup>224</sup>

### 3.1.5 International/Regional Guidelines on Internally Displaced Persons

The UN Guiding Principles on Internal Displacement were developed under the auspices of the UN Special Representative on Internally Displaced Persons (IDPs), adopted by the UN Commission on Human Rights, and consequently endorsed by the UN General Assembly. These guidelines both establish an international definition of IDPs and provide guidance for Member States calling on them to provide protection and assistance to this group. Principle 19 specifically addresses IDPs who are wounded or sick, including those with disabilities. Those IDPs are entitled to receive needed medical care and attention. Special attention is given to women's reproductive health, and to the prevention of contagious and infectious diseases, including HIV.

In 2016, the ILO Governing Body adopted the Guiding principles on the access of refugees and other forcibly displaced persons to the labour market<sup>225</sup> which can be used by governments, employers' and workers' organization to develop policies to support both host and refugee communities on labour market integration issues. While not directly addressing HIV and health issues, the Guiding principles call for member States to adopt policies promoting equality of opportunities and treatment with regard, among others, to the access to quality public services and "to the right to social security benefits for refugees and other forcibly displaced persons",<sup>226</sup> as well as to include measures to "combat and prevent all forms of discrimination in law and in practice".<sup>227</sup>

At regional level, a binding treaty has been adopted at the Africa regional level specifically on the protection of internally displaced persons (IDPs), namely the 2009 Kampala Convention (African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa).<sup>228</sup> The Convention provides a broad definition of harmful practices, which includes behaviour, attitudes and/or practices negatively affecting, among others, the right to health (Article 1(j)); it prohibits armed groups from denying IDPs satisfactory conditions of health (Article 7(c)); it calls for States Parties to provide IDPs access to health services including access to reproductive and sexual health (Article 9 2(b) and 2(d)), providing special protection to IDPs with special needs including those with communicable diseases (Article 9 2(c)). The Convention also calls for the

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<sup>224</sup> UNHCR. 2006. *Note on HIV and AIDS and the Protection of Refugees, IDPs and Other Persons of Concern*. United Nations High Commissioner of Refugees (Geneva, 2006).

<sup>225</sup> ILO: *Guiding principles on the access of refugees and other forcibly displaced persons to the labour market*, adopted 7 July 2016 [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---migrant/documents/genericdocument/wcms\\_536440.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/genericdocument/wcms_536440.pdf).

<sup>226</sup> Id. at para. 22.

<sup>227</sup> Id. at para. 23 (a).

<sup>228</sup> African Union. 2009. *Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention)*, adopted in October 2009, entry into force December 2012.

States Parties to protect the rights of internally displaced persons from “sexual and gender based violence in all its forms, notably rape, enforced prostitution, sexual exploitation” (Article 9 1(d)), which are factors often linked to the greater vulnerability to HIV.

### 3.1.6 Protocols on Trafficking in Human Beings and Smuggling of Migrants

The separate crimes of human trafficking and smuggling are addressed in the two protocols to the UN Convention Against Transnational Organized Crime, and are collectively referred to as the Palermo Protocols.<sup>229</sup>

#### Human Trafficking and HIV Vulnerability

With approximately 40 million people living with HIV globally, there is an immediate need to address the causes that heighten vulnerability to trafficking and HIV. The twin problems of trafficking and HIV are influenced by the same set of factors – poverty, discrimination and unsafe conditions of mobility. Human rights and gender concerns are at the forefront of the challenge to reduce HIV vulnerability and trafficking in general.

- **Vulnerability:** Though there is not necessarily a direct causal correlation between trafficking and HIV and AIDS, once a person is trafficked they are often in an alien environment in which they have little power or agency, which increases their vulnerability to HIV.
- **Being female:** The susceptibility of a trafficked woman to HIV is higher than that of a person who engages in sex work out of choice. In addition to being exposed to forced and unsafe sex with multiple partners, victims may be injected with drugs to increase their compliance, or they may choose to inject drugs as a coping mechanism. Victims may also receive medical or surgical treatment that might include forced or voluntary pregnancy terminations in unsanitary conditions by unqualified practitioners, using contaminated instruments or unscreened blood supplies. Women who are living with HIV have less access to health care as compared with men. They generally also have less free time to access whatever facilities are available. They tend to have less money at their disposal and cannot afford medical care. The clandestine status of trafficking victims makes them invisible, and further reduces their access to health services, particularly those that focus on HIV and AIDS.<sup>230</sup>
- **Lack of Education:** Most victims of human trafficking are poorly educated. Their knowledge of HIV risk factors is therefore likely to be low, meaning they have inadequate knowledge of how HIV is transmitted or what they can do to prevent transmission. They may therefore inadvertently transmit the virus to others if they are not aware of their HIV status.<sup>231</sup>

<sup>229</sup> United Nations General Assembly, *The Protocol to Prevent, Suppress, and Punish Human Trafficking in Persons, Especially Women and Children* and *The Protocol Against the Smuggling of Migrants by Land, Sea and Air, Resolution 55/25* (15 November 2000).

<sup>230</sup> UNODC/UN Global Initiative to Fight Trafficking. 2007. *Human Trafficking and HIV/AIDS*. UNODC (Vienna 2007) <https://www.unodc.org/pdf/gift%20brochure.pdf>.

<sup>231</sup> UNODC/UN Global Initiative to Fight Trafficking. 2007. *Human Trafficking and HIV/AIDS*. UNODC (Vienna 2007) <https://www.unodc.org/pdf/gift%20brochure.pdf>.



### 3.1.7 Instruments on Forced Labour and Child Labour

Freedom from forced or compulsory labour is a fundamental human right. ILO has adopted a series of Conventions and Recommendations and a Protocol on the abolition of forced labour and elimination of child labour. These include:

- the *Forced Labour Convention, 1930* (No. 29);
- the *Forced Labour (Indirect Compulsion) Recommendation, 1930* (No. 35);
- the *Abolition of Forced Labour Convention, 1957* (No. 105);
- the *Worst Form of Child Labour Convention, 1999* (No. 182), together with the *Worst Forms of Child Labour Recommendation, 1999* (No. 190); and
- The Protocol of 2014 to the Forced Labour Convention, 1930.

Forced labour situations and conditions, as well as those of child labour, put victims at manifestly higher risk of exposure to HIV, with little or no access to preventative education, health care or indeed any medical attention, nor to treatment should they be infected. As noted above for victims of trafficking, persons in forced labour situations and child labour alike face powerless situations, often in alien environments that compound risks and vulnerability while denying any access to prevention, care or remedies.

The ILO Committee of Experts (CEACR) has noted with concern the impact that HIV and AIDS could have in the continuation of child labour in a country<sup>232</sup> and the extremely serious problem of the sexual exploitation of children, pointing out that human trafficking increases vulnerability to HIV infection.<sup>233</sup>

## 3.2 UN Declarations, Treaty Body Comments, and Jurisprudence on HIV and AIDS Regarding Migrants

UN General Assembly declarations and resolutions play a critical role in international law. Beginning with the Universal Declaration of Human Rights, these documents have helped define international human rights law. UN treaty body comments are also important in addressing migration and health. The General Comments, by providing interpretations of specific treaty provisions, are essential tools to aid States in understanding and implementing their obligations under the treaties.

### 3.2.1 United Nations General Assembly Resolutions and Declarations on HIV and AIDS

A series of UN General Assembly resolutions and declarations on HIV and AIDS have been adopted that establish global targets on prevention, treatment and protection of PLHIV, including migrants.<sup>234</sup> They emphasize the multifaceted approach necessary to address HIV, including considerations of human rights, workers' rights, gender equality, stigmatization, discrimination, social protection and the various needs of different

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<sup>232</sup> ILO: *Report of the Committee of Experts on the Application of Conventions and Recommendations*, Report III (Part 1A), International Labour Conference, 102nd session, 2013: 367.

<sup>233</sup> ILO: *HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals*, International Labour Organization (Geneva, 2013): 36.

<sup>234</sup> See for example: *Declaration of Commitment on HIV and AIDS*, A/RES/S-26/2 (2001); *Political Declaration on HIV and AIDS*, A/RES/60/262 (2006).



groups of persons affected by HIV, including children. In addition, these resolutions and declarations have focused specifically on migrant and mobile populations.

### **The 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS**

The 2011 Declaration<sup>235</sup> established a set of targets and commitments to be achieved by 2015. It specifically notes that States should address, through national legislation, the needs of migrants and mobile populations and their vulnerability to HIV infection, as well as their lack of access to HIV prevention, treatment, care and support. Other components of the Declaration do not mention migrants specifically, but are clearly applicable to migrants because of the Declaration's blanket provision that all individuals vulnerable to and affected by HIV are encompassed in its recommendations. These include the "call upon employers, trade and labour unions, employees and volunteers to eliminate stigma and discrimination, protect human rights and facilitate access to HIV prevention, treatment, care and support"<sup>236</sup>, taking into account the principles of the ILO HIV and AIDS Recommendation, 2010 (No. 200).

### **The 2016 Political Declaration: On the Fast Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030**

In 2016, the General Assembly once again took up the issue of HIV and AIDS, adopting a Political Declaration emphasizing that not enough has yet been done for certain populations: "many national HIV prevention, testing and treatment programmes provide insufficient access to services for women and adolescent girls, migrants and key populations that epidemiological evidence shows are globally at higher risk of HIV".<sup>237</sup> The 2016 Declaration calls on Member States to:

- elevate access to tailored HIV comprehensive prevention services for migrants;
- incorporate the specific healthcare needs experienced by migrant and mobile populations into policymaking;
- eliminate entry restrictions based on HIV status;
- eliminate the return of people based on HIV status; and
- support migrant and mobile population's access to HIV treatment, care, and support.<sup>238</sup>

## **3.2.2 General Comments from the UN Human Rights Treaty Bodies on HIV and AIDS**

UN human rights treaty monitoring bodies have issued General Comments that make explicit reference to HIV and AIDS. These comments apply to all individuals, including migrants.

<sup>235</sup> *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, A/RES/65/277 (2011).

<sup>236</sup> *Id.* at para. 85.

<sup>237</sup> *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight Against HIV and to End the AIDS Epidemic by 2030*, A/RES/70/266 (2016), para. 42.

<sup>238</sup> *Id.* at para. 63(g).

### **Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14**

General Comment No. 14, clarifying the normative content of Article 12, emphasizes that “The prevention, treatment and control of epidemic, endemic, occupational and other diseases” (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV, and those adversely affecting sexual and reproductive health”.<sup>239</sup> Furthermore, the Comment emphasizes Member States’ obligations to justify any measures restricting fundamental rights in keeping with international human rights standards: “The Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements to their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation and civil, political, social or other status which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.”<sup>240</sup>

Paragraph 34 of the Comment further states that: “States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women’s health status and needs”.

### **Committee on Migrant Workers (CMW), General Comments No. 1 and No. 2**

General Comment No. 1 on migrant domestic workers issued by the CMW urges States to repeal discriminatory laws, regulations and practices related to HIV, including those resulting in the loss of work visa based on the HIV status, and to ensure that medical testing of migrant domestic workers, including for pregnancy or HIV is conducted only on a voluntary basis, with the informed consent of the individual.<sup>241</sup>

General Comment No. 2 on the rights of migrant workers in an irregular situation and members of their families also expresses the Committee’s concern regarding the use of detention of migrant workers with HIV, noting that it has a negative impact on both physical and mental health, particularly for vulnerable categories of migrant workers and members of their families, which “may include victims of torture, unaccompanied older persons, persons with disabilities and persons living with HIV and AIDS.”<sup>242</sup>

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<sup>239</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 14 on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/2000/4 (11 August 2000), para. 16.

<sup>240</sup> Id. at para. 18.

<sup>241</sup> Committee on the Protection of the Rights of all Migrant Workers and Members of Their Families, General Comment No.1 on migrant domestic workers, CMW/C/GC/1, (23 February 2011), para. 61.

<sup>242</sup> Committee on the Protection of the Rights of all Migrant Workers and Members of Their Families, General Comment No.2 on the rights of migrant workers in an irregular situation and members of their families, CMW/C/GC/2, (28 August 2013), para. 46.

### Committee on the Elimination of Racial Discrimination (CERD), General Recommendation 30

General Recommendation 30 on discrimination against non-citizens, by the Committee on the Elimination of Racial Discrimination (CERD), does not address HIV directly, but it does so indirectly, given that discrimination against non-nationals is one of the primary obstacles that prevents migrants from gaining access to HIV prevention, testing and treatment services. The Recommendation recommends the States parties to “Remove obstacles that prevent the enjoyment of economic, social and cultural rights to non-citizens, notably in the areas of education, housing, employment and health.”<sup>243</sup> It also states that States parties should “respect the right of non-citizens to an adequate standard of physical and mental health by, *inter alia*, refraining from denying or limiting their access to preventative, curative and palliative health services.”<sup>244</sup>

### Committee on the Elimination of Discrimination against Women (CEDAW) General Recommendation No. 26

General Recommendation No. 26 on women migrant workers, by the CEDAW, specifically addresses the particular challenges migrant women face throughout the migration process. In particular, “women migrant workers may face sex- and gender-based discrimination, including compulsory HIV testing for women returnees”.<sup>245</sup> Noting that migrant women “often suffer from inequalities that threaten their health. They may be unable to access health services, including reproductive health services, because insurance or national health schemes are not available to them, or they may have to pay unaffordable fees”<sup>246</sup>, Recommendation 26 calls for countries of origin to provide information and awareness on general and reproductive health, including HIV prevention<sup>247</sup> and requires that “all required pre-departure HIV/AIDS testing or pre-departure health examinations must be respectful of the human rights of women migrants.”<sup>248</sup>

### 3.2.3 Selected Jurisprudence Relating to HIV

Both UN Treaty Bodies<sup>249</sup> and international and national courts have issued decisions that address migration and HIV status. For example, in 2011, the European Court of Human Rights issued a landmark decision finding that Russia violated the European Convention on Human Rights in refusing a residence permit to a foreign national solely on the basis of his HIV status.<sup>250</sup> Similarly, UN treaty bodies and national courts have also taken up the issue of discrimination against non-nationals in the context of HIV testing and treatment.

<sup>243</sup> Committee on the Elimination of Racial Discrimination (CERD), *General Recommendation No. 30 on discrimination against non-citizens (2004)*, HRI/GEN/1/Rev.7/Add. 1 (4 May 2005): para. 29.

<sup>244</sup> *Id.* at para. 36.

<sup>245</sup> Committee on the Elimination of Discrimination against Women, *General Recommendation No. 26 on women migrant workers*, CEDAW/C/2009/WP.1/R (5 December 2008): para. 11.

<sup>246</sup> *Id.* at paras. 17 and 20.

<sup>247</sup> *Id.* at para. 24(b)(i).

<sup>248</sup> *Id.* at para. 24(b)(d).

<sup>249</sup> While these decisions are not generally considered binding on States, they do represent a reasoned interpretation of the relevant treaty to which the States parties have agreed to be legally bound.

<sup>250</sup> European Court of Human Rights, *Kyutin v. Russia Judgment*, A2700/10, (Strasbourg, March 2011).

### **Kyutin v. Russian Federation (2011)**

#### *European Court of Human Rights*

The Court held that Russia's refusal to grant Mr. Kyutin a residence permit because he was HIV positive constituted unlawful discrimination under the Convention for the Protection of Human Rights and Fundamental Freedoms. Mr. Kyutin was an Uzbek national living in Russia. He was married to a Russian national and had a child with her. When he applied for a residency permit, Russian legislation required him to undergo mandatory HIV testing. When he tested positive, Mr. Kyutin's application for a residence permit was rejected by the Russian authorities. The Court recognized in this case that denial of a residency permit for reasons of HIV status was inherently discriminatory and therefore unlawful.

This important ruling affirmed the rights of people living with HIV in Europe by recognizing them as a vulnerable group with a history of prejudice and stigmatisation "and that the State should be afforded only a narrow margin of appreciation in choosing measures that single out this group for differential treatment on the basis of their HIV status" (para. 64). The Court also called on Russia to amend its legislation on these matters.

### **L.G. v. Republic of Korea (2015)**

#### *Committee on the Elimination of Racial Discrimination*

L.G. was a New Zealand national employed in the Republic of Korea as an English teacher. Korea required that all persons holding the type of work visa she had, be tested for HIV and illegal drugs as a precondition for registering as a resident alien. The test was only required once; in practice, however, it was required annually at the time of contract renewal. Native Korean teachers and ethnically Korean non-national teachers were not required to undergo the same test. When L.G. refused to undergo the test again, her contract was not renewed.

The Committee on the Elimination of Racial Discrimination held that Korea violated the Convention on the Elimination of All Forms of Racial Discrimination (Article 2.1(c) and (d), requiring that States investigate allegedly discriminatory policies and prohibit racial discrimination, and Article 6, on remedies). It also found a violation of L.G.'s right to work under Article 5(e)(i), given that foreign English teachers of Korean ethnicity were not required to undergo the HIV test, referencing General Recommendation 30 of the Convention directing States not to stereotype or profile non-citizens based on race or ethnicity.

The decision included a very clear statement on mandatory HIV testing: "The Committee also observes that mandatory HIV/AIDS testing for employment purposes, as well as for entry, stay and residence purposes, is considered to be in contradiction with international standards, as such measures appear to be ineffective for public health purposes, discriminatory and harmful for the enjoyment of fundamental rights" (Para. 7.4).<sup>251</sup>

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<sup>251</sup> International Convention on the Elimination of All Forms of Racial Discrimination, L.G. v. Republic of Korea, Opinion, CERD/C/86/D/51/2012 (12 December 2012).

**Attorney General, et al. v. Dickson Tapela et al. (2015)***Court of Appeal of the Republic of Botswana at Gaborone*

In two cases joined on appeal, Zimbabwean nationals living with HIV imprisoned in Botswana sought free antiretroviral and highly active antiretroviral therapy. Two of the prisoners had been refused treatment under a 2004 government directive restricting the free therapy (as well as testing, assessment and other treatment) to prisoners who were citizens of Botswana. They filed suit and a lower court held that refusal to provide them with free treatment violated the Government's responsibility to provide health care to prisoners. The government then appealed. Later, a third prisoner contracted HIV while in prison and developed AIDS. Based on the earlier case, he applied for free treatment, but was refused. The lower court held that the decision in the first case applied to all foreign citizen prisoners in Botswana. The Government also appealed this decision.

The Court of Appeal dismissed the appeals, upholding the lower court finding that it was discriminatory to provide free testing, assessment, and antiretroviral therapy to citizen prisoners but to deny it to non-citizen prisoners. It also held that all non-citizen prisoners who were HIV positive were to benefit from the free treatment, in accordance with the Prisons Act.

The Court made it clear that its decision was restricted to non-citizen prisoners, and could not be interpreted broadly to signify a constitutional right to health care. It made two statements of particular relevance to migration and public health. First, the Court held that the Government could not justify excluding foreign prisoners from treatment on the basis of financial cost: "Lack of funds will not in the normal course justify disobedience of the law."<sup>252</sup> Second, the Court noted that a policy of giving free treatment to citizen prisoners but withholding it from non-citizen prisoners "clearly discriminates against the non-citizen on account of their place of origin."<sup>253</sup>

**Novruk and Others v. Russia (2015)***European Court of Human Rights*

The case was brought by Mikhail Novruk, a Moldovan national who was born in 1972; Anna Kravchenko, a Ukrainian national who was born in 1982; Roman Khalupa, a Moldovan national who was born in 1974; Irina Ostrovskaya, an Uzbek national who was born in 1953; and V.V., a national of Kazakhstan who was born in 1983. All of the plaintiffs were non-Russian nationals living with HIV who were denied residency in the country due to their HIV status.<sup>254</sup>

The Court observed that while the right to enter or settle in a particular country was not guaranteed by the Convention for the Protection of Human Rights and Fundamental Freedoms, a State was nevertheless required to exercise its immigration policies in a manner which was compatible with a foreign national's human rights, in particular the right to respect his or her private or family life and the right not to be discriminated against.

<sup>252</sup> Court of Appeal of the Republic of Botswana *Attorney General, et al. v. Dickson Tapela et al.* (2015), para. 70.

<sup>253</sup> *Id.* at para. 55.

<sup>254</sup> European Court of Human Rights *Novruk and Others v. Russia, Judgement*, Applications nos. 31039/11, 48511/11, 76810/12, 14618/13 and 13817/14, (Strasbourg, March 2016).

In this respect, the Court found that the Russian Federation’s legislation and practice, which provide that foreign nationals in Russian territory are subject to deportation if it is discovered that they are HIV-positive, constituted a violation of Article 14 (prohibition of discrimination) of the European Convention on Human Rights taken together with Article 8 (right to private and family life).

The Court found that “in the light of the overwhelming European and international consensus geared towards abolishing the outstanding restrictions on entry, stay and residence of HIV-positive non-nationals who constitute a particularly vulnerable group, the respondent Government have not advanced compelling reasons or any objective justification for their differential treatment for health reasons.”<sup>255</sup> It also emphasized that “the legal provisions of the Entry and Exit Procedures Act, the Foreign Nationals Act, and the HIV Prevention Act – which were at the heart of the instant case – incompatible with the Russian Constitution in so far as they allowed the authorities to refuse entry or residence or to deport an HIV-positive non-national with family ties in Russia solely on account of his or her diagnosis.”<sup>256</sup>

### 3.3 Relevant Codes and Policy Frameworks Addressing Migration, Health and/or HIV

#### 3.3.1 ILO Code of Practice on HIV and AIDS and the World of Work (2001)

This Code of Practice reflects the commitment of the ILO and its tripartite constituents to prevent the spread of the epidemic, mitigate its impacts on workers and their families, and to provide social protection to help those affected in coping with the disease. Addressing the negative impact of HIV and AIDS on fundamental rights at work, including on the respect of non-discrimination, the Code aims at securing conditions of decent work in the face of the global humanitarian and development crisis posed by the epidemic.

The Code provides a set of guidelines to help workplace actors respond to the epidemic in the world of work and within the framework of the promotion of decent work. The concept of decent work, formulated by the ILO’s constituents, contains four agendas: employment creation, social protection, rights at work, and social dialogue, with gender equality as a crosscutting objective. Key areas of action identified in the Code include: prevention of HIV, management and mitigation of the impacts of HIV and AIDS in and through the world of work, care and support for workers living with and affected by HIV, elimination of stigma and discrimination on the basis of real or perceived HIV status, and gender equality.

The Code sets out the following ten key principles for rights-based HIV responses in the workplace:<sup>257</sup>

- (1) Recognition of HIV and AIDS as a workplace issue
- (2) Non-discrimination
- (3) Gender equality

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<sup>255</sup> Id. at para. 111.

<sup>256</sup> Id. at para. 133.

<sup>257</sup> ILO: *An ILO code of practice on HIV and AIDS and the world of work* (Geneva, ILO, 2001).

- (4) Healthy work environment
- (5) Social dialogue
- (6) Screening for purposes of exclusion from employment or work processes
- (7) Confidentiality
- (8) Continuation of the employment relationship
- (9) Prevention
- (10) Care and support

The Code has a broad scope of application, applying to all employers and workers in the public and private sectors, as well as to all aspects of the employment relationship, whether formal or informal. All migrant workers, regardless of their status, are covered by the Code's provisions.

### 3.3.2 ILO Multilateral Framework on Labour Migration (2006)

The ILO Multilateral Framework on Labour Migration (Multilateral Framework) provides relevant guidance for national law, policy and practice on governing migration, complemented by the recently adopted ILO Fair Labour Migration Agenda (FLMA) endorsed by the International Labour Conference in 2014. The Multilateral Framework is a compilation of “non-binding principles and guidelines for a rights-based approach to labour migration” defined and agreed through a global tripartite research and negotiating process culminating in an authoritative tripartite meeting of experts representing countries and respective governments, employers’ and workers’ organizations from all regions in 2005. Its principles draw from international legal instruments including the ILO Conventions and its guidelines are a compilation of policy recommendations from international conferences and actual, successful “potentially replicable good practices” worldwide.

Nine thematic areas address several key concerns of migration governance:<sup>258</sup>

- Decent work;
- International cooperation on labour migration;
- Global knowledge base;
- Effective management of labour migration;
- Protection of migrant workers;
- Prevention of and protection against abusive migration practices;
- Migration processes;
- Social integration and inclusion; and
- Migration and development.

While not directly mentioning HIV, the framework provides the basis for linking national laws and policies on labour migration to relevant ILO standards on social security, maternity protection, and occupational safety and health, which could support the inclusion of HIV and health issues in these national instruments. The Framework also guides governments

<sup>258</sup> ILO: *Multilateral Framework on Labour Migration* (Geneva, ILO, 2006).



to take measures to ensure that migrant workers and accompanying members of their families are provided with access to health care and health protection.<sup>259</sup>

### 3.3.3 ILO's Fair Labour Migration Agenda (2014)

The ILO Director General's report "Fair migration: Setting an ILO agenda"<sup>260</sup> complements the Multilateral Framework with an analysis of the current migration trends and challenges and makes recommendations for urgent attention by the ILO itself and its tripartite constituents. The report's recommendations and constituents' inputs have been synthesized into what the ILO now promotes as its Fair Labour Migration Agenda:

- Making migration a choice and not a necessity, by creating decent work opportunities in countries of origin;
- Respecting the human rights, including labour rights, of all migrants;
- Ensuring fair recruitment and equal treatment of migrant workers to prevent exploitation and level the playing field with nationals;
- Formulating fair migration schemes in regional integration processes;
- Promoting bilateral agreements for well-regulated and fair migration between member States;
- Countering unacceptable situations through the promotion of the universal exercise of fundamental principles and rights at work;
- Contributing to a strengthened multilateral rights-based agenda on migration;
- Promoting social dialogue by involving Ministries of Labour, trade unions and employers' organizations in policy making on migration; and
- Knowledge and capacity building.

Furthermore, the ILO has also launched a global "Fair Recruitment Initiative" (ILO-FAIR)<sup>261</sup> and adopted General principles and operational guidelines for fair recruitment<sup>262</sup> to:

- help prevent human trafficking
- protect the rights of workers, including migrant workers, from abusive and fraudulent practices during the recruitment and placement process
- reduce the cost of labour migration and enhance development gains

An effective response to HIV that addresses the concerns of migrant workers needs to be integrated into the ILO-FAIR's approach. This include: ensuring that HIV and health data is used to enhance global knowledge on national and international recruitment practices; integrating HIV and health concerns, including discrimination based on

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<sup>259</sup> See also ILO: *Conclusions concerning fair and effective labour migration governance*, International Labour Conference, 106th Session, Geneva, 2017. [http://www.ilo.org/wcmsp5/groups/public/---ed\\_norm/---relconf/documents/meetingdocument/wcms\\_558628.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_558628.pdf) [accessed 22 September 2017].

<sup>260</sup> ILO: *Fair Migration: Setting an ILO Agenda* (Geneva, ILO, 2014).

<sup>261</sup> See ILO: *The Fair recruitment initiative*: [http://www.ilo.org/global/topics/fair-recruitment/WCMS\\_320405/lang-en/index.htm](http://www.ilo.org/global/topics/fair-recruitment/WCMS_320405/lang-en/index.htm) [accessed 22 September 2017].

<sup>262</sup> ILO: *General principles and operational guidelines for fair recruitment*, Governing Body, 328th Session, Geneva, Oct-Nov 2016. [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---migrant/documents/genericdocument/wcms\\_536263.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/genericdocument/wcms_536263.pdf), 2016 [accessed 22 September 2017].

migrant workers' health status, into laws, policies and enforcement mechanisms to promote fair recruitment; encouraging fair business practices which take into account efforts to reduce HIV-related discrimination and equal access to health services, to empower and protect workers.

### **3.3.4 International Guidelines on HIV and AIDS and Human Rights (OHCHR and UNAIDS)**

This joint instrument, adopted in 2006, was the response to a request made by the UN Commission on Human Rights for the development of guidance to States on how to take concrete steps for protecting human rights in the context of HIV.

These Guidelines provide a reference for States to bridge the gap between international human rights norms and their application in practice. The Guidelines contain three main parts: guidelines comprising action-oriented measures to be employed by Governments in areas of law, administrative policy and practice; recommendations for dissemination and implementation of the Guidelines; and international human rights obligations and HIV. The instrument emphasizes that human rights do not conflict with public health interests, and calls on States to consider protective measures aimed at specific groups that may be particularly vulnerable to HIV and HIV-related discrimination.

The Guidelines call on States to, among other things: review and reform public health laws to ensure that they adequately address issues raised by HIV; enact or strengthen their legal frameworks to ensure that criminal laws and corrections systems are not misused in the context of HIV and to provide protection against discrimination on the basis of real or perceived HIV status in all settings, including employment, and to prohibit mandatory HIV testing and protect confidentiality of HIV status. The Guidelines also call for community involvement in all aspects of HIV policy and programme design and implementation and to enhance legal literacy and ensure effective enforcement to guarantee the protection of HIV-related human rights.<sup>263</sup>

These Guidelines, emphasizing the link between the protection of human rights and effective HIV programmes, call for States to support the implementation of HIV prevention and care programmes, designed “for those who have less access to mainstream programmes”<sup>264</sup> in particular refugees and internally displaced persons, and migrants.

### **3.3.5 WHO Report on the Global Health and Migration Consultation**

The 2010 Global Consultation on Migrant Health was convened as a result of adaptation of the 2008 World Health Assembly Resolution on the Health of Migrants, which pressed States to take action on establishing migrant-sensitive health policies and practices. The Report is the result of this joint WHO and IOM initiative, supported by ILO and OHCHR.

The Report provides useful policy guidance based on a broad multi-stakeholder consultation process and summarizes the key health challenges encountered by migrants.

<sup>263</sup> OHCHR and UNAIDS. 2006. *International Guidelines on HIV and AIDS and Human Rights Consolidated Version*, (Geneva 2006).

<sup>264</sup> Id. at para. 60 (j).

The Report sets out an operational framework to take further action on migrant health, as well as recommendations for moving the migrant health agenda forward. Priorities identified include: ensuring standardization and comparability of migrant health information and mapping of good practices; adopting or amending relevant national policy and legal frameworks by Member States; ensuring migrant-sensitive health systems; and establishing partnerships, dialogues and multi-country frameworks to address and promote migrant health.

### 3.4 Relevant Regional Instruments and Initiatives

The international instruments, policies and strategies are complemented by instruments adopted at the regional level to promote access to HIV prevention and treatment for migrant populations. Regional economic entities have also instituted programmes and policies that address HIV in the migration context.

#### Europe

The European Union committed to address migrant health, and HIV in particular, notably through the *European Centre for Disease Prevention and Control Technical Report on Migration Health: Access to HIV Prevention, Treatment and Care for Migrant Populations in EU/EEA Countries* (2009). This report identified key challenges including policy and legal frameworks which represent “a challenge to the provision of HIV services to migrants,” “information gaps” in regard to data collection, “legal, administrative and cultural barriers to access” to service delivery in certain countries, and finally, a need for action “to tackle negative social attitudes towards migrants.”<sup>265</sup> Additionally, the report put forward key suggested actions, including better data collection and policies. EU Member States are encouraged to establish a single definition of “migrant”, to create or develop policy and legal frameworks that better protect migrants’ rights with respect to HIV care, to take “priority networking actions,” and to recognise the “need for culturally appropriate materials and interventions, related training for health and community workers, and greater involvement of migrant communities in service delivery. Community approaches to HIV testing, such as outreach, and comprehensive approaches to treatment and care, together with increased efforts to inform migrant communities about available services, were suggested to improve coverage and uptake of services...”<sup>266</sup>

The EU has also adopted a series of policy documents regarding HIV and AIDS. The 2009 Commission Communication on Combating HIV/AIDS in the EU and Neighbouring Countries identifies policies to help reduce the number of new infections and improve the quality of life for people living with HIV. The EU policies provide political support to authorities and stakeholders in EU countries and neighbouring countries to: improve access to prevention, treatment, care and support, reach migrants from countries with a high prevalence of HIV, and improve policies targeting the populations most at risk. Detailed plans to achieve the policy goal have been outlined in the Action Plan on HIV/

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<sup>265</sup> European Centre for Disease Prevention and Control (ECDC). 2009. *Migrant Health: Access to HIV Prevention, Treatment and Care for Migrant Populations in EU/EEA Countries*, Technical Report (Stockholm, 2009): 1-30.

<sup>266</sup> Id at 2.

AIDS in the EU and Neighbouring Countries: 2014-2016.<sup>267</sup> It identified migrants and mobile populations as one of the priority groups in the response to HIV and AIDS.<sup>268</sup>

A European Parliament briefing of January 2016 by the European Parliamentary Research Service on “the Public Health Dimension of the European Migrant Crisis” outlines responses and actions taken by the EU.<sup>269</sup> It highlights that the European Commission’s commitment to mobilise additional “emergency funding, inter alia to support reception capacity, including healthcare, for migrants in those Member States facing particular migratory pressure.”<sup>270</sup>

## Africa

The African Union’s (AU) Migration Policy Framework for Africa adopted by the AU Heads of State meeting in Banjul in 2006, recognizes that “migrants, particularly irregular migrants, should be afforded access to basic health care including Reproductive Health, ARV for HIV/AIDS and other services.”<sup>271</sup> The AU-ILO-IOM-UN Economic Commission for Africa Joint Labour Migration Programme for Africa – with activity in all eight African regional economic communities – includes specific support for promoting HIV prevention, care and treatment measures targeted at migrant worker populations.

Most of the eight recognized regional economic communities in Africa have established HIV and AIDS responses with components addressing migrants.<sup>272</sup>

The 2010-2015 Southern African Development Community (SADC) HIV and AIDS Strategic Framework<sup>273</sup> contains five objectives for Member States, focusing on prevention, access to care, social developmental impact and monitoring and evaluation mechanisms.<sup>274</sup> The Framework has been catalytic in starting a regional process for harmonised policies on migrant and mobile labour, displaced populations and HIV and AIDS. In particular, it calls for HIV programmes to address prevention among specific groups, including migrants and mobile populations, ensuring integration of prevention into reproductive and child health, and primary health care services..<sup>275</sup>

<sup>267</sup> European Commission. 2014. *Action Plan on HIV/AIDS in the EU and Neighbouring Countries 2014-2016*, Commission Staff Working Document. [http://ec.europa.eu/health/sti\\_prevention/docs/ec\\_hiv\\_actionplan\\_2014\\_en.pdf](http://ec.europa.eu/health/sti_prevention/docs/ec_hiv_actionplan_2014_en.pdf) [accessed 25 September 2017].

<sup>268</sup> Ibid.

<sup>269</sup> N. Scholz: *The Public Health Dimension of the European Migrant Crisis – European Parliament Briefing*. European Parliamentary Research Service (Brussels, 2016): 1-8. [www.europarl.europa.eu/RegData/.../EPRS\\_BRI\(2016\)573908\\_EN.pdf](http://www.europarl.europa.eu/RegData/.../EPRS_BRI(2016)573908_EN.pdf) [accessed 25 September 2017].

<sup>270</sup> European Commission. 2015. *A European Agenda on Migration – Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions*, COM (2015) 240 final, (Brussels, 2015). <http://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1448288334252&uri=CELEX:52015DC0240> [accessed 25 September 2017].

<sup>271</sup> African Union. 2006. *A Migration Policy Framework for Africa* (2006): 26.

<sup>272</sup> IOM substantially contributed to these results through its Partnership on Health and Mobility in East and Southern Africa (PHAMESA) programme. See <http://southafrica.iom.int/programmes/partnership-on-health-and-mobility-in-east-and-southern-africa-phamesa> [accessed 25 September 2017].

<sup>273</sup> Southern African Development Community (SADC). 2009. *SADC HIV and AIDS Strategic Framework, 2010-2015*, October 2009: <http://www.sadc.int/files/4213/5435/8109/SADCHIVandAIDSStrategyFramework2010-2015.pdf> [accessed 25 September 2017].

<sup>274</sup> Ibid.

<sup>275</sup> Id. at 35.

The Intergovernmental Authority on Development (IGAD) in Eastern Africa has focused on HIV mainly through the IGAD Regional HIV/AIDS Partnership Program (IRAPP) Support Project, which contains two objectives: 1) increasing preventative action, and reducing misconceptions about cross border and mobile populations; and 2) establishing a common and sustainable regional approach to supporting these populations in the IGAD Member States.<sup>276</sup>

## Asia

The Association of Southeast Asian Nations (ASEAN) Declaration on the Protection and Promotion of Migrant Workers (2007) commits Member States to “Intensify efforts to protect the fundamental human rights, promote the welfare and uphold human dignity of migrant worker”<sup>277</sup> and “facilitate access to resources and remedies through information, training and education, access to justice, and social welfare as appropriate and in accordance with the legislation of the receiving state, provided that they fulfill the requirements under applicable laws, regulations and policies of the said state, bilateral agreements and multilateral treaties”.<sup>278</sup>

While not explicit in the Declaration, these obligations incorporate a human rights-based approach to migrants’ health, including access to HIV prevention and treatment services.

In 2011, the ASEAN adopted their version of a “Three Zeros” agenda in the ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero Aids-Related Deaths. It details specific commitments by the ten ASEAN countries to ensure that adequate financial resources are provided for scaling up evidence-based HIV prevention programmes for key populations at higher risk and vulnerability, which includes migrant and mobile populations, as well as people who use drugs, sex workers, men having sex with men and transgender people<sup>279</sup>.

The Asia-Pacific Economic Forum (APEC) has established the Health Working Group to address health-related threats to trade and security. Combatting the spread of HIV and AIDS in the APEC region is a defining priority. In this respect, APEC developed the HIV/AIDS Workplace Guidelines: Guidance on Migrant and Mobile Workers<sup>280</sup> to create an enabling environment for employers to implement effective workplace practices for PLHIV.

## Latin America and the Caribbean

The Organization of American States (OAS) Draft Resolution on the Promotion and Protection of Human Rights of People Vulnerable to, Living With, or Affected by HIV and AIDS in

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<sup>276</sup> The World Bank, IGAD Regional HIV/AIDS Partnership Program (IRAPP) Support Project 2007-2015, <http://www.worldbank.org/projects/P104523/igad-regional-hiv-aids-partnership-program-irapp-support-project?lang=en> [accessed 25 September 2017].

<sup>277</sup> ASEAN. 2007. *ASEAN Declaration on the Protection and Promotion of the Right of Migrant Workers*: Principle 5.

<sup>278</sup> Id. Principle 7.

<sup>279</sup> ASEAN. 2011. *ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths*: para. 9.

<sup>280</sup> Asia-Pacific Economic Cooperation (APEC) 2008. *APEC HIV/AIDS Workplace Guidelines: Guidance on Migrant and Mobile Workers*, HTF 07/2008A/11(Hanoi, 2008) [http://publications.apec.org/file-download.php?filename=WorkplaceGuidelines\\_08\\_hwg\\_HIV\\_wksp\(1\).pdf&id=624\\_toc](http://publications.apec.org/file-download.php?filename=WorkplaceGuidelines_08_hwg_HIV_wksp(1).pdf&id=624_toc) [accessed 25 September 2017].

the Americas, adopted in June 2013,<sup>281</sup> sets out recommendations for Member States, with particular attention to the gender perspective and stigma dimension associated with the epidemic. In the same session, the OAS issued another draft resolution specifically addressing the rights of the migrants, including migrant workers and condemning “forms of intolerance against migrants, among them those related to access to employment, professional training, housing, education, health care services.”<sup>282</sup>

Within the Caribbean Community (CARICOM) Single Market and Economy, the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) was established at the February 2001 Meeting of the CARICOM Heads of State and endorsed in the Nassau Declaration on Health 2001.<sup>283</sup> PANCAP aims to scale up the response to HIV/AIDS in the region. PANCAP’s membership includes member countries, United Nations agencies, bilateral and multilateral organizations, regional and international organizations, networks of people living with HIV, academic institutions, the private sector, and faith-based organizations.<sup>284</sup> Regarding migrants, PANCAP, in cooperation with EPOS Health Management (a provider of health sector consulting services), GIZ (a contractor) and key stakeholders in five countries, implemented the four-component PANCAP/GIZ/EPOS project on “Improving Access of Migrant and Mobile Populations to HIV Services in the Caribbean”.<sup>285</sup> The Andean Community in South America (Bolivia, Colombia, Ecuador, and Peru) adopted the *Convenio Hipólito Unanue*<sup>286</sup>, which is dedicated to health issues including HIV and AIDS.

<sup>281</sup> Organization of American States. *Promotion and Protection of Human Rights of People Vulnerable to, Living with, or Affected by HIV/AIDS in the Americas (Draft Resolution)*, AG/doc.5388/13, General Assembly, 43rd session, La Antigua, 2013.

<sup>282</sup> Organization of American States. *The Human Rights of Migrants, including Migrant Workers and their Families (Draft Resolution)*, AG/doc.5368/13, General Assembly, 43rd Session, La Antigua, 2013.

<sup>283</sup> The Caribbean Community (CARICOM). 2001. Nassau Declaration on Health 2001 (Nassau, 6 July 2011).

<sup>284</sup> IOM, WHO, and the Ministry of Health and Social Policy of Spain. 2010. *Health of Migrants-the Way Forward*, World Health Organization (Geneva 2010): 74.

<sup>285</sup> PANCAP: *Improving Access of Migrant and Mobile Populations to HIV Services in the Caribbean, 2010-2013* [https://pancap.org/pc/pcc/media/pancap\\_project/Presentation-Improving-Access-to-HIV-Services-for-Mobile-and-Migrant-Populations.pdf](https://pancap.org/pc/pcc/media/pancap_project/Presentation-Improving-Access-to-HIV-Services-for-Mobile-and-Migrant-Populations.pdf) [accessed 25 September 2017].

<sup>286</sup> Organismo Andino de Salud (OAS). 2007. *Instrumentos Juridicos, Convenio Hipólito Unanue* (ORAS-CONHU, Lima, 2007).







## Part 4. A Framework for Action

Migration, decent work, health and HIV are fundamental challenges for governance, for economic viability and for social cohesion in countries and communities worldwide. These four issues are inter-related. Migration has become an essential means of maintaining viable work forces in the growing number of countries facing population ageing, work force decline and vast changes in technology and the organization of work. Meanwhile, warfare, suppression of human rights and failed development are expelling millions of persons from their homelands, some recognized as refugees, others simply as “migrants”.

The lack of rights protection faced by many migrants permits abuse and exploitation at work and sustains poor living conditions. The non-realization of crucial employment, environmental and social determinants of health results in poor outcomes for these and other populations; their working and living conditions exacerbate risks of accidents and exposure to ill-health, including HIV.

Experience and analysis show that only comprehensive rights-based governance addressing coherently migration, decent work, health and HIV will resolve any of these challenges.

The responses to the HIV epidemic have shown that even in the face of daunting challenges, enormous success can be achieved when all stakeholders can participate in a comprehensive, coordinated response that focuses on fundamental rights. Only by taking a rights-based approach can the necessary measures to promote awareness of the rights of migrants and to ensure their protection be facilitated, so that communities and countries have the best tools to contribute to realize the highest attainable standard of health for everyone, and to halt HIV transmission everywhere.

The application of relevant international human rights and labour standards, their enforcement in national law and policy, and a host of practical actions are essential aspects of the environment needed to halt and reverse the epidemic. Only that recipe will provide the enabling environment for effectively governing migration, for ensuring decent work for all, and for realizing rights to health for everyone, these being essential components of preventing the spread of HIV.

Promotion of rights must also be associated with other efforts, in order to ensure effectiveness. For example, disaster risk reduction measures help ensure that populations are not repeatedly exposed to displacement and to an increase in HIV vulnerability. Sound immigration and integration policies that provide sufficient avenues for regularized migration are also essential. Multilateral action to prevent and resolve armed conflicts that today result in so many people being forcibly displaced from homes and homelands is also essential. Furthermore, it is crucial to incorporate understandings of the diverse circumstances of migrant and refugee populations.

The gap between international normative frameworks and their transposition into national law, as well as the gap between existing, appropriate national laws and their

implementation, are major impediments to upholding the rights of migrants. The creation of an enabling legal and policy environment is essential, and must be complemented by programmes ensuring access of migrant and mobile populations to HIV prevention, treatment, care and support.

Data needs to be disaggregated by sex, age and other characteristics. Situation and needs analysis are clearly necessary to plan and provide health and HIV prevention, treatment, care and support to migrant and mobile populations. Differentiated interventions built on such data should be set up. Outreach to these populations requires particular attention, commitment, political will as well as resource allocations by national public health systems, and by national administrative and parliamentary bodies. Furthermore, it is crucial to incorporate an understanding of the diverse circumstances that exist for different migrant populations. For example, certain kinds of sexual behaviour or drug dependency may increase reluctance to seek HIV services.

In particular, health and HIV prevention must be disassociated from immigration enforcement if migrants are to avail themselves of prevention, voluntary counselling and testing, and other services and support. If migrants fear repercussions as a result of seeking medical assistance, they are likely to refrain from getting the health care they need, resulting in negative outcomes for themselves and increased health risks for the communities in which they live. Where health care personnel are either required to request information on legal status or to report individuals suspected of being in an irregular situation, they cannot uphold their ethical, professional obligations to provide care. The public health and safety importance of ensuring ‘firewalls’ between provision of health and other social services and any immigration enforcement activity needs to be recognized. Every individual, regardless of their status, must have access to and be encouraged to avail themselves of health care attention and services without fear.

In order to properly address migrants’ needs regarding HIV and health, particularly the needs of migrant workers, relevant health services designed by governments, employers, trade unions or civil society organizations must be provided in appropriate languages and through settings that are accessible to them. Similarly, general health information, especially on HIV and AIDS, should be complemented with supplementary information responding to migrants’ broader concerns and priorities, as well as covering their families and communities. The aim should explicitly be to facilitate safer, rights-protected migration and life in destination countries as well as to implement better health care and services generally.

It is essential to address the situation of undocumented migrants and those working in the informal economy, who are an important category of concern in many countries. Given that they are difficult to track due to the nature of their situations, the response should focus on reaching migrants working in informal activity and those in undocumented situations through their workplaces and the communities where they reside.

#### **4.1 Governmental and Institutional Commitment**

Recognition of migrant health concerns and extension of health protection to migrants, including on relevant HIV issues, requires particular and urgent action by those most concerned: public health actors, migration officials, health practitioners, social partner and civil society advocates, legislators, and migrants themselves. This will depend to

a great extent on strengthening the commitment of governments towards migrant and mobile populations, including coordination between the ministries concerned, especially those responsible for health and labour, as well as those addressing interior/home affairs, social protection, family and other relevant areas. Recognition and extension of health protection to migrants also requires the allocation of resources for training officials, developing materials, and providing prevention and treatment services. Provision of health services should, however, be clearly distinguished from enforcement of immigration law.

Inclusion, participation and freedom of association are essential pillars for effective action on migration, health and HIV. Participation by key stakeholders including migrants as well as social partners in policy, decision-making and practice concerning them is crucial. It is indispensable for migrant communities and their representatives as well as public authorities to be informed of migrants' and refugees' rights and to be empowered to realize them. Attention should be paid to enhancing public understanding of and respect for migrants' rights through communication and education, and by enlisting the cooperation of employers' and workers' organizations and other civil society organizations.

## 4.2 Defining the Framework for Action

This framework for action is designed to highlight, for all stakeholders working at the intersection of migration, health and HIV issues, the key mechanisms for ensuring that migrants' rights, their dignity and their health are protected, thereby contributing to HIV reduction. This framework comprises an extensive agenda for action on migration, health and HIV. It demonstrates that there are no simple solutions or "quick fixes" in any of these areas, let alone to their complex inter-relationships, but rather that a holistic approach is needed.

This framework for action derives from the global knowledge base and international standards, as well as formal policy guidelines established by authoritative international conferences, inter-governmental consultations and civil society entities, including the 2nd Global Consultation on Migrant Health: Resetting the Agenda<sup>287</sup> held in Colombo, Sri Lanka in February 2017. It includes approaches and elements well established in the different arenas concerned: migration governance, human rights, labour, gender equality, social protection, health, HIV and AIDS, refugees and internally displaced persons (IDPs), mobile workers, and populations facing specific risks. The framework is also shaped by the concrete experience of hundreds of practical actions, measures and programmes worldwide, some 70 of which are set out below.

The framework is divided into ten subjects, addressing the inter-related aspects of HIV prevention and care, migration and health:

- *human rights*
- *migration governance*
- *social protection*
- *public health policy*

<sup>287</sup> Consultation jointly organized by IOM, WHO and the Government of the Democratic Socialist Republic of Sri Lanka.

- *working conditions and occupational safety and health*
- *law and policy development*
- *ensuring access to HIV services*
- *specific actions for refugees, and IDPs*
- *specific approaches for mobile workers*
- *segments of migrant populations at particular risk*

Each topical section contains a summary of Key Actions on each theme, reflecting the multifaceted nature of dealing with each of those thematic areas. Some action points overlap across different themes, and this is retained to emphasize essential elements of this comprehensive agenda applying across different components.

Several key principles are highlighted separately at the outset because they are crosscutting, applying across all of the ten topics. These approaches are both substantive and procedural in nature. Each subject contains a section on current initiatives and experiences that could guide be adapted, or provide inspiration and guidance at national or regional levels.

### ***Cross-cutting key principles for action:***

**A. Upholding inclusion, participation and freedom of association.** All policy and action should explicitly advocate migrants' inclusion in communities where they reside and their full participation in the formulation, implementation and evaluation of policies and practices concerning them. Policy and advocacy should likewise uphold full respect for freedom of association rights, including for migrants. Building a positive and enabling policy environment requires *involving the key stakeholders in policymaking and practice*, particularly the social partners – employers in both the private and public sectors and workers' organizations – as well as migrant workers, civil society and other partners. Comprehensive HIV and AIDS workplace policies developed through social dialogue between government, workers' and employers' organizations and, particularly, migrant workers, lead to better health and safety outcomes.

**B. Complying with relevant international law and standards.** Relevant international human rights conventions and labour standards, particularly those concerning migration, health and HIV and AIDS, provide the foundation for and should be adhered to in the development of national legislation, policies and practices. Laws and policies should address migrant issues directly and should not contain any provisions that impede access to rights or entitlements.

**C. Incorporating gender analysis.** Migration and health policies and practices, in particular those addressing HIV and AIDS, should be gender-responsive and seek to address unequal power relations between women and men, and promote women's empowerment to reduce the specific risks women may face during the migration process and in destination countries, and to decrease the risk-factors for women partners and children remaining in

home countries. Gender analysis should be undertaken of all policies and practices at the conception phase, through to implementation, monitoring and evaluation.

**D. Addressing discrimination and stigma.** Legislation, policies and practical measures on migration, health and HIV and AIDS should explicitly uphold and implement the principles of non-discrimination and equality of treatment. Health facilities, goods and services should be accessible to all, including all migrant workers and their families, especially migrants with HIV, without discrimination based on gender, sexual orientation, nationality, race, colour, migratory status or other factors. Laws and policies should ensure that real or perceived HIV status is not a ground for discrimination, preventing the recruitment or continued employment of a migrant worker, or the pursuit of equal opportunities, nor should it lead to termination of employment. Legislation, regulations and administrative practices that provide for entitlements such as social protection should not contain provisions or utilize measures that could impair migrants' access to social protection.

**E. Facilitating communication and respect.** Particular attention is required in policy and in practical measures concerning health and HIV and AIDS –including testing-- to facilitate communication in languages migrants concerned can understand. Complementary to this is facilitating their access to language training in host community/country languages. Appropriate facilities and programmes as well as the personnel concerned should be respectful of and responsive to cultural differences to ensure that all migrants—especially women and children – obtain full access to health services and social protection enabling their realization of the right to health and health-related rights.

### 4.3 Protecting Human Rights and Labour Rights of All Migrants

Recognizing and effectively protecting the human rights, including labour rights, of all migrants is a necessary foundation for all national and local law, policy and practice regarding migration. These rights are defined in international legal standards intended to serve as the basis for national law, policy and practice in all countries. The application of these international standards has been further elucidated in the context of evolving circumstances and country specific application by international treaty bodies and international courts.

Respect for, realization of, and enforcement of these rights is guaranteed by their enactment in national law. Non-binding codes and general commitments to rights are unlikely to ensure respect and compliance in the face of powerful economic, political and social pressure for non-protection, abuse and exploitation. Effective realization of rights of all migrants requires their enactment in national legislation. Ratification and domestication of international Conventions in national law establish the binding –and accountable – basis for their implementation in policy and practice and their enforcement by legal, judicial and political means.

Transparent national legal and policy frameworks ensuring full respect for human and labour rights in countries of origin, transit and destination are essential to realize the right to health and health-related rights for all migrants. Such frameworks require inclusion of deliberate measures to reduce the risks of migrants to HIV exposure and to ensure

their access to HIV information and services. Promoting ratification and implementation of international treaties, including fundamental labour Conventions, the protection of migrants' rights, and the elimination of forced labour, human trafficking and child labour are essential.

National frameworks should ensure a positive and enabling legal and policy environment at national and local levels, making explicit reference to the rights of migrant populations or the rights of all people without distinction on the basis of nationality, country of origin, ethnicity, religion, residential status, as well as gender identity or sexual orientation. Relevant rights include access to information and education, health services, social security and occupational safety and health, and food security.

However, obtaining effective realization of human, labour and health-related rights for migrants requires extensive advocacy as well as direct practical action. Key elements for this agenda follow.

## Key Actions:

**A. Protect the human rights, including labour rights, of all migrants.** Ensure recognition of rights through the ratification and implementation of the ILO fundamental Conventions<sup>288</sup> and international Conventions specifically addressing the rights of migrant workers, namely the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, the Migration for Employment Convention (Revised), 1949 (No. 97), the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) and the Domestic Workers Convention, 2011 (No. 189), and actively promote ratification and application by organizing campaign coalitions among labour, human rights, women's, health rights, humanitarian, faith-based and other groups. Actions may include national public education activity and promotional dialogue and advocacy with Parliament to obtain ratification. Attention should also be directed to ratification and implementation of international instruments on rights at work, health-related rights and social protection.

**B. Incorporate fully international standards into national legislation.** Promote the full application of relevant international and regional human rights and labour standards by incorporating all of their provisions into national law and repealing or modifying national legislation or regulations that impede migrants from fully exercising their human and labour rights including health-related rights. This may require careful review of national legislation and concerted advocacy to *mind the gaps*.

**C. Engage in direct support, advocacy and training to implement international standards and relevant national legislation 'on the ground'.** Organize practical action along with policy advocacy and training to support and implement rights protection. Actions can include supporting migrant access to legal assistance, social services and health care, as well as providing counselling, *know your rights* training in both pre-departure and host

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<sup>288</sup> Namely the Conventions on non-discrimination, forced labour, child labour and freedom of association set out in Part 3.

country settings, support for migrant worker grievance claim procedures, and support in legal proceedings.

**D. Provide for effective enforcement.** Provide for effective application and enforcement of national laws and regulations in accordance with international human rights and labour standards and applicable regional instruments. In particular, ensure that labour inspection and occupational safety and health supervision effectively reaches migrant workers and that enforcement procedures are accessible. Provide training for personnel engaged in law enforcement, immigration, the judiciary, and labour inspection as well as policy makers and other government officials concerned on application of human and labour rights law to migrants and ensure migrants' workers have effective access to remedies.

**E. Ensure gender equality.** Gender equality should be an objective of national legislation, and the active participation of all migrants--men, women and transgender individuals, regardless of sexual orientation—should be encouraged in all spheres. Focus should be on specific challenges, aspirations, needs and vulnerabilities of female migrant workers and female members of migrant workers' families including by taking action to prevent, respond to and prohibit sexual harassment in workplaces and prevent sexual violence and exploitation.

**F. Guarantee freedom of association.** Governments at all levels, employers, trade unions and other stakeholders should guarantee that migrant workers enjoy freedom of association by supporting the formation of workers' associations by migrant workers and their inclusion in existing trade union organizations.<sup>289</sup> Support can be provided for the self-organization and participation by migrants in employers/entrepreneurs organizations, community and youth associations, cultural groups, sports clubs, women's associations, and other civil society organizations.

**G. Focus on children and youth.** Protect migrant children and young persons including through attention to ensuring their access to social protection, health care, schooling and vocational/professional training, proper nutrition and decent living conditions. Ensure that all policies and practices implement the universal principle of the best interests of the child. Combating child labour and child trafficking should be a particular focus from a legislative, policy and enforcement standpoint, in accordance with the ILO Declaration on Fundamental Principles and Rights at Work, 1998, the Minimum Age Convention, 1973 (No. 138) and the Worst Forms of Child Labour Convention, 1999 (No. 182). States should also take measures to protect migrant children from sexual exploitation and abuse.

<sup>289</sup> Relevant Conventions are: Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87) and the Right to Organise and Collective Bargaining Convention, 1949 (No. 98).



### 4.3.1 Initiatives and Experiences on Protecting Basic Human Rights and Labour Rights of Migrants and their Families

#### The Steering Committee for the Global Campaign for Ratification of the International Convention on Migrant Workers' Rights

**Context:** *The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* (ICRMW) (1990) is one of the fundamental human rights Conventions. It provides a broad legal foundation for governance of migration at national and local levels. In defining the application of and protection under fundamental human rights for all migrant workers and members of their families, the ICRMW outlines obligations of States Parties regarding medical care and health services. However, in 1998, eight years after adoption by the UN General Assembly, the instrument had little attention and only eight ratifications.

**Purpose and Objectives:** The *Global Campaign for Ratification of the Migrants Rights Convention* was launched in 1998 by the Steering Committee, a broad, multi-sectoral coalition of international agencies, global unions, international faith-based, women's, racial justice, human rights and migrant organizations, to proactively organize promotional activities, mobilize multiple constituencies, and support national ratification efforts.

**Activities:** The *Steering Committee* focused on giving visibility to the ICRMW, organizing promotional events and fostering national ratification campaigns. It mobilized its participating organizations to conduct side-event forums at international conferences, at UN and other human rights bodies and at other international intergovernmental, civil society and academic forums. It identified *target* countries for promotion, encouraged constituents to organize national ratification coalitions, and mobilized international and national advocacy as well as technical support for ratification. The Steering Committee provided crucial encouragement, support and coordination for constituents to communicate and work with their respective national authorities and the media, mobilizing public opinion and supporting governments and parliaments to ratify the Convention. Steering Committee participating organizations, namely ILO, IOM and OHCHR, cooperated in providing technical advice and assistance to governments and legislative bodies, e.g. reviewing legal and legislative implications of incorporating the Convention standards in national law, reviewing draft legislation, providing guidance, and sharing good practice examples on administrative mechanisms and institutions for implementing the Convention.

**Outcomes:** The initiation of this Steering Committee activity coincided with a dramatic increase in ratifications and signatures, from one to four per year over a decade, allowing the Convention to enter into force in 2003 with the requisite 20 ratifications, and subsequently to achieve the current total of 51 States Parties and 16 additional signatories pending ratification.<sup>290</sup> The Steering Committee existence and activity contributed to making the Convention and its content a defining reference in international discourse and practice on migration governance.<sup>291</sup>

<sup>290</sup> As of 19 September 2017. Current list of ratifications and signatories at: [https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg\\_no=IV-13&chapter=4&clang=en](https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-13&chapter=4&clang=en).

<sup>291</sup> OHCHR. 2009. *Guide on Ratification: International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* (Geneva, 2009). <http://www.ohchr.org/Documents/Press/HandbookFINAL.PDF> [accessed 22 September 2017].

### Pourakhi Organization, Nepal

**Context:** Lack of employment in Nepal and growing role of women in economically supporting their families has led women to leave the country to take up employment abroad. Gender inequalities persist in Nepal and destination countries, limiting women's access to services, to decent work and to control over productive resources.

**Purpose and Objectives:** *Pourakhi* – meaning “self-reliant” in Nepalese – was founded in 2003 with the support of UN Women to promote respect for the rights of women migrant workers throughout the entire process of migration from pre-departure to post-return support programs.

**Activities:** Pourakhi runs a hotline providing psychosocial, legal and medical counselling to women migrant workers. It offers reintegration programmes with entrepreneurship training for return migrants and a Child Education Fund to support the children of exploited migrant workers. It has been active in lobbying for the rights and entitlements of women migrant workers both at home and abroad. *Pourakhi* developed a partnership with the Pravashi Nepali Coordination Committee, which maintains a large network among Nepali migrant workers across Gulf countries, to work with Nepalese embassies to provide support for the rescue and repatriation of Nepali women in abusive situations. It also operates an emergency shelter in Kathmandu.<sup>292</sup>

### HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals

**Context:** HIV-related stigma and discrimination in employment and occupation requires action in and through the workplace. This is especially true for reaching key and vulnerable groups – among which are migrants – at higher risk of HIV transmission and less likely to access HIV-related prevention, treatment, care and support services. Rights-based national and international policies and legislation exist and are enforced through labour courts or other national dispute resolution mechanisms in order to facilitate reliable, accessible and adequate redress for HIV-related human and labour rights violations.

**Purpose and Objectives:** The ILO published the *HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals* in 2015, with the purpose of assisting judges, judicial training institutions and legal professionals in addressing HIV- and AIDS-related matters in the world of work. The material is explicitly rooted in the ILO *HIV and AIDS Recommendation, 2010 (No. 200)* and other international labour standards, and sets out some examples of national legal decisions and frameworks.

**Content:** The Handbook contains twelve modules and an accompanying CD-ROM providing an overview of concerned populations, existing instruments and institutions and the role of judges and legal professionals in protecting the labour rights of those living with or affected by HIV or AIDS. The last module provides a sample three-day training course programme, activities and case studies to encourage practical and continuous learning.<sup>293</sup>

<sup>292</sup> UN Women. 2012. *Supporting women workers towards a safer migration journey*, in UN Women (website): <http://www.unwomen.org/en/news/stories/2012/12/supporting-women-workers-towards-a-safer-migration-journey>.

<sup>293</sup> ILO: *HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals* International Labour Organization (Geneva, 2013).

### National legislation for the Protection of Domestic Workers in Jordan

**Context:** Jordan is a country with a significant domestic employment sector; many domestic workers are women migrants. As in other countries, women domestic workers were reported to be commonly subject to exploitative working conditions and to abusive situations. In 2009, Jordan became the first among the Arab States to amend its Labour Code to provide protection for domestic workers. The legislative amendment provided a foundation for legally recognizing and protecting the rights of domestic workers – many of whom are migrant workers.

**Purpose and Objectives:** Regulation No. 90 of the revised Labour Code incorporates and clarifies rights and entitlements to protect domestic workers, cooks, gardeners and similar workers. Previously, in 2003, the Government adopted a uniform standard working contract for all migrant domestic workers including provisions for employers to pay workers' travel costs; to provide work and residence permits; life and accident insurance; suitable accommodation and meals; clothing and medical care; and no restrictions on workers' communications and correspondence.

**Activities:** To render the legislation effective, information was disseminated to raise employer and worker awareness on the new protections and consequences of violations. Complaint mechanisms have also been established to enforce these initiatives. Tough enforcement mechanisms enhance the accountability of recruiters and employers according to their statutory and contractual obligations with regards to domestic workers.<sup>294</sup>

### Joint United Nations Statement on Ending Discrimination in Health Care Settings, 2017

**Context:** The Statement<sup>295</sup> is the result of the joint efforts by the UNAIDS co-sponsors, including the ILO, to address discrimination in health care settings. At the core of this statement is that discrimination in health care settings often affects the most marginalized groups. The Statement also reflects the spirit of the Agenda 2030, which calls for Member States not to leave anyone behind. The statement acknowledges the multiple and intersecting forms of discrimination, including based on age, sex, race or ethnicity, health status, disability or vulnerability to ill health, sexual orientation or gender identity, nationality, *asylum or migration status*, or criminal record.

**Purpose and Objectives:** UN Agencies commit to “targeted, coordinated, time-bound, multisectoral actions” in the areas of:

- Guarantees against discrimination in law, policies, and regulations
- Measures to empower health workers and users of health services focusing on their rights, roles and responsibilities
- Accountability and compliance with the principle of non-discrimination in health care settings
- Implementation of the United Nations Shared Framework for Action on Combating Inequalities and Discrimination

<sup>294</sup> The Protection Project at The Johns Hopkins University. 2013. *100 Best Practices in the Protection of Migrant Workers* (Baltimore, MD: The Protection Project at The Johns Hopkins University, 2013): 13.

<sup>295</sup> UNAIDS. 2017. Joint United Nations Statement on ending Discrimination in Health Care Settings. [http://www.unaids.org/sites/default/files/media\\_asset/ending-discrimination-healthcare-settings\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf) [accessed 25 September 2017].

### Centro de los Derechos del Migrante, Mexico-United States

**Context:** Several million Mexican citizens work permanently or seasonally in agriculture in the United States. Migrant farm-workers in the United States commonly experience sub-standard working conditions and abuse in workplaces and they face threats of retaliation that constrain raising complaints. It is often easier to reach migrating farm-workers before they leave Mexico to inform them about their rights and about problems in working conditions they may face.

**Purpose and Objectives:** Founded in 2005 and based in Mexico, the *Centro de los Derechos del Migrante, Inc. (CDM)* aims at improving the conditions of low-wage Mexican workers in the United States by providing a space for migrant workers to share experiences and learn about their rights, especially concerning occupational safety and health, prior to departure from Mexico. The Centre has received grants from the Initiative for Public Interest Law at Yale University and Stanford University's Public Interest Law Foundation. The Centre initially opened its doors in Zacatecas and currently has its headquarters in Mexico City with offices in Juxtluaca and Oaxaca in Mexico and Baltimore, United States.

**Activities:** CDM hosts pre-departure educational workshops entitled "*Know Your Rights*" to prevent workplace abuses in the United States. These workshops address laws on wage and working hours, health and safety regulations, and non-discrimination laws. Since 2014, it has worked with *Radio Bilingüe*, a Latino public radio based in California, to produce the *Voy Contratado: Migrant Rights on Radio* series with educational messages, feature stories and news reports on the rights and experiences of guest-workers and other transnational migrant workers. CDM also files legal claims for recovery of unpaid wages and initiates strategic litigation to establish legal precedents and foster policies to protect migrants

**Outcomes:** Since its creation, CDM has met with more than 6,000 people in 23 States across Mexico and collaborated with workers and allies to recover more than five million dollars to compensate for unpaid labour. Its litigation in the United States has established several important legal precedents improving protection of migrants' rights.<sup>296</sup>

**Website:** <http://www.cdmigrante.org/?s=health>

## 4.4 Migration Governance: Ensuring Regulated and Fair Migration

Experience worldwide shows that an explicit, coherent and comprehensive national migration policy framework is essential for effective governance of migration to ensure appropriate regulation of migration, integration of migrants in labour markets and communities, and to maintain social cohesion. The ILO *Multilateral Framework on Labour Migration: Non-binding principles and guidelines for a rights-based approach to labour migration* provides particularly relevant, experience-based guidance for comprehensive policy and administration on migration.

<sup>296</sup> The Protection Project at The Johns Hopkins University, 2013. *100 Best Practices in the Protection of Migrant Workers* (Baltimore, MD: The Protection Project at The Johns Hopkins University, 2013): 106. For additional information see website: <http://www.cdmigrante.org/about-cdm/organizational-background-history/> [accessed 25 September 2017].

It is not enough for laws and guidelines to exist: prospective migrants require access to information and services designed to prepare them for migration and to empower them to avoid or overcome exploitation, thereby making migration fairer and safer. When migration is fair and safe, and rights are respected, HIV vulnerability is reduced. Furthermore, supporting the integration of migrants into the workforce as well as into the communities in which they reside elevates the level of social cohesion within society as a whole. This too contributes to a reduction in overall health risks, including risks of exposure to HIV.

### Key Actions:

**A. Create comprehensive and integrated national legal and policy frameworks.** Formulate and implement coherent, comprehensive, transparent national and regional legal regimes and policy frameworks to govern migration effectively; ensuring coherence between migration, health, social protection, employment, education, public safety, security and other policies across government – recognizing that most ministries and departments address migration/migrant-related concerns. Ensure that these policy frameworks are based on and comply with international human rights and labour standards and other relevant international instruments and agreements. Organize broad stakeholder consultations in elaborating frameworks, including all relevant ministries and departments across government and include representative social partners, civil society and migrant-refugee community participation in the design and implementation.

**B. Increase legal migration channels.** Expand avenues for regular migration, taking into account labour market needs at all skill levels, specific labour force and demographic trends, and family considerations, as well as concerns of recruitment, transit, reception, legal and social protection and integration, and for return and reintegration where relevant. This entails enhancing international dialogue and cooperation towards bilateral and multilateral migration arrangements.

**C. Implement free movement regimes.** Advocate for and support the full implementation of regional free movement accords where they exist or are being elaborated. Ensure respect for human and labour rights, including equality of treatment, and full access to and portability of social protection.

**D. Combat trafficking in persons and forced labour.** Governments should formulate and implement measures to prevent trafficking in persons and forced labour while ensuring protection for victims.

**E. Facilitate informed and fair migration.** In both origin and destination countries, provide men and women migrant workers with guidance, including pre-departure and post arrival health-related training and orientation programmes, through all stages of migration, including planning and preparing for migration, transit, arrival and integration, and, where relevant, eventual return and reintegration. In both countries of origin and destination, migrants should have access to gender-responsive guidance that helps them plan and prepare for all stages of migration.

**F. Adopt fair recruitment policies.** Design and implement measures to enable public health systems in both origin and destination countries to train and retain health workers

as well as to reduce the depletion of the health work force in developing countries. Promote improved working conditions, respect for occupational safety and health, adequate remuneration, and HIV-specific education and training for health workers. Advocate for international development assistance support for enhanced training opportunities and employment conditions to retain health workers in concerned countries.

**G. Regulate recruitment and placement.** All entities that recruit and place migrant workers should be licensed and supervised in accordance with the Private Employment Agencies Convention, 1997 (No. 181) and the Private Employment Agencies Recommendation, 1997 (No. 188), the Forced Labour Convention, 1930 (No. 29), Protocol of 2014 to the Forced Labour Convention, 1930, and its accompanying Forced Labour (Supplementary Measures) Recommendation, 2014 (No. 203), and the ILO Fair Recruitment Initiative.

**H. Prevent and address xenophobia and discrimination.** Strengthen and enforce anti-discrimination legislation in accord with international standards –in particular the ILO Discrimination (Employment and Occupation) Convention, 1958 (No. 111), and the International Convention on the Elimination of All Forms of Racial Discrimination. Promote inclusion of nationality as a prohibited ground of discrimination in national law. Strengthen monitoring institutions as well as public education against racism and xenophobia. Engage legal prosecution of hate speech, as well as acts of racial and xenophobic violence. Incorporate anti-discrimination and anti-xenophobic discourse and measures in all programmatic and practical activities.

**I. Recognize the contributions of migration to employment, economic growth, development and alleviation of poverty for both origin and destination countries.** Enhance research and documentation of relevant roles and contributions of migrants and migration; *change the narratives*; advocate for and support accurate, evidence-based media reporting and public education.

**J. Prioritize collection and application of data and knowledge.** Advocate for and contribute to the collection, analysis, dissemination and utilization of sex and age disaggregated data across relevant migration, employment, education, health, social protection and other indicators. Contribute to developing a global knowledge base on migration, health, and HIV and AIDS.

#### 4.4.1 Initiatives and Experiences on Migration Governance: Ensuring Regulated Migration and Integration

##### **Monitoring the WHO Global Code of Practice on International Recruitment of Health Personnel in the Philippines**

**Context:** The health workforce is central to the functioning of health systems everywhere and consequently to global health. International migration of health workers has demonstrably weakened health systems in some countries; it has undermined public health planning and it has eroded current

and future health skills bases in countries experiencing significant emigration of health workers. The *WHO (World Health Organization) Global Code of Practice on the International Recruitment of Health Personnel* adopted in 2010 aims to establish and promote voluntary principles and practices for the fair international recruitment of health personnel and to facilitate strengthening of affected health systems.

**Purpose and Objectives:** In 2012, the Department of Health of the Philippines initiated a monitoring process with multiple stakeholders, to assess the implementation of the WHO Global Code in the country.

**Activities:** Five groups were identified in the Philippines as key stakeholders in the Code's implementation: the Government, trade unions, employers' organizations, recruitment agencies, and professional associations. A worksheet was developed to facilitate understanding of the Code and the National Reporting Instrument (NRI); and to collect supplementary information that addressed the gaps in the NRI. Preliminary awareness raising sessions on the WHO Code and fair recruitment were organized for each group of stakeholders before they completed the NRI and supplementary tool. A draft joint report combining the inputs of each stakeholder group was produced and discussed in a multi-stakeholder meeting. The information collected was evaluated and included in the final report presented to the WHO.

**Outcomes:** The monitoring process helped increase knowledge in the Philippines of the WHO Code, of fair recruitment, and of the roles and responsibilities of each stakeholder to promote fair recruitment through a genuine social dialogue process. The reporting model applied in the Philippines has been shared and discussed in various international forums as an example of a good practice.<sup>297</sup>

### **AVERROES Project: Equal Access to Healthcare**

**Context:** The European Union, under the Spanish EU presidency in 2010, considered migration one of the key themes related to health inequalities. It supported enhancing action in this field through the *Second Programme of Community Action in the Field of Health 2008-2013*. On March 2011, in the *Resolution on Reducing Health Inequalities in the EU Member States* were called to tackle health inequalities in access to health care for undocumented migrants. States were to “ensure that the most vulnerable groups, including undocumented migrants, are entitled to and provided with equitable access to healthcare” and to “assess the feasibility to support healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined by their national legislation...”

**Purpose and Objectives:** The AVERROES Project: Equal Access to Healthcare funded by the EU public health programme and run by the Médecins du Monde organization aimed to improve access to healthcare for asylum seekers and undocumented migrants in the EU.

<sup>297</sup> ILO: *Monitoring of the WHO Global Code of Practice on the International Recruitment of Health Personnel: The Philippine Multi-Stakeholder Approach* (30 April 2015). [http://www.ilo.org/dyn/migpractice/migmmain.showPractice?p\\_lang=en&p\\_practice\\_id=101](http://www.ilo.org/dyn/migpractice/migmmain.showPractice?p_lang=en&p_practice_id=101) [accessed 25 September 2017].



**Activities:** The project supported the development of a network of non-governmental organizations called *Health for Undocumented Migrants and Asylum Seekers (HUMA)*, offering this population direct access to healthcare in 16 countries in the EU. Furthermore AVERROES published three reports on migrant health, organized conferences and put up a dedicated website to increase knowledge and awareness on the state of the health of migrants and asylum seekers and barriers to healthcare.

**Outcome:** Among the results of the AVERROES efforts, over 140 European organizations representing over 3 million health professionals signed a declaration against discriminatory access to healthcare.

## 4.5 Supporting Decent Working Conditions and Occupational Safety and Health

Migration today is about work. Nearly all migrants of working age intend to engage in remunerative activity, are working, or have been engaged in employment in a country or countries outside that of their birth or citizenship. All are thus concerned by the working environment, the conditions of work and especially health and safety at work.

The working environment should be decent, safe and healthy for all migrant workers. Measures domesticating and implementing relevant ILO Conventions need to be adopted to ensure that all migrant workers benefit from decent working conditions as well as occupational safety and health (OSH) protection in law and practice.<sup>298</sup> Specific measures are needed to address the specific risks in certain occupations and sectors, particularly agriculture, construction, mines, hospitality, and domestic work.<sup>299</sup> Such measures should ensure equality of treatment and protection for all workers and incorporate gender perspectives that address the specific risks faced by women, including in relation to HIV and AIDS.

HIV-specific policies and interventions for migrant workers should be linked to national policies that are multi-sectoral, comprehensive, and designed to give strategic attention to employment while ensuring that migrant workers and their families are recognized as resident members of host societies and communities.

Workplaces are also a primary point of entry for reaching people, particularly migrant workers, to provide information on HIV and AIDS, to facilitate HIV prevention, and to link them to care and treatment services.

<sup>298</sup> Particularly relevant Conventions include: the Occupational Safety and Health Convention, (No. 155) 1981, and Recommendation 164, 1981, the Occupational Health Services Convention, 1985 (No. 161); the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187), and Recommendation 197, 2006.

<sup>299</sup> Relevant conventions include: Nursing Personnel Convention, 1977 (No. 149); Safety and Health in Construction Convention, 1988 (No. 167); Working Conditions (Hotels and Restaurants) Convention, 1991 (No. 172); Safety and Health in Mines Convention, 1995 (No. 176); and Safety and Health in Agriculture Convention, 2001 (No. 184) as well as the recent Decent Work for Domestic Workers Convention, 2013 (No. 189).

## Key Actions:

**A. Defend decent work for all workers including migrants.** Ensure the domestication and implementation of all relevant international labour standards including occupational safety and health standards, with explicit coverage of migrant workers. Promote the inclusion of equal treatment of and decent work for migrant workers in collective agreements. Encourage attention by and cooperation among government institutions, trade unions, employers' organizations, and civil society organizations on decent work, occupational health and safety, equality of treatment, and HIV concerns regarding migrant workers.

**B. Establish effective occupational safety and health policies and programmes.** Adopt and enhance national policies and programmes to promote occupational safety and health and occupational safety and health standards for migrant workers, including with a specific focus on HIV and AIDS. Participation by employers and workers, members of the health sector, and organizations representing people living with HIV (PLHIV) and migrants' associations should be included in the development of policies and programmes.

**C. Ensure decent work and occupational safety and health mechanisms are comprehensive.** Promote the effective implementation and supervision measures engaging governments, employers' and workers' organizations to ensure that decent working conditions as well as prevention, safety and health are provided for in accordance with relevant international labour standards. and international legal instruments. Ensure that safety and health measures to prevent migrant workers' exposure to HIV at work include universal precautions, accident and hazard prevention measures, such as organizational measures, engineering and work practice controls, personal protective equipment, as appropriate, environmental control measures and post-exposure prophylaxis and other safety measures to minimize the risk of contracting HIV and tuberculosis, especially in occupations most at risk, including in the health-care sector.

**D. Extend labour inspection to workplaces where migrants are employed.** Support adequate and effective labour inspection and occupational safety and health supervision at workplaces and in sectors where migrants are employed, including in the informal economy. Advocate for appropriate training of labour inspectors to address the specificities of migrant/foreign worker employment, their rights, and related working and living conditions issues.

**E. Provide training for labour inspectors, occupational safety and health personnel, and public health monitors.** Establish or strengthen existing training for personnel engaged in labour inspection, occupation safety and health and public health monitoring to address the specific issues of migrant workers and their family members. Ensure that such training deals with the following: multiple grounds of discrimination; the particularities of application of labour standards to migrant and mobile workers; and related factors such as housing conditions, access to appropriate food, and availability of health care facilities in situations of isolated working-living sites in agriculture, construction, mining, etc., or employer-provided housing.

**F. Address HIV in the workplace and disseminate information widely about HIV and health at work.** Promote and contribute to the dissemination of information on HIV, health and occupational safety and health policies and programmes as widely as possible to reach workers, employers and the public. Address HIV through occupational health services and other relevant workplace mechanisms related to occupational safety and health. Ensure

that all workers including migrant workers receive education and training on modes of HIV transmission and measures to prevent exposure and infection, and are encouraged to seek voluntary and confidential counselling and testing for HIV. Ensure that information circulated addresses misconceptions about HIV and AIDS, health wellbeing and practices, and correct information about occupational exposure.

**G. Ensure that HIV-related illness is treated equitably.** Policymakers and employers should ensure that migrant workers who are temporarily absent from work because of illness related to HIV or AIDS are treated in the same way as workers who are absent for other health reasons, and that migrant workers with HIV-related illnesses are not prevented from continuing to carry out their work for as long as they are medically fit to do so.

#### 4.5.1 Initiatives and Experiences on Supporting Decent Working Conditions and Occupational Safety and Health (OSH)

##### National Guideline to Prevent and Address HIV in the World of Work, Costa Rica

**Context:** The world of work is central to migration and it plays a key role in addressing HIV and AIDS, as it is an entry point to reach populations facing particular risks such as migrant workers. The development and implementation of workplace policies and programmes on HIV and AIDS may considerably facilitate access to prevention, treatment, care and support for workers and their families. **Costa Rica** has recognized the importance of incorporating HIV and AIDS concerns into its labour legislation.

**Purpose and Content:** Through the national guideline entitled “*Prevention and Management of HIV in the World of Work*”, Costa Rica sought to introduce HIV and AIDS into national occupational safety and health programmes. These guidelines were the product of a multi-sectoral process undertaken in 2009 by the National Council of Occupational Health and Safety and the ILO, with support from the Pan-American Health Organization. The national guidelines require the inclusion of HIV- and AIDS-related information in workplace occupational health and safety programmes. Amendments to the national Labour Code included non-discrimination, access to information, prevention, and availability of relevant health services at work and post-exposure prophylaxis. A participatory process with the occupational safety and health committee and with HIV and AIDS NGOs led to the establishment of a human rights framework which mainstreamed gender equality and sexual diversity.

**Activities:** A toolkit was created to facilitate the guideline’s implementation at the workplace and to assist occupational safety and health committees in designing and implementing effective HIV workplace programmes.<sup>300</sup>

<sup>300</sup> ILO: *Integrating HIV and AIDS in Occupational Safety and Health Programmes: the Costa Rican Experience* (1 July 2010). [http://www.ilo.org/aids/good-practices/WCMS\\_159837/lang-en/index.htm](http://www.ilo.org/aids/good-practices/WCMS_159837/lang-en/index.htm) [accessed 25 September 2017].

### **Strengthening Labour Inspection: Africa, Eurasia, Latin America and Caribbean**

**Context:** Labour inspection, and implementing labour inspectorates are a key means of monitoring, upholding and enforcing labour standards, notably regarding occupational safety and health, at workplaces. Labour inspection can be an especially effective means of extending occupational safety and health protection and decent working conditions for migrant workers. Spurred by the ILO-AIDS programme work and the ILO HIV and AIDS Recommendation, 2010 (No. 200), addressing HIV and AIDS has increasingly become an important component of labour inspection and in training of labour inspectors.

**Purpose and Objectives:** To support implementation of HIV and AIDS Recommendation, 2010 (No. 200) and to specifically enhance the knowledge, roles and engagement of labour inspectorates regarding HIV and AIDS workplace awareness and prevention, ILO and the ILO International Training Centre (ITC) in Turin developed HIV and AIDS components for the training programs and modular training manuals. The support also targeted labour inspectors in countries in Africa, the Caribbean, Eurasia and Latin America for HIV-focused training and national strategies to advocate for and implement HIV and AIDS legislation and workplace responses.

**Activities and Outcomes:** In **Paraguay** and **Mozambique**, occupational safety and health inspectors have been targeted for training. In **China**, 555 labour inspectors have been trained so far to facilitate implementation of HIV and AIDS legislation and policies. In their visits to companies, labour inspectors respond to workers' complaints and give guidance on how to better comply with the law.

Several **Caribbean** region countries benefited from similar training programmes, including **Barbados**, **Belize**, **Jamaica**, **Suriname**, and **Trinidad and Tobago**. Labour inspectors in the **Dominican Republic** and **Honduras** also received training on HIV, including on ILO Recommendation No. 200, relevant national legal obligations and the role of inspectors in relation to HIV workplace responses.

In Eastern Europe and Central Asia, training to mainstream HIV into the work of labour inspectors have also been held in Armenia, the Russian Federation, Tajikistan and Uzbekistan.<sup>301</sup>

### **Technical Training Centers in Bangladesh**

**Context:** Bangladesh is a major country of origin of migrant workers. According to current data,<sup>302</sup> in 2017, there were 7.2 million Bangladeshi migrants. Over 80 per cent of Bangladeshi migrant workers are employed in Gulf countries, a significant percentage of which are women working in the domestic sector. Despite the economic advantages of working abroad, Bangladeshi migrant workers often experience unsafe and indecent working and living conditions, which increase their risks of HIV exposure and infection.

**Purpose and Objectives:** The Government Bureau of Manpower, Employment and Training (BMET) has developed and implemented training programs and pre-departure briefing sessions to prepare intending migrants for employment abroad and inform them of their rights as well as specifically raising awareness on HIV risks and prevention.

<sup>301</sup> ILO: *Good Practices in Labour Inspection on HIV and AIDS* (Geneva, ILO, 2012):17.

<sup>302</sup> Global Knowledge Partnership on Migration and Development (KNOMAD): <http://www.knomad.org/data/migration/emigration?tid%5B71%5D=71> [accessed 20 September 2017].

**Activities:** *BMET* provides training through thirty-eight Technical Training Centres, of which six are exclusively for female workers. The course curriculum is developed according to requirements outlined by foreign employers and its content covers languages, rights, information on the migration process, and personal safety. The twenty-one day household-training curriculum includes modules of varying duration on HIV/AIDS that provide an overview of the ways through which the virus spreads and available preventive measures. The trainees are given a handbook with additional information on HIV/AIDS. Trainers are professional instructors, and doctors and health caregivers are invited as guest lecturers. In addition to the official program, the *Bangladeshi Ovhibashi Mohila Sramik Association (BOMSA)* offers female migrant workers a two-day pre-departure training programme that covers financial and personal management, and information on rights and health, including HIV/AIDS.

**Outputs:** Yearly 7,000 to 8,000 women are trained in different technical areas at these centers.<sup>303</sup>

### Leadership and Advocacy for Women in Africa, Ghana Alumnae Incorporated

**Context:** A substantial number of domestic workers are employed in Ghana, many among them internal migrants having moved from rural areas to the cities. Violations of rights of domestic workers remains a recognized concern in the country. Local community organizations, academic institutions and transnational networks have joined forces to advocate and work for protection of the rights of internal migrant workers.

**Purpose and Objectives:** Leadership and Advocacy for Women in Africa, Ghana Alumnae Incorporated (LAWA-Ghana) works for the protection of domestic workers' rights, through the sensitization of both employers and employees to their respective rights and responsibilities, including health and HIV-related rights. Through partnerships with academic institutions, it aims to identify problems with the employment of domestic workers and to advocate for the formalization of the employment relationships between domestic workers and their employers; and to equip domestic workers with skills to advocate for the improvement of their rights.

**Activities:** In 2003, LAWA-Ghana partnered with law students from Ghana and the United States in order to identify the main issues and make recommendations on the employment of domestic workers. LAWA-Ghana proposed programmes to raise awareness and build consensus on draft labour regulations and then met with policy-makers for drafting workshops and capacity-building trainings. It worked directly with employment agencies in order to develop formal contracts in the placement of domestic workers. It collaborates with the Multidisciplinary Women's Health Network to encourage appropriate responses for medical personnel when responding to reports on domestic and sexual violence.<sup>304</sup>

<sup>303</sup> International Organization for Migration (IOM). 2012. *HIV and Bangladeshi Women Migrant Workers* <http://www.junima.org/resources/pdf/BangladeshiHIVreportweb.pdf> [accessed 25 September 2017].

<sup>304</sup> The Protection Project at The Johns Hopkins University. 2013. *100 Best Practices in the Protection of Migrant Workers* (Baltimore, MD: The Protection Project at The Johns Hopkins University, 2013): 27.

### **Household Workers Association (ASTRODOMES), Costa Rica**

**Context:** Costa Rica's domestic workforce is predominantly composed of migrant women coming from the neighbouring countries of Nicaragua, El Salvador and Guatemala. These populations are particularly vulnerable to labour rights violations, sexual violence and limited access to social and health care services.

**Purpose and Objectives:** The Household Workers Association (*Asociación de Trabajadoras Domésticas – ASTRADOMES*) is a non-governmental organization based in **Costa Rica** that is affiliated to the Latin America and Caribbean Confederation of Women Workers in the Home (CONLACTRAHO). Its main objectives are to educate domestic workers on their rights (with emphasis on sexual and reproductive health), improve their living conditions and represent their interests through advocacy efforts.

**Activities:** Among the services provided by ASTRODOMES are: a telephone enquiry service answering questions of both domestic workers and their employers; advice, support legal and social guidance for female workers on labour issues; a temporary shelter for dismissed workers; and training on labour rights and duties, self-esteem, sexuality and reproductive health. It thus provides domestic workers with responses to immediate needs as well as tools to advocate for their rights vis-à-vis their employers.<sup>305</sup>

### **South African Domestic Service and Allied Workers Union**

**Context:** Workers unions have been instrumental in the development of legislation guaranteeing a minimum wage and fair working conditions for domestic workers. In spite of the incorporation of targeted protections in the labour law itself, much effort is still required in ensuring that domestic workers receive other entitlements, including maternity leave and access to health care and protective mechanisms against sexual harassment at work.

**Purpose and Objectives:** The South African Domestic Service and Allied Workers Union (SADSAWU), founded by Myrtle Witbooi, an advocate for domestic workers' rights and Hester Stephens, a full-time domestic worker, has been at the forefront of advocacy efforts regarding the institution of national legislation for domestic workers. The main purpose of this union, with currently over 25,000 members, is to continue defending domestic workers' human and labour rights with special attention to the health component.

**Activities:** Ongoing SADSAWU advocacy efforts include: preventing exploitation by recruitment agencies, performing living wage campaigns, defending the Health Act Campaign and preventing sexual harassment at work. Partnering with the Government, SADSAWU offers development training for domestic workers and employers. Other successes include participation in designing unemployment insurance and a dispute resolution system.<sup>306</sup>

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<sup>305</sup> The Protection Project at The Johns Hopkins University. 2013. *100 Best Practices in the Protection of Migrant Workers* (Baltimore, MD: The Protection Project at The Johns Hopkins University, 2013): 87.

<sup>306</sup> The Protection Project at The Johns Hopkins University. 2013. *100 Best Practices in the Protection of Migrant Workers* (Baltimore, MD: The Protection Project at The Johns Hopkins University, 2013): 26.

### **Building and Wood Workers International (BWI) Action on HIV & AIDS in the Construction Sector**

**Context:** Construction work is mobile and often involves cross-border work. Construction companies tend to dispose of services from labour contracting companies that hire workers from other countries where labour prices are lower. This practice leads to greater competition and social dumping due to cheaper labour from neighbouring countries. Casual work, sub-contracting and unregulated work may jeopardize health and safety conditions related to work and limit access to health care services.

**Purpose and Objectives:** Building and Wood Workers International (BWI) affiliated unions at the regional, national and local level have been carrying out actions with the purpose of ensuring that HIV/AIDS is better understood as a workplace and gender issue.

**Activities and Outcomes:** Among the main activities conducted by BWI's affiliated unions are: awareness campaigns; education; training; advocacy for adoption, implementation and effective enforcement of international standards; and lobbying for policies regarding social protection including the rights to health care and treatment and for the inclusion of an HIV/AIDS clause in collective agreements. The National Federation of Building and Forestry Workers of Burkina Faso initiated an AIDS theatre program as a means to educate and raise awareness in the community. By 2013, the Ethiopia Industrial Federation of Construction and Wood successfully mainstreamed and integrated HIV and AIDS issues into trade union work. It reviewed three collective agreements with clauses addressing Discrimination, Care and Support. The Ethiopian Federation also formed a taskforce on HIV and AIDS response in order to operationalize policies and to better collaborate with social partners. In Senegal, The National Union of Construction Workers of Senegal (SNTC) visited all the Eiffage Construction Company work sites offering awareness raising sessions, talks and voluntary testing opportunities.<sup>307</sup>

**Website:** <http://www.bwint.org>

### **Apparel Lesotho Alliance to Fight AIDS**

**Context:** With 23.3 per cent of adults diagnosed with HIV, Lesotho has one of the highest HIV prevalence rates in the world. In the manufacturing industry sector – the largest in the country – two out of every five workers are HIV positive. Clothing factories are predominantly foreign-owned and comprised of a mainly female labour force. Around 40 per cent of the women workers were tested positive for HIV, which may be in part due to many women in Lesotho having male partners employed in the mining sector in South Africa.

**Purpose and Objectives:** in 2006, the *Apparel Lesotho Alliance to Fight AIDS (ALAFA)* set up its Healthcare in the Workplace Programme with the purpose of helping workers and their families limit exposure to HIV. The key priorities of ALAFA are: industry-wide reach; HIV prevention, treatment and care; medical monitoring and testing, and facilitating support groups.

**Activities:** The ALAFA programme developed workplace-level peer education programmes specifically tailored for certain groups: women, men and young workers. Through these, women are encouraged to exert increased communication power in their relationships, and men are encouraged to assume

<sup>307</sup> ILO: *Labour Migration and HIV*, [www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_241234.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_241234.pdf) [accessed 21 September 2017].



responsibility in avoiding high-risk sex and regularly testing for HIV. For young employees, emphasis is placed on responsible sexual activity through both risk avoidance and communication. In addition to information sessions, the programmes provide workers and their families with regular testing and condoms. The programme also provides training sessions for factory managers, conducted in the national Sesotho language or in Mandarin for Chinese managers. A medical tracking scheme was developed to track absenteeism to assist in identifying workers who may be AIDS-affected. In collaboration with the Lesotho Network of AIDS Service Organizations, the programme is building the capacities of rural clinics.

**Outcomes:** Since 2006, the programme arranged for 51,499 HIV tests. More than 100 Lesothan and Chinese managers received HIV training in 2011. The HIV positive testing rate among apparel workers fell from 40 per cent in 2006 to 14 per cent in 2012. As well, up to October 2011, ALAFA clinics had treated 443 workers for tuberculosis.<sup>308</sup>

**Website:** [http://alafa.info/MigHealthHIV\\_guidebook\\_Section\\_5\\_practices\\_12aug2016.docx](http://alafa.info/MigHealthHIV_guidebook_Section_5_practices_12aug2016.docx)

### **HIV and AIDS Workplace Education Project, Malawi**

**Context:** In the Lujeri Tea Estate in Malawi, many of the workers are migrants who live together in compounds. They reported having multiple partners and that village women approach male workers for sex in exchange for money.

**Purpose and Objectives:** The **ILO HIV and AIDS Workplace Education Project in Malawi** partnered with ten enterprises in four sectors including the Lujeri Tea Estate and its 5,337 employees, in order to promote education of HIV and AIDS in the workplace.

**Activities:** Peer educators examined a typical daily schedule (which included breaks under mobile shades) to create a regular slot where colleagues would have time and feel comfortable to talk about HIV and AIDS. This became a means of integrating HIV and AIDS education in the daily life of the estate.

**Outcomes:** A survey conducted among 100 workers before and after the intervention demonstrated that the number of workers requesting condoms increased from 28% to 86% and the number of workers asking for voluntary counselling and testing (VCT) information from 6% to 18 per cent.<sup>309</sup>

### **Nirman Mazdoor Sanghna (NMS) Intervention on HIV and AIDS**

**Context:** HIV risk among migrant construction workers in India is especially high. A 2008 study in Panvel, Maharashtra revealed that 25 per cent of workers reported having unprotected sex with sex workers and low or inconsistent condom use. A number of women reported facing regular sexual harassment at work and engagement in sex work as a result of force or coercion.

<sup>308</sup> ILO: *Leaving No One Behind: Reaching Key Populations through workplace action on HIV and AIDS* (Geneva, ILO, 2014): 57-59.

<sup>309</sup> ILO: *Mobile Shades: A Time and Place for HIV and AIDS Education in the Daily Life of Tea Pickers, Mulanje District, Malawi* (1 July 2010) [http://www.ilo.org/aids/good-practices/WCMS\\_159197/lang--en/index.htm](http://www.ilo.org/aids/good-practices/WCMS_159197/lang--en/index.htm) [accessed 25 September 2017].

**Purpose and Objectives:** Nirman Mazdoor Sanghna (NMS), an Indian trade union, has taken up a project in collaboration with the ILO in order to organize construction workers, and improve their conditions of employment, welfare, social security and enhance their access to health care.

**Activities:** Prevention strategies included behaviour change communication, condom promotion and management of sexually transmitted infections, along with improving access to care and support services through a referral network in collaboration with the Maharashtra State AIDS Control Society. It has also formed workers' committees, through which peer education sessions and comprehensive training enhance workers' knowledge and awareness of HIV prevention, treatment and care strategies.

**Outcomes:** This intervention reached construction workers and their families in six *nakas* (market places), three *bastis* (workers communities) and six construction sites. By 2009, 6,598 workers had been enrolled under the insurance scheme of the Government. From October 2008 to May 2009, 566 workers were referred for treatment of sexually transmitted infections, 354 workers were referred for counselling and 5 workers started to receive free antiretroviral therapy. This union-led intervention on HIV and AIDS served as an inspiration for other ILO projects in India under the grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (e.g. in Andhra Pradesh and in Delhi). In Delhi, the project works in close collaboration with a non-governmental organization that carries out interventions with sex workers. The union-centered approach enables participating organizations to reach out to the clients of sex workers, most of whom are employed at nearby construction sites. The National Policy on HIV and AIDS and the World of Work (2009) covers both internal as well as international migrants.<sup>310</sup>

### Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT)

**Context:** Migrant workers from Cambodia, Laos and Myanmar are a major source of labour for Thailand, especially in the fishing industry. In 2003, HIV prevalence among migrant fishermen was as high as 5 per cent in some provinces. The main mode of transmission is unprotected sex, as more than 50% of migrant workers in the fishing industry did not use condoms during sex with casual partners. Furthermore, numerous barriers to HIV prevention and care for migrant workers exist, among which are lack of health insurance, budgetary constraints, and HIV-related discrimination and stigma.

**Purpose and Objectives:** The *Prevention of HIV/AIDS Among Migrant Workers in Thailand* programme (PHAMIT) (2003-2008) was launched with the purpose of reducing the number of new HIV infections among migrant workers in Thailand and in the neighbouring countries.

**Activities:** In Thailand, it focused on nineteen coastal and three non-coastal provinces bordering Myanmar – reaching migrants working in fishing and seafood processing, as well as those in sectors such as industry, construction and agriculture. The programme was implemented through a partnership between eight NGOs and the Ministry of Public Health, and was operationalized due to funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The work with NGOs helped enhance service delivery and strengthen advocacy, as well as the partnership with government departments to put in place “migrant-friendly services”. The focus on migrant communities through the innovative concept of “migrant health assistants” – registered migrants selected, recruited and trained to support fellow migrants in assessing public health services – contributed to the reach of the programme.

<sup>310</sup> ILO: *Reaching out to migrant construction workers in India* (1 January 2009) [http://www.ilo.org/aids/good-practices/WCMS\\_161169/lang--en/index.htm](http://www.ilo.org/aids/good-practices/WCMS_161169/lang--en/index.htm) [accessed 25 September 2015].

**Outcomes:** The programme reached over 460,000 beneficiaries with HIV-prevention information. There was an increase in condom-use by programme beneficiaries and in the number of HIV-positive migrants receiving home-based care and treatment for opportunistic infections. In policy terms, this effort was translated in migrants being recognized as a target population by the Thai Government in the 2007-2011 Thai National AIDS Strategic Plan. Through this, the government would subsidize ARV treatment for HIV-positive migrant workers in Thailand.<sup>311</sup>

### Hometown Fellows Campaign, China

**Context:** Although the overall prevalence of HIV is relatively low in China, there are pockets of high levels of infection – both regarding populations and localities. Internal migrant workers are seen as at higher risk of HIV exposure due to the precarious conditions many face, including lack of access to health prevention and care services. Research conducted through the *ILO/US Department of Labor (USDOL) Workplace AIDS Education Programme* in China suggested that a majority of young migrant workers were sexually active, yet lacked sufficient knowledge on HIV transmission and prevention.

**Purpose and Objectives:** The *Hometown Fellows Campaign* in China was a multi-media campaign launched by the ILO and the Chinese State Council AIDS Committee Office in 2008, aiming at disseminating HIV-prevention messages to migrant workers. It was implemented in partnership with the Ministry of Labour, employer and worker bodies, and 19 large-scale enterprises in the construction, mining and transport sectors based in provinces identified as being most affected by HIV.

**Activities:** Messages were delivered by migrants themselves, acting as peer educators in workplaces, dormitories and nearby entertainment areas, through company-owned television and radio channels. The centerpiece of the campaign was a short film produced with the support of the renowned director Gu Changwei and the famous actor and former migrant worker, Wang Baoqiang. The film was screened in 850 train stations, on Shenzhen buses, and in workplaces, vocational training centres and employment agencies across China. The initiative featured a prominent gender dimension to ensure that young women migrants were aware of their basic employment, sexual and reproductive health rights.

**Outcomes:** The strategy of screening the film in public transportation sites that are highly frequented by migrant workers contributed to the campaign's success in reaching as many as 50 million migrant workers in 2009. In 2008, 20,000 migrants were trained on HIV at employment agencies and 29 large-scale state and private partner enterprises had installed behavioural change programmes.<sup>312</sup>

<sup>311</sup> UNDP.2010. *HIV, Health and Development - Innovative approaches: Raks Thai /PHAMIT Programme*. United Nations Development Programme Asia-Pacific Regional Centre. [http://www.junima.org/resources/pdf/RaksThai\\_FINAL\\_web.pdf](http://www.junima.org/resources/pdf/RaksThai_FINAL_web.pdf) [accessed 25 September 2017].

<sup>312</sup> ILO: *Leaving No One Behind: Reaching Key Populations through workplace action on HIV and AIDS* (Geneva, ILO, 2014); UNAIDS. 2009. Never abandon, never give up: ILO film helps China's migrant workers challenge AIDS stigma. UNAIDS Feature Story, (Geneva 2009). <http://www.unaids.org/en/resources/presscentre/featurestories/2009/april/20090430ilofilmschina> [accessed 25 September 2017].

## 4.6 Ensuring Access to Social Protection

Adequate access to social protection, especially to affordable and accessible health care, is key to prevent HIV and mitigate the risk of AIDS among migrants. States should adopt measures to ensure that all migrant workers and their families benefit from social protection regimes. Key areas should include access to health care services for all migrants, with special attention to the needs of migrant women, such as maternity protection and ensuring the rights for domestic workers.

The ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), the ILO Equality of Treatment (Social Security) Convention, 1962 (No. 118), and the ILO Recommendation concerning National Floors of Social Protection, (No. 202) provide the normative foundations and specific legal provisions regarding the scope and nature of social protection, international access to and portability of coverage and benefits, and a universal social protection floor ensuring at least minimum coverage for all.

### Key Actions:

**A. Establish social protection guarantees.** Establish basic social security guarantees through national law, available to all, including migrant workers and their families. These guarantees should ensure, at a minimum, that all in need including migrant workers and their family members have access over the life cycle to essential health care and to basic social security, which together secure effective access to goods and services defined as necessary at the national level.<sup>313</sup> Ensure that legislation does not contain discriminatory provisions that could impair access by migrants to equal social protection in accord with international standards.

**B. Ensure appropriate scope of protection.** Provide for the access of migrant workers and their families to a nationally defined set of social protection care and services that comprises equal access to preventative, curative and palliative health care, including emergency medical care, HIV prevention and treatment, maternity protection, and reproductive health and care, with special attention to the specific needs of women and girls.

**C. Incorporate specific references to migrants.** Ensure that national labour legislation and social security laws and regulations cover all male and female migrant workers, including domestic workers and other groups at risk of exclusion from minimum social protection. Particular attention should be paid to the areas of employment, maternity protection, access to health care and services, wages, and occupational safety and health and other conditions of work, in accordance with relevant international instruments, including the ILO Conventions and Recommendations.<sup>314</sup>

**D. Adopt employment protection measures.** Support the adoption of measures ensuring that migrant workers enjoy equality of opportunity and treatment regarding employment and trade union rights, and for training opportunities after a reasonable period of employment, and that, in the event of loss of employment, they are allowed sufficient time to find other work. In particular, these guarantees are essential so that migrant workers

<sup>313</sup> ILO, *Social Protection Floors Recommendation, 2012* (No. 202), adopted 14 June 2012, Para 4.

<sup>314</sup> ILO: *ILO Multilateral Framework on Labour Migration* (Geneva, ILO, 2006): Para 9.8.

and family members have adequate financial means to access health services, including HIV prevention, treatment and care services in case of need.

**E. Disseminate relevant information.** Ensure that information is made available to enable migrants to access social protection including ways and modalities to access health care and the other eight benefits of social security protection defined in the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102)

#### 4.6.1 Initiatives and Experiences on Ensuring Access to Social Protection

##### **Portability of Social Security Rights for Nationals of EU Member Countries and Third Country Nationals in the EU**

**Context:** The basic principle enshrined in the Treaty of Rome was the removal of obstacles to the free movement of persons between the European Union's Member States. The coordination of social security systems, thus, proves essential to protecting the rights of nationals of EU and third countries who are working and residing in a Member State. Health is identified as one of the nine fundamental areas of social protection in the landmark ILO Social Security (Minimum Standards) Convention, 1952 (No. 102).

**Purpose and Objectives:** Ever since Regulation 1408/71 was adopted in June 1971, the European Union has endeavored to coordinate social security rights, including on access and portability, of persons moving among the EU Member States. Regulation 1408/71 has been replaced by Regulations that modernized coordination, including Regulations 883/2004 and 987/2009. Social security coordination implies that individuals are covered by the legislation of one country at a time and that they hold the same rights and obligations as nationals of the country concerned. If a national of an EU Member State is entitled to a cash benefit from one EU country, they may generally receive it even if they move to a country outside of the EU (i.e. third country). The EU common rules on social security apply to all nationals of the EU and to those of Iceland, Liechtenstein, Norway and Switzerland, as well as to stateless persons and refugees who are resident in and who are or have been insured in one of these countries, and their family members. They also apply to nationals of non-EU countries who are lawful residents of and to those who have moved between the above countries.<sup>315</sup>

##### **ECOWAS Regional Convention on Social Security: Providing for Access to and Portability of Social Security throughout West Africa for Nationals of All ECOWAS Member States.**

**Context:** The Economic Community of West African States (ECOWAS) established free movement and rights to residence and establishment for nationals of its 15 Member States across all member countries. Today, 80 per cent of migration originating in ECOWAS member countries goes to other Community members. The integration of social security and social protection coverage for ECOWAS nationals became an imperative to implement free movement and to ensure ECOWAS citizens' rights of access to and portability of social security throughout the community. Arduous negotiations among Member States led to the adoption of a landmark ECOWAS Convention on Social Security in 2011 harmonizing basic social security rights, including on access and portability of persons moving among the ECOWAS Member States.

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<sup>315</sup> ILO: *Portability of Social Security Rights to Nationals of Both the EU and Third Countries* (19 May 2015). [http://www.ilo.org/dyn/migpractice/migmain.showPractice?p\\_lang=en&p\\_practice\\_id=18](http://www.ilo.org/dyn/migpractice/migmain.showPractice?p_lang=en&p_practice_id=18) [accessed 25 September 2017].

**Purpose and Objectives:** The Convention essentially gives effect to principles articulated in the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102). It calls for progressive coordination and harmonization of social security approaches among the Member States, including on exchange of information on payments and entitlements for nationals of ECOWAS countries residing in other member countries. To accelerate its implementation, the Convention was adopted with the consent of Member States as a binding ECOWAS instrument not requiring subsequent ratification by Member States in order to be put into effect.

**Outcomes:** As realization of the intent of such a comprehensive instrument takes years to effect in national legislation, policy, administration and practices, it is early to assess the impact. However, most national social security administrations in the 15 member states have begun to establish –or at least consider– measures to facilitate access to and portability of contributions or benefits for citizens of other ECOWAS Member States established on their territories.

#### **MERCOSUR Multilateral Social Security Agreement and Administrative Regulations, and Implementing System**

**Context:** In 1990, Argentina, Brazil, Paraguay and Uruguay signed the Treaty Establishing a Southern Common Market (MERCOSUR). Initially, member countries made bilateral social security agreements, including with countries in other regions, to regulate social security rights and obligations accrued by workers in the signatory countries. In 1997, the four countries adopted the MERCOSUR Multilateral Social Security Agreement and its Administrative Regulations.

**Purpose and Objectives:** This agreement and its operational guidelines recognized rights, obligations and contributions to pension systems of workers that work or have worked in one or more of the MERCOSUR countries, and their families. A sophisticated system was subsequently built to administer multi-country social security coverage and portability for nationals of participating States among those countries.

**Implementation:** The MERCOSUR social security regime was approved by Parliaments in the four member countries plus Chile and Venezuela as Associated States. The implementing mechanism has an overall administrative commission with parallel bodies in each country. Administration in each country includes the two lead political parties, the social partners and the pensioners. The system is based on the principle of *pro rata temporis*<sup>316</sup> and transferability of individual capitalization. Validations of inter-country transfers are based on a diagnostic of multiple factors and considerations of national administrations.

**Outcomes:** The agreement and its successful implementation demonstrate common political will among Member States. The regime now functions as a regionally integrated social security system. It operates as a unified process; each member country has its designated implementing agency. A centralized administrative center functions under the auspices of the Uruguay national social security agency. Bilateral agreements by countries party to the accord with non-parties also permit transferring contributions to and from third countries.

<sup>316</sup> *Pro rata temporis* definition: in proportion to the percentage of the total period of coverage spent in each country concerned

### **NowHereLand Project: Improving Services for Undocumented Migrants in the EU**

**Context:** Although European Union Member States generally acknowledge universal rights to health care, undocumented migrants face considerable obstacles in accessing services. National regulations often restrict access to only special situations, like emergency care, and only for specific groups (e.g. children and pregnant women). Health care organizations and professionals find themselves in a paradoxical situation: by providing health care they may be contravening legal and financial restrictions, and by denying access to health care they are preventing the realization of human rights as well as violating the Hippocratic Oath of medical professionals.

**Purpose and Objectives:** *NowHereLand* aims at creating a knowledge base for providing, exchanging and developing good practice of health care services for undocumented migrants by identifying national legal and financial frameworks of the EU Member States and compiling existing practice at the regional and local levels.

**Activities:** The primary activity within the framework of the project is research. Preliminary recommendations can be made to address the policy frameworks and practice level of health care provision.

**Outcomes:** The project identified that, as of 2012, four EU countries had the same range of services and entitlements to health care for migrants in irregular status: **Spain, France, the Netherlands and Portugal**. In all four countries, full access is tied to a variety of pre-conditions including: proof of identity, residence, destitution and minimum duration of stay. **Belgium and Italy and the United Kingdom** are countries with partial access to health care. This means that in these countries, there are either explicit entitlements for specific services, or for specific sub-groups of migrants in an irregular situation (e.g. children, unaccompanied migrants, pregnant women) or for a specific diagnosis (e.g. medically necessary treatment) in place.

These research results provided invaluable assistance for health practitioners and advocates to identify measures and proposals to extend fuller health protection to migrants in irregular situations in those countries.<sup>317</sup>

## **4.7 Developing and Improving Public Health Policy, Services and Outreach**

Migrant workers and their family members rarely have the same entitlements or access to health care as nationals, often even less to the insurance schemes that make health care expenses affordable. Migrants in irregular situations and those in temporary status or in non-standard forms of employment face dramatic constraints to accessing health care and services. Migrant workers in rural areas, in mining sites and other geographically isolated locations distant from urban centres often have little access to health services. Culturally and linguistically appropriate health services as well as HIV prevention, treatment, care and support programmes are also scarce in many countries.

<sup>317</sup> U. Karl-Trummer et al.: "Access to Health Care for Undocumented Migrants in the EU: A first landscape of NowHereLand", in *Eurohealth* (2010, Vol. 16, No.4):14.



In contrast, rights-based public health policies not only comply with States' obligations under international instruments, they effectively support good health outcomes for the entire population in countries of destination.

States should ensure the right to the highest attainable standard of health of every person through public health policy, services and outreach. These should guarantee availability, accessibility, acceptability and quality of public health and health-care facilities, goods and services, and programmes for effective prevention, care, and treatment of HIV, including for all migrants and their families.<sup>318</sup> Special attention needs to be paid to the development of sexual and reproductive health services, including access to family planning, pre- and post-natal care, and access to information related to sexual and reproductive health.

### Key Actions:

**A. Promote the right to health.** Adopt and implement relevant international standards on the protection of migrants and the right to health and health-related rights in national law and practice; support and contribute to the development and implementation of national health policies that incorporate a public health approach to the health of migrants; and promote equal access to health services for migrants.

**B. Ensure health policy and practice is inclusive of all.** Support universal coverage. Promote the establishment of social protection floors for all, with explicit inclusion of all migrants. Engage specific inclusion and outreach measures to reach and incorporate migrants and returnees in health coverage.

**C. Ensure an integrated approach.** Pursue an integrated approach to health and the realization of health-related rights, including with respect to education, prevention, care, treatment and support. Facilitate communication and coordination across government ministries and departments, with public and private health institutions and practitioners, with the social partners, civil society organizations, and with concerned migrant, refugee, internally displaced persons and returnee communities.

**D. Expand health care to the underserved.** Promote and support provision of health facilities in areas with little availability of health services with a comprehensive approach to service delivery. Advocate for a comprehensive public health approach including the needs of migrant populations in assessing and addressing the need for adequate infrastructure of hospitals, clinics and other health-related buildings and equipment; trained medical and professional personnel who receive domestically competitive salaries; and accessing essential drugs including ARV drugs for people living with HIV.

**E. Ensure accessibility.** Establish or reinforce legislation and measures that ensure health care and services are accessible to all, including migrants living with HIV, without discrimination based on gender, nationality, race, colour, sexual orientation, migratory status, and other grounds. Conduct a mapping to identify where migrant and refugee populations are located, including those in isolated rural areas, in mining camps, at infrastructure construction sites as well as in urban settlements lacking health care

<sup>318</sup> Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), E/C.12/2000/4 (11 August 2000), Para. 12.

facilities and medical personnel. Promote and support the establishment of health services and facilities accessible to isolated localities as well as in urban neighbourhoods where migrants are concentrated. Ensure that health services and facilities and access to them take account of specific needs and situations of women and girl migrants. Take into account the need for longer night-time and weekend opening hours, as migrants are often working in two or more jobs to survive and consequently cannot use such services during the daytime. Provide for language services and culturally appropriate outreach permitting access by migrants, including those recently arrived.

**F. Ensure Affordability.** Ensure that health facilities, goods and services are affordable for all, including migrant workers and their families. Advocate for payment for health care services and services related to underlying determinants of health based on the principle of equity. Insist that key elements include affordable health insurance and health services for migrant households with low income.

**G. Focus on sexual and reproductive health.** Promote the important role of sexual and reproductive health of all men and women migrant workers in public education and health services. Advocate for full access by migrants to family planning, pre- and post-natal care, access to prevention of mother-to-child HIV transmission and distribution of condoms.

**H. Identify determinants of health of migrants and implement monitoring and evaluation mechanisms.** Identify the social, economic, environmental, physical, etc determinants of health of migrants. Ensure that migrant health, migrants' health-seeking behaviours, and their utilization of health services is monitored, including by defining indicators on health status and outcomes specifically for migrants in national and local health data collection and surveys. Monitor the implementation of relevant national legislation, policies and regulations to gauge their effectiveness and to recommend remedial action as needed.

**I. Engage in international cooperation.** Contribute to and engage in sharing resources, expertise, information and experiences through international exchanges, cooperation, and assistance programmes concerning migration, health and HIV. Promote and facilitate continuity of health care of migrants between countries of origin and destination, and for those moving on or resettling to another country. In particular focus on working in cooperation with high HIV prevalence countries to assist in the development of health policy, services, and outreach programmes for prevention, treatment, care and support related to HIV.<sup>319</sup>

#### **4.7.1 Initiatives and Experiences on Developing Public Health Policy, Services and Outreach**

Included here are several examples of health services and education for migrants, looking at a broader health outreach context.

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<sup>319</sup> *HIV and AIDS Recommendation*, 2010 (No. 200), Para. 49

### ***Biruh Tesfa* HIV Prevention for Vulnerable Adolescent Girls Program, Ethiopia**

**Context:** Young women who have relocated to urban areas and slums in **Ethiopia** are at risk of coerced sex, sex work and exploitative labour. The girls who enrolled in the *Biruh Tesfa* project came from disadvantaged backgrounds: over half of them have had no education, one third were engaged in child domestic work, one-quarter were daily manual labourers and two-thirds were migrants.

**Purposes and Objectives:** From 2006 to 2014, the *Biruh Tesfa* (“*Bright Future*”) project addressed vulnerabilities of young women, many of whom were migrants, in urban areas and slums. A main activity of *Biruh Tesfa* was mentoring out-of-school girls and young adults ages 7-24 on topics such as HIV and AIDS, reproductive health, and violence and coercion. The mentorship program empowered young women by identifying, training and hiring female community leaders as mentors and by creating ‘safe spaces’ where participants received and shared HIV- and AIDS-related information and experiences and were offered health services, social assistance and literacy classes.

The project was developed by the Population Council (United States), working in collaboration with the Ethiopia Ministry of Women, Children and Youth Affairs and reaching kebele administrations, the local administrative units in Ethiopia. It was funded by the World Bank, UN Foundation, UNFPA, Nike Foundation, George and Patricia Ann Fisher Family Foundation, the Italian Trust Fund for Children and Youth in Africa, and USAID/PEPFAR.

**Activities:** The mentorship programme provided women adolescents with information on HIV transmission and prevention, reproductive health, gender-based violence and rape, condoms and other family planning methods, financial literacy and entrepreneurship. Participants obtained social support for violence and coercion as well as assistance in developing communication and psychosocial skills. After the identification of specific needs of participants, organizers promoted partnerships to incorporate other essential services. The Population Council bridged the mentorship programme to health clinics to improve access to basic and reproductive health services. It funded a local NGO called Organisation for the Prevention Rehabilitation and Integration of Female Street Children (OPRIFS), which provided support services to rape victims and shelters for evicted domestic workers. To facilitate access to the labour market, the *Biruh Tesfa* project partnered with Nia Foundation, which provided vocational training sessions and identified job placement opportunities.

**Outcomes:** Starting in Addis Ababa and Bahir Dar, where the project reached 3,700 girls by 2009, *Biruh Tesfa* was scaled up to cover the most deprived areas of 18 cities in Ethiopia. By 2013, the number of out-of-school girls ages 7-24 participating in the project was more than 63,000. Controlled evaluations indicated that participation in the project corresponded to better performance on reading and numeracy tests.<sup>320</sup>

**Website:** <http://www.popcouncil.org/research/biruh-tesfa-safe-spaces-for-out-of-school-girls-in-urban-slum-areas-of-ethi>

<sup>320</sup> Population Council. 2013. *Biruh Tesfa* (“*Bright Future*”) Project. <http://www.popcouncil.org/research/biruh-tesfa-safe-spaces-for-out-of-school-girls-in-urban-slum-areas-of-ethi> [accessed 25 September 2017].

### **Women's Rehabilitation Centre (WOREC), Nepal**

**Context:** The returned migrant population in Nepal is estimated by the project at half a million, many of whom have been in high HIV-incidence districts in India. Adding to concern are returned women migrants who suffered sexual and other forms of abuse in other countries. Improving coverage and promoting behavioural change are priority areas for HIV prevention in Nepal. National policy developments contributed to improving outreach to female and male sex workers in the country. However, reaching migrant and returned migrant populations has proved more challenging.

**Purpose and Objectives:** The Women's Rehabilitation Centre (WOREC) is a non-governmental organization established in 1991 with the purpose of fighting violence against women, and to ensure their economic, social and cultural well-being. Through its 'Women Health Right Program' and 'Safe Migration Program', WOREC specifically targets migrant women, focusing on their labour, sexual and reproductive rights.

**Activities:** WOREC initiated a National Alliance of Women Human Rights Defenders platform in 2005, through which advocates in 72 Nepalese districts share experiences and help develop the capacity of women human rights defenders in different communities. It launched the '*Our Bodies, Ourselves*' initiative to develop manuals introducing women to a more intimate understanding of their bodies, the workings of the body and body politics. WOREC adopts an integrated programmatic approach, providing health counselling along with training on bio-intensive farming and political engagement.<sup>321</sup>

**Website:** <http://www.worecnepal.org>

### **Outreach Programmes in Europe by *Médecins du Monde***

**Context:** In the absence of adequate health care services provided by national governments and difficulty to reach particular vulnerable groups in Europe, *Médecins du Monde* has developed several localized programmes addressing sexual and reproductive rights concerns for migrant and displaced populations.

**Purposes and Objectives:** *Médecins du Monde* aims to extend the offer of health services to excluded groups, by providing outreach and targeted services that complement the national offer.

**Activities:** In Spain, with support of the National Ministry of Health, Social Services and Equality, *Médecins du Monde* developed '*CASSIM*' and '*CASSPEP*' programmes. While the former has as its goals to reduce health inequalities affecting migrants and to facilitate their access to mainstream health services more generally, the latter targets sex workers specifically. *CASSPEP* programmes carry out harm reduction efforts and provide information on rights and sexually transmitted diseases. In Palma de Majorca, *Médecins du Monde* supports the '*Dones del Mon*' programme facilitating integration of migrant women with Spanish society through intercultural health mediation. This effort encourages mutual understanding and awareness between health professionals and migrants.

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<sup>321</sup> For more information on the Women's Rehabilitation Centre (WOREC), see: <http://www.worecnepal.org/index.php/about-us/>.

In **Portugal**, the *Noite Saudavel* (healthy night) project was created to improve access to primary healthcare and to reduce the transmission of Sexually Transmitted Infections among the homeless population of Lisbon. A nocturnal outreach team was created to offer these services. '*Saude pa nos Bairros*' (health for our neighborhoods) and '*Rotas para a Saude*' (routes to health) were initiatives placing emphasis on communication and information services, targeting deprived neighbourhoods in the cities of Loures and Seixal, respectively.

In **Germany**, Médecins du Monde worked in collaboration with the organization 'Café 104' to ensure that undocumented migrants have basic medical and dental care, as well as psychosocial services.<sup>322</sup>

### **Regional Cooperation Program for Technical Assistance for HIV and other Infectious Diseases in the Commonwealth of Independent States**

**Context:** During the Presidency of the **Russian Federation** in the Shanghai Cooperation Organization (2008-2009), Russia announced its intention to initiate cooperation with partner countries in the field of health care with particular attention to fighting infectious diseases.

**Purpose and Objectives:** The Russian Federation with the collaboration of UNAIDS implemented between 2013 and 2015 the *Regional Cooperation Program for Technical Assistance for HIV and other Infectious Diseases in the Commonwealth of Independent States*. Its purposes were to strengthen health systems, ensure better epidemiological surveillance of HIV, and scale up HIV prevention and treatment programmes among key populations at higher risk, especially migrants in Armenia, Kirghiz Republic, Tajikistan and Uzbekistan.

**Activities:** The initiative was led by the Federal Service on Customers' Rights, Protection and Human Well-being Surveillance (*Respotrebnadzor*), which worked with regional civil society organizations (such as *AIDS Infoshare*) and counterparts in the four partner countries. UNAIDS assisted national authorities in the creation of legal documents relating to the epidemiologic monitoring of HIV, Sexually Transmitted Infections and viral hepatitis, and in training specialists working in national systems of epidemiological surveillance. UNAIDS helped develop new national instructions on prophylaxis of mother-to-child HIV-transmission, pediatric care for HIV-positive children, and providing material for research geared towards controlling infections in maternity hospitals and pediatric medical institutions. *AIDS Infoshare* led training programmes, workshops and events with the purpose of creating outreach services and complementary clinical and consultative assistance and diffused information to health specialists and migrants and members of their families through media campaigns. More specifically, in the Khatlon Region of Tajikistan, the Russian Government offered a mobile clinic and diagnosis center with the latest medical equipment in order to provide inhabitants with access to integrated HIV testing, counselling and other forms of medical diagnostics and treatment.<sup>323</sup>

**Website:** <http://rusaid.ru/about-project/>

<sup>322</sup> Médecins du Monde. 2009. *Survey Report 2008*. (European Observatory on Access to Healthcare, 2009): <http://www.epim.info/wp-content/uploads/2011/02/Access-to-healthcare-for-Undocumented-Migrants-in-11-EU-countries-2009.pdf>.

<sup>323</sup> UNAIDS. 2013. *Russia Strengthens Commitment to Reversing AIDS Epidemic in the Region*. <http://www.unaids.org/en/resources/presscentre/featurestories/2013/june/20130614russiaprogramme>.

### **Migrant Health Centers, USA**

**Context:** Migrant farmworkers have been cultivating and harvesting American crops for generations. The domestic labour shortage during the Second World War prompted the development of the bi-national *Bracero Guestworker Program* in 1943 to attract farmworkers from Mexico. Although that programme was terminated in 1964, a majority of the U.S farm worker labour force continues to be foreign born with limited access to private health insurance or Medicaid. Migrant and seasonal farmworkers are at increased risk for HIV in comparison to other Latino groups and the U.S population as a whole, due to a variety of factors including limited access to health care, language barriers, low literacy rate, poverty, and behaviour associated with often isolated and highly-mobile living conditions.

**Purpose and Objectives:** In order to provide migrant farmworkers with primary and supplemental health services, the Migrant Health Act was passed in 1962 and consolidated in 1995.<sup>324</sup> Today, there are 166 federally funded migrant health centre entities: 151 of which are jointly funded “*Community and Migrant Health Centers*” and 15 are “*Voucher Programs*”. Most of them are not-for-profit corporations owned and operated by community-based organizations or state and local health departments, receiving grants under the Public Health Services Act.

**Activities:** These centres and voucher programs offer comprehensive primary and preventive health care services. Many of the centres also provide transportation, translation, outreach, dental, pharmacy, and environmental health services. Collectively, they operate more than 700 satellite service sites and comprise a loosely knit network of independent organizations serving migrant and seasonal farmworkers. Their sizes and the services provided vary according to their location – whether in frontier, densely populated or rural areas – to better correspond to the needs of their communities. One of the organizations working with these centres to increase access to health and HIV and AIDS information is *Farmworker Justice*, which implements two health education and advocacy initiatives ‘*Poder Sano*’ (health power) and ‘*Aliados*’ (allies).

**Outcomes:** In 2015, the network of 174 migrant health centres provided services to over 833,000 migrant and seasonal farmworkers and family members in more than 1,052 delivery sites across the United States.<sup>325</sup>

**Website for Farmworker Justice:** <https://www.farmworkerjustice.org/>

### **Regional Initiative on Sexual and Reproductive Health, HIV Prevention and Sexual Violence for Women and Young Migrants, Latin America**

**Context:** Deficiencies in sexual and reproductive health conditions, including issues related to HIV and AIDS and sexual violence, and disparities in access to health education in Latin America mirror the predominant social inequalities across the region. These deficiencies reflect context-specific political, socio-economic and cultural factors. However, health assessments often fail to account for cross-border populations.

<sup>324</sup> The United States Senate, Senate Report on Public Health Act 100-274 (12 March 2008) <http://www.gpo.gov/fdsys/pkg/CRPT-110srpt274/html/CRPT-110srpt274.htm> [accessed 25 September 2017].

<sup>325</sup> National Center for Farm Worker Health. 2015. *A Profile of Migrant Health*. <http://www.ncfh.org/fact-sheets--research.html>.

**Purpose and Objectives:** From 2008 to 2011, the United Nations Population Fund, supported by the Spanish Agency for International Cooperation and Development put in place a *Regional Initiative on Sexual and Reproductive Health, HIV/AIDS Prevention and Sexual Violence for Women and Young Migrants* in five border regions in Latin America: Argentina-Bolivia; Ecuador-Colombia; Costa Rica-Nicaragua; Dominican Republic-Haiti; and El Salvador-Guatemala-Mexico. This initiative aimed at implementing targeted situation specific strategies for the promotion of rights-based access to healthcare and for prevention of HIV and sexual violence in the five border regions.

**Activities and Outcomes:** The respective components of this initiative identified central issues of access to health-care for cross-border and migrant populations and established strategic actions to improve access and rights protection, in cooperation with local authorities and civil society actors. The initiative also supported a series of analytical research studies published in a comprehensive volume on “Borders and health in Latin America: Migration HIV/AIDS, sexual violence and sexual and reproductive health”.<sup>326</sup>

**Argentina-Bolivia:** Since Argentina already had strong national legal instruments ensuring health and HIV rights of migrants, the main goal of the initiative was to build institutional capacity, diffuse the normative framework and increase knowledge on the migration phenomenon. The programme allowed for the cooperation between frontier and public health authorities in Argentina and Bolivia. Subsequently, the Commission for Refugee Support promoted a project based on communication, capacity-building and legal support for the promotion of sexual rights and reproductive health for migrants, in cooperation with organizations of Bolivian migrant women, the *Bolivian Communications Network in Argentina*, the *Association of Communitarian Radios and the Juridical Clinic Supporting Migrants and Refugees* (a program of the NGOs CAREF, CELS and UBA).

In **Colombia**, the project helped implement the *INTEGRA* strategy in the municipalities of Tumaco and Ipiales adjacent to the border with **Ecuador** for HIV testing. This area (on both sides of the border) hosted large numbers of people displaced due to armed conflict in parts of Colombia. These populations have experienced high rates of maternal mortality, teenage pregnancy, HIV and reported trafficking of women.

A **result** of this Colombia-Ecuador border region health project was the formation of a working group on *Work and Sexual and Reproductive Health* within the Technical Bi-national Committee on Social and Cultural Affairs. The initiative also encouraged and supported public administrators of the (Colombia) National Program on HIV and AIDS to integrate women sex workers into its programs.

### Migrant Worker’s Task Force, Lebanon

**Context:** Lebanon hosts at least 200,000 migrant domestic workers, primarily from Ethiopia, the Philippines, Bangladesh, Sri Lanka and Nepal. As in many countries, migrant workers in Lebanon often face difficult and degrading working conditions. The sponsorship system that controls foreign labour in Lebanon ensures that migrant workers who leave or quit their employers lose their residency status, no matter whether departure is for cause of abuse or contract violations.

<sup>326</sup> R. Leyva Flores, René and G. Guerra y Guerra (eds): *Fronteras y salud en América Latina: Migración VIH-SIDA, violencia sexual y salud sexual y reproductiva* [Borders and health in Latin America: Migration HIV/AIDS, sexual violence and sexual and reproductive health] (Cuernavaca, México, Instituto de Salud Pública, 2011). [http://www.imumi.org/attachments/article/281/frontera\\_salud\\_al.pdf](http://www.imumi.org/attachments/article/281/frontera_salud_al.pdf) (this practice brief is drawn from that study on borders and health in Latin America).



**Purpose and Objectives:** The Migrant Worker's Task Force (MWTF) is a grassroots volunteer organization advocating for improved treatment and social advancement of the migrant worker community in Lebanon, with significant efforts dedicated to increase health awareness.

**Activities:** MWTF offers peer education sessions on sexual and reproductive health (encompassing modules on female and male anatomy, menstrual cycle and masturbation, hygiene, Sexually Transmitted Infections and HIV/AIDS and protection). In collaboration with AltCity.me, it organizes a "health days" event which provide an occasion for migrants to receive a general check-up and undergo voluntary HIV tests. In the waiting rooms, patients are exposed to slide shows and informational sessions on health issues, including on protection and treatment of sexually transmitted infections, including HIV. MWTF also helps put in place a referral system with doctors and free access to clinics for migrants who cannot obtain affordable health care in Lebanon.<sup>327</sup>

**Website:** <https://mwtaskforce.wordpress.com/MigHealthHIV> guidebook Section 5 practices 12aug2016.docx

### **DomestiCare, South Africa**

**Context:** A defining characteristic of domestic workers in **South Africa** is that most are internal migrant workers. Many live in isolated situations and work under strenuous conditions. The common violation of labour rights and absence of social protection intensifies the risks faced by this working population to HIV.

**Purpose and Objectives:** *DomestiCare* is a private, affordable healthcare insurance option for South African domestic workers run by two of the largest healthcare companies in the country: Occupational Cares South Africa (OCSA) and CareCross Health.

**Activities:** At minimal cost to the employer, the insurance gives domestic workers employed in private households the right to occupational and private primary healthcare, previously unavailable for this group of employees. It provides for consultations with general practitioners, medicines, X-rays and blood testing. At additional cost, *DomestiCare Plus* also offers basic optometry and dentistry benefits, after required waiting periods.

**Outcomes:** Proponents of this initiative remark that it not only enhances realization of basic health rights, it also contributes to healthier workers, reducing sick leave and turnover, improving productivity, and enhancing worker loyalty and satisfaction.<sup>328</sup>

**Website:** <http://www.domesticare.co.za/>

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<sup>327</sup> The Protection Project at The Johns Hopkins University, *100 Best Practices in the Protection of Migrant Workers* (Baltimore, MD: The Protection Project at The Johns Hopkins University, 2013): 12.

<sup>328</sup> The Protection Project at The Johns Hopkins University, *100 Best Practices in the Protection of Migrant Workers* (Baltimore, MD: The Protection Project at The Johns Hopkins University, 2013): 20.

The **Swedish** government initiated significant reforms advancing the right to access to healthcare for all migrants, regardless of their immigration status. From July 2013, the new reform granted access to ordinary healthcare to undocumented children below the age of 18 and granted access to emergency healthcare – including dental, maternity, sexual and reproductive care, and contraceptive counselling – to all migrants in irregular situations. The law also stipulates that county councils are able to offer undocumented migrants the same level of care available to residents.<sup>329</sup>

In **Italy**, local authorities also implemented a creative approach to guarantee access to healthcare for all migrants. In 2009, the regional government of Puglia introduced legislation granting undocumented migrants full access to healthcare as well as the right to select a family doctor and a pediatrician for their children. Effective responses were put in place to overcome the practical and cultural barriers faced by irregular migrants. In cooperation with the non-governmental organization “Emergency” and the local health care unit of Foggia, a mobile clinic called “Polibus” was launched and delivered healthcare services throughout the region. Between June and November 2012, Polibus reached 1,709 patients. This initiative has had a relevant and positive impact and served as an important tool for raising awareness on HIV amongst both undocumented migrants and health care professionals.<sup>330</sup>

In **Belgium**, a team of 80 cultural mediators working in 60 hospitals acted as interpreters and accompanied patients to the doctor. These mediators were often recruited among migrant communities to facilitate dialogue and inclusion. Such presence helped overcome possible misunderstandings and conflicts and was judged useful by health practitioners.<sup>331</sup> The incorporation of training on cultural competence into the education of health professionals or separate training is another response to bridge cultural barriers of migrants to access healthcare services.

Universities in **Canada**, the **US**, the **UK**, the **Netherlands** and **Sweden** have included cultural competence into undergraduate medical training programmes. The aim of this approach is not to classify patients according to a certain ‘culture’, which would be similar to stereotyping migrants, but rather to train health professionals to develop skills in intercultural communication, openness, attitude and respect and to acquire insight of their own culture and implicit assumptions.<sup>332</sup>

## 4.8 Developing Law and Policy to Ensure Global Standards on HIV Apply to All Migrants

States should adopt laws and policies to attain existing global standards as well as amend existing legislation to ensure it is in accordance with existing standards. This includes the elimination of mandatory HIV testing for entry into and maintaining employment, and elimination of travel restrictions based on HIV status. It also means putting in place the implementation mechanisms and training to ensure the practical application of standards on HIV to all migrants.

<sup>329</sup> Platform for International Cooperation on Undocumented Migrants. 2013. *Guaranteeing Access to Health Care for Undocumented Migrants in Europe: What Role Can Local and Regional Authorities Play* (Brussels, PICUM, 2013).

<sup>330</sup> Ibid.

<sup>331</sup> H. Verrept: “Intercultural Mediation: An Answer to Health Disparities?” in *Crossing Borders in Community Interpreting: Definitions and Dilemmas* (John Benjamin Publishing Company, 2008).

<sup>332</sup> K. Bozorgmehr et al.: “The ‘Global Health’ Education Framework: a Conceptual Guide for Monitoring, Evaluation and Practice” in *Globalization and Health* (2011, Vol. 7, No. 8, April).

## Key Actions:

**A. Develop legislation and policy in an inclusive manner.** Adopt or revise national legislation to bring it in line with international standards on HIV and AIDS and non-discrimination. Establish explicit public health and workplace policy on HIV and AIDS and ensure that it appropriately and inclusively addresses all migrants, and returnees. Representative organizations of employers and workers, civil society groups as well as organizations representing PLHIV should engage with national parliaments and executive branches of government in developing national legislation, policies and programmes.

**B. Reinforce non-discrimination.** Include real or perceived HIV status as a prohibited ground of discrimination in national legislation.

**C. End Mandatory Testing for HIV.** Prohibit mandatory testing, ensuring that no individual, including any migrant, is forced to undergo HIV testing against his or her will. Advocate that mandatory HIV testing be phased out, including repealing laws and regulations that establish mandatory HIV screening of migrants.

**D. End travel restrictions.** Lift restrictions on international travel, cross border movement and on residency based on migrants' HIV status and repeal legislation permitting coercive measures such as isolation, detention and quarantine on the basis of HIV status. Advocate for bilateral and multilateral agreements between origin, transit and destination countries to remove HIV-related travel, entry and residence restrictions.

**E. Create implementing mechanisms.** Ensure that migrants are explicitly protected in HIV legislation and develop Codes of Practice that complement national legislation, where they do not exist, taking into account the ILO Code of Practice on HIV/AIDS of 2001, the ILO HIV and AIDS Recommendation, 2010 (No. 200), and the International Guidelines on HIV/AIDS and Human Rights.

**F. Address the specific situation of women migrants.** Ensure that the specific needs of women are included in national responses to HIV and AIDS. Urge, among other measures, their engagement in sexual and reproductive health education.

**G. Address the specific needs of migrant children and youth as well as family members in homelands.** Ensure adequate health care and welfare support as well as specific HIV prevention for children and youth whose parent or parents are migrants abroad. Also ensure that measures are taken to prevent child labour and trafficking of children that may arise from death or illness of family members or caregivers due to AIDS.

**H. Training on HIV standards.** Provide training and capacity building for judges, law enforcement authorities, public officials and advocates as well as migrants to receive training to enhance their understanding of HIV and AIDS and of international, regional and national standards that safeguard the rights of migrants living with HIV, as well as on methods to prevent discrimination against PLHIV and migrant workers.

**I. Include HIV information in migration-related programming.** All stakeholders in migration issues should support the incorporation of health and HIV-related issues into programmes during pre-departure, post-arrival, return and reintegration processes and other programmes and activities implemented among migrant and refugee communities and organizations.

#### 4.8.1 Initiatives and Experiences in Developing Law and Policy Applying Global Standards on HIV to All Migrants

Many countries have recognized the importance of ensuring that their legislation relative to HIV at the workplace is applicable to all sectors of the economy. A number of countries have adopted laws on HIV and AIDS at the workplace that cover all workers regardless of the sector where they are employed.

In **Mozambique**, the law states explicitly that its protections apply to all workers and candidates for employment no matter where they are working, whether in the public administration, public or private sectors, and including domestic workers.<sup>333</sup>

In **Brazil**, the law requires employers to address HIV prevention issues in their safety and health committees, stating explicitly that rural employers are not exempt from this obligation.

Other countries, such as **South Africa, Namibia, Fiji, Costa Rica** and the **Dominican Republic** explicitly include HIV status as a prohibited ground of discrimination for employment purposes.<sup>334</sup>

**Ukraine** amended its national legislation on HIV and AIDS in 2010. The revised legislation removed HIV-related restrictions on entry of foreigners to the country, made it possible for non-governmental organizations to receive State contracts for providing HIV services, abolished the requirement for statutory disclosure of HIV status to a partner and established the rights to compensation for unlawful disclosure of one's HIV status, and ensured provision of opioid substitution therapy for injecting drug users. The revised law is a result of collaborative work involving non-governmental sectors, especially the All-Ukrainian Network of People living with HIV, the support from the USAID-funded HIV/AIDS Service Capacity Project in Ukraine and the United Nations Team Group on HIV/AIDS.<sup>335</sup>

In July 2010, **Namibia** lifted its travel restrictions against people living with HIV. People living with HIV were no longer barred from entering, staying or seeking residence in Namibia based solely on HIV positive status.

In August 2015, **Singapore** lifted its two-decade-long ban on HIV-infected people entering the country for short-term visitors staying for less than three months.

<sup>333</sup> Law No. 19/2014, of 27 August 2014, on Protection of the Rights of people, workers or prospective workers living with HIV from non-discrimination in the workplace.

<sup>334</sup> ILO: *Good Practices in Labour Inspection on HIV and AIDS* (Geneva, ILO, 2012): 17.

<sup>335</sup> World Health Organization. 2010. *Revised HIV Law in Ukraine*, WHO Regional Office for Europe (15 October 2010). <http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/news/news/2010/11/revised-hiv-law-in-ukraine> [accessed 25 September 2017].

## 4.9 Ensuring Migrant Access to Health Prevention, Treatment, Care and Support on HIV

UNAIDS and its cosponsors, including the ILO, are expected to support national governments and other actors in providing for appropriate HIV-related services and support in the context of mobility, including HIV and Sexually Transmitted Infections (STIs) information, provision of condoms and voluntary, confidential testing.<sup>336</sup> Adequate treatment, including provision of access to ARVs, should be included in the general framework of national and local public health policies.

In order to maintain healthy populations, ensure productive participation in work and society and to reduce transmission risks of HIV and other communicable diseases, health services tailored to migrants need to be accessible at all stages of migration – prior to departure, on arrival, during stay, settlement and integration, and upon return and reintegration for those returning to origin countries. They are therefore needed in countries of origin, transit and destination. Governments and other stakeholders may have to take additional, targeted measures for particular groups in society, among them migrant workers, so that they can enjoy equal access to prevention services, care and treatment of HIV. National obligations to ensure access for all to medical services include ensuring that no one is refused healthcare on the basis of HIV positive status.

Policies need to address the root causes of HIV vulnerability for migrants, including poverty, gender inequality, lack of employment options, lack of education, cultural and language barriers, as well as human rights violations affecting migrants in both regular and irregular status. Strategies should pay particular attention to obstacles to accessing health care, such as isolated living and working conditions. Gender, psychological disruption, and the nature of mobile work should also be taken into account. Failure to tailor services to the needs and circumstances of migrants may lead to incorrect diagnoses, inappropriate treatment and poor compliance on the part of patients.

### Key Actions:

**A. Make HIV related health care services accessible to all migrants.** Ensure that national laws and regulations recognize the right to health of migrants regarding HIV and AIDS and do not create barriers for them to access health and HIV-related services. Monitor legislation, regulations, and policies and programmes to ensure the physical accessibility and geographic proximity of services for migrants. This includes ensuring that health services and facilities, and access to them, take account of specific needs and situations of women and girl migrants as well as language and cultural barriers.

**B. Engage migrants and the public to counter discrimination and stigma.** Support the implementation of culturally sensitive information and education programmes to overcome discrimination, and particularly stigma regarding HIV and AIDS, both within migrant communities and for the general public. Ensure that these efforts, which may include campaigns, are designed to dispel misconceptions and to counter discrimination and social exclusion of migrants as well as PLHIV among migrant populations. Mechanisms

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<sup>336</sup> General Assembly resolution 65/277, *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, A/RES/65/277, (10 June 2011). [http://www.unaids.org/sites/default/files/sub\\_landing/files/20110610\\_UN\\_A-RES-65-277\\_en.pdf](http://www.unaids.org/sites/default/files/sub_landing/files/20110610_UN_A-RES-65-277_en.pdf) [accessed 25 September 2017].

for providing protection from HIV-related stigma, especially for key vulnerable populations, should also be put in place.

**C. Address the needs of specific groups.** Specific groups, including undocumented migrants and internal migrants, need to be addressed. Identify specific populations of concern and establish specific outreach policy and action. Advocate for and facilitate cooperation among public health authorities and institutions and civil society and migrant organizations to engage in proactive outreach, which may require mapping locations where mobile populations transit, congregate or settle, meaning places where they work, trade, and seek services. Subsequent to mapping, promote and support establishing appropriate health and HIV education, diagnosis and treatment services accessible to those places.

**D. Provide appropriate health care and related services addressing HIV and AIDS.** Establish or strengthen direct health care services with HIV and AIDS components including prevention, information-education, testing and treatment as well as professional training. Conduct assessment reviews to identify needs and availability of services. Advocate for adequate public health finances to support HIV care services for all in need. Facilitate cooperation among different actors, particularly public health institutions, private actors, civil society organizations, migrant communities and international partners. Organize and provide training for health care personnel and other practitioners including specifically on HIV prevention and treatment as well as on eliminating discrimination.

**E. Ensure that information on HIV and AIDS reaches all migrants.** Ensure that information about HIV and available services reaches migrants and members of their families directly, to increase the likelihood that they will engage in prevention and take advantage of available services. Provide contact information to migrants regarding health, social service, civil society and migrant organizations offering support, solidarity and participation, including those specifically addressing HIV, Tuberculosis (TB), Sexually Transmitted Infections (STIs) and other infectious illnesses.

**F. Focus on family members remaining “at home”.** Ensuring the engagement of family members during the pre-departure training, providing them with information on health, including HIV prevention and access to health services during the absence of and return of their spouse.

**G. Ensure financial means for HIV health services for migrants.** Advocate for and support adequate funding means and streams to ensure that migrants have the same economic access as nationals to health services for HIV prevention, treatment, care and support programmes. Identify gaps and engage non-governmental, civil society and private actors in advocacy and action on HIV and AIDS services for all migrants.

#### 4.9.1 Initiatives and Experiences in Ensuring Migrant Access to HIV Prevention, Treatment, Care and Support

Shown here are a range of initiatives around the world addressing migrant access to HIV prevention, care, treatment and support.

### **Enhancing Mobile Populations' access to HIV Services, Information and Support (EMPHASIS), Bangladesh, India & Nepal**

**Context:** According to the Serological Surveillance in Bangladesh in 2011, HIV prevalence among people who use drugs, female and male sex workers, men who have sex with men, and Hijras (transgendered community) was 0.7 per cent. Although this HIV prevalence was below 1 per cent, it was significantly higher than the 0.1 per cent prevalence in the general population.

**Purpose and Objectives:** EMPHASIS was a 5-year (2009-14) HIV intervention programme led by CARE country offices in India, Bangladesh and Nepal, and funded by BIG Lottery Group of the United Kingdom. The EMPHASIS initiative had three main objectives: improving access to social and health services across the mobility continuum; reinforcing capacities of the key stakeholders and populations concerned; and improving policy environment on migration and mobility issues. It provided a diverse range of services focused on cross border migrants and their partners to decrease the vulnerability of mobile populations to HIV and AIDS, giving special attention to women migrants and male migrants' wives.

**Activities:** The project was composed of four interdependent focus areas: an information network; access to HIV and other-related services; safe mobility for migrants; and women's empowerment. Following the logic of migration, an information network of static and drop-in service centres, community-led management committees, referral networks and cross-border reflection meetings was carefully crafted. Migrants and their families were given greater access to health and HIV-related services due to the panoply of referral mechanisms for antiretroviral therapy (ART), health camps and mobile clinics. Two mobility corridors were identified to more closely monitor and address violence and harassment against women and to provide them with the tools to obtain economic empowerment. As well, 'creative spaces' were created as places for expression and exchange. The endeavour required participation and development of partnerships with private sector actors such as hoteliers, as well as transport unions, spouse groups, District AIDS Coordination Committees and migrant workers at district level.

**Outcomes:** The project reached 340,000 individuals in the sub-region over its five-year time-frame. It worked closely with national networks of people living with HIV, and was seen to have facilitated access to testing, treatment and counselling services as well as enrolment in governmental targeted intervention programs.<sup>337</sup>

### **CARAM Cambodia Programs and Partnerships<sup>338</sup>**

**Context:** HIV prevalence in Cambodia among general population adults aged 15 to 49 declined from 2 per cent in 1998 to 0.7 per cent in 2013. In spite of this decline, the HIV epidemic remains concentrated among certain populations at higher risk of infection: entertainment workers (EW) (i.e. women who exchange sexual services for money or goods, either regularly or occasionally where the sex worker may not consciously define such activity as income-generating), men who have sex with men, and people

<sup>337</sup> ILO: *Leaving No One Behind: Reaching Key Populations through workplace action on HIV and AIDS* (Geneva, ILO, 2014):60-62; D. Walker et al.: "Migration, Health and Dignity in South Asia Lessons from the EMPHASIS project on migration, women's empowerment and HIV in Bangladesh, India and Nepal" in *EMPHASIS Learning Series: Towards safety, dignity and better health of migrants*. Overseas Development Institute, Big Lottery Fund and Care, 2011.

<sup>338</sup> The Protection Project at The Johns Hopkins University, *100 Best Practices in the Protection of Migrant Workers* (Baltimore, MD: The Protection Project at The Johns Hopkins University, 2013): 55.



who inject drugs. The prevalence of HIV among EW, for instance, is estimated at 14 per cent. Engaging in relations with multiple partners is a driving force of the epidemic, as 48 per cent of all new infections result from spousal transmission, 25 per cent through sex work, and a further 11 per cent of estimated new infections from casual sex.

**Purpose and Objectives:** Founded in 1999, the Coordination of Action Research on AIDS and Mobility Cambodia (CARAM Cambodia), affiliated with the Asia regional CARAM network, is an organization working to assist migrant workers and their families in obtaining the necessary information and services related to HIV prevention, treatment and support.

**Activities and Outcomes:** CARAM Cambodia services focus on support for decent work, such as through pre-departure training for domestic workers, legal support for migrant workers, assistance in the repatriation and reintegration of exploitation victims. It has conducted safe migration advocacy work through radio, television and public forums. Its outreach programs work through locally engaged peer facilitators and educators. From 2005 to 2009, over 40 entertainment workers were selected as peer educators to facilitate trainings. In 2012 and 2013, CARAM Cambodia conducted a number of its activities with Winrock International (a US-based private development organization).<sup>339</sup> CARAM Cambodia also works with KHANA<sup>340</sup> “the largest national NGO providing HIV prevention, care and support services at the community level” to improve sexual health conditions of both Cambodian and Vietnamese Entertainment workers operating in Phnom Penh.

**Website:** <http://www.caramcambodia.org>

### SAARC Regional Strategy on HIV and AIDS

**Context:** At the end of 2005, out of the total of 8.3 million adults and children living with HIV in Asia, over 5 million were estimated to be within the area of the South Asia Association of Regional Cooperation (SAARC).

**Purpose and Objectives:** Considering the higher prevalence of the epidemic in the region and the need for a coordinated response, SAARC formulated the *Regional Strategy on HIV and AIDS (2006-2010)*. This strategy envisaged: halting and reversing the spread and the impact of HIV and AIDS; encouraging national leaders to respond to HIV and AIDS; and providing people living with HIV with access to affordable treatment and care.

**Activities:** Activities were divided in three main areas: policy and advocacy; prevention; and treatment and care. In the policy and advocacy area, the strategy called for and promoted greater regional dialogue on cross-border issues relevant to HIV and AIDS. Through ministerial meetings, program manager meetings and meetings of the Technical Committee on Women, Youth and Children, stakeholders discussed policies to better account for safe mobility and displacement, addressing also drug use and related risks. The process benefited from collaboration with UN agencies, including UNHCR, UNODC and UNAIDS.<sup>341</sup>

<sup>339</sup> Website at: <https://www.winrock.org/about/>.

<sup>340</sup> Website at: <http://www.khana.org/kh/>.

<sup>341</sup> F. Samuels and S. Wagle: *Population Mobility and HIV and AIDS review of laws, policies and treaties between Bangladesh, Nepal and India* Background note (Overseas Development Institute 2011). [http://www.junima.org/resources/pdf/population\\_mobility\\_HIV\\_AIDS.pdf](http://www.junima.org/resources/pdf/population_mobility_HIV_AIDS.pdf).

### ***Bué Fixe* “Youth Media, Our Response to HIV/AIDS” Programme, Portugal**

**Context:** Many young migrants coming to **Portugal** from the Community of Portuguese Language Countries (CPLP) in Africa have limited access to information on sexual and reproductive health – including HIV – which may be conducive to risky sexual behaviour. Vulnerability to the HIV epidemic is exacerbated by social exclusion deriving from and contributing to unemployment, drug abuse, dissolution of family ties, and violence.

**Purpose and Objectives:** *Bué Fixe* is a youth organization that aims at encouraging migrants from the CPLP living in deprived neighbourhoods of Amadora in the outskirts of Lisbon to adopt safer attitudes and behaviour regarding HIV and AIDS. Through the *Youth Media, Our Response to HIV/AIDS* programme initiated in 2009, *Bué Fixe* works to attain this goal by: scaling up existing and effective HIV prevention initiatives in order to reach other young migrants; expanding adequate support and opportunities to people living with HIV in the community; empowering the youth (especially young women) so that they mitigate HIV risks through safer attitudes and behaviour; and developing community-based initiatives focusing on reducing stigma and discrimination towards people living with HIV.

**Activities:** *Bué Fixe* trains young community leaders through workshops, conferences and debates in order to increase their knowledge and skills on HIV- and AIDS-related matters, distributes condoms in places commonly frequented by the targeted population (e.g. night clubs, hair dresser salons and public spaces), circulates informative material in schools, shopping centers and libraries, and provides information and services on HIV and AIDS through text messages and a participative radio broadcast. The programme uses media outlets (i.e. a radio, a magazine, a *Facebook* page and a blog) to diffuse information on HIV and AIDS for young migrants. Members regularly participate in European dialogues and engage in partnerships with other organizations to exchange practices and collaborate on HIV prevention strategies.

**Outcomes:** In the first year of the programme, *Bué Fixe* produced forty radio programmes on HIV and AIDS and five editions of its magazine, distributed 10,000 condoms, sent weekly text messages to around 600 young migrants, and distributed informative leaflets.<sup>342</sup>

**Facebook Website:** <https://www.facebook.com/AssociacaoBUEFIXE/>

**Youtube Channel:** <https://www.youtube.com/channel/UCAgBWFR5RHp4Ko-FeHsn6EQ>

### **Tunisian Association Against Sexually Transmitted Diseases and HIV/AIDS**

**Context:** Tunisia has been identified by the *Global Network of Researchers on HIV and AIDS in the Middle East and North Africa* as a country with one of the most far-reaching and comprehensive approaches to respond to HIV and AIDS in the region. Efforts encompassed the distribution of condoms, lubricants and single-use syringes; free treatment of people with HIV; and awareness projects among sex workers, drug users, prisoners and men who have sex with men. In spite of such efforts, stigma remains as a major impediment to the delivery and access to HIV prevention and treatment strategies.

**Purpose and Objectives:** The *Tunisian Association Against Sexually Transmitted Diseases and AIDS* (ATL MST SIDA) was created in 1990 with the following objectives: to prevent HIV among young people

<sup>342</sup> See Facebook Page: <https://www.facebook.com/AssociacaoBUEFIXE/>.

and high risk populations (i.e. injecting drug users, sex workers, and men who have sex with men); to provide anonymous and voluntary testing for HIV; to support people living with HIV; and to fight against discrimination and stigma associated with the disease.

**Activities:** Since its foundation in the height of the HIV epidemic, *ATL MST SIDA* works together with other national and regional non-governmental organizations, the Ministry of Social Affairs of Tunisians, the embassies of Canada and the United States, UNFPA and UNICEF and has created several sections across the country. *ATL MST SIDA* has undertaken activities in: promoting awareness sessions and distribution of condoms in school structures and in other targeted locations (e.g. beaches, festivals, detention centres and cultural events); training peer educators including members of high-risk populations; providing psycho-social support for people living with HIV; offering free and anonymous screening; and providing care and support for sex workers.<sup>343</sup>

**Website:** <http://www.atlmstsida.org/news.php>

The Channeling Hope Project was a joint initiative organized by WorldVision **Russian Federation**, Moscow patriarchate - department for Church external relations, the non-governmental organization "Positive Initiative" and the AIDS centre in Orenburg, as well as "Diakona" and the AIDS centre in St-Petersburg. The project aimed at equipping youth with skills in order to reduce their HIV-related vulnerability. Activities included training and workshops for the staff of educational institutions, training and mobilization workshops for the faith communities, development of peer and educational manuals. HIV counselling and testing was also provided. At least 4,800 youths were targeted while another 9,000 were targeted through trained peer educators, comprising 50 priests from these two regions, 50 staff of the educational institutions and at least 50 health providers. Such intervention and targeted approaches helped to address the stigma associated with HIV and AIDS, while the methodology used was approved by the Ministry of Education of Orenburg and became part of the education curriculum of the educational institutions.<sup>344</sup>

#### 4.10 Specific Actions for Refugees and Asylum-Seekers and for Internally Displaced Persons (IDPs) on HIV and AIDS

The 2001 United Nations General Assembly Declaration of Commitment on HIV and AIDS recognizes that "populations destabilized by armed conflict, humanitarian emergencies and natural disasters, including refugees and internally displaced persons, in particular women and children, are at a higher level of risk of exposure to HIV infection" and that there is a need to "implement national strategies that incorporate HIV and AIDS

<sup>343</sup> See ATLMSTSIDA website: [http://www.atlmstsida.org/viewpage.php?page\\_id=6](http://www.atlmstsida.org/viewpage.php?page_id=6).

<sup>344</sup> K. Zezulova: *Cross-border cooperation for HIV/AIDS prevention and impact mitigation in Southern Caucasus and Russian Federation*. Report. (World Vision Georgia, 2013).

awareness, prevention, care and treatment elements into programmes or action that respond to emergency situations...”.<sup>345</sup>

The overlapping issues faced by refugees, asylum seekers and internally displaced persons (IDPs) are key concerns within the bigger picture of human migration. Specific, targeted approaches are needed for refugees and asylum seekers, and for internally displaced persons. In some cases, this requires regional as well as national approaches while some situations may require combined interventions.

IDPs should be able to enjoy the same HIV prevention, treatment, care and support services as any other citizen in the country. Policies and programmes need to safeguard refugees' and asylum seekers' rights as well as their well-being, whether they opt to seek asylum on refugee grounds, find refuge in another State, return home voluntarily, integrate locally, or resettle in a third country.

During the emergency phase of a disaster as well as in warfare, there is often considerable disruption to available health services, including the ability to ensure continued access to ARV therapy. Providing HIV services to IDPs and others affected by humanitarian crisis is a difficult undertaking, due to the damage inflicted to health and community structures in situations of conflict or natural disaster.

Similarly, arrivals of large numbers of refugees into countries of safe haven –often those neighbouring countries in conflict – can overwhelm health care and other services. In many situations, refugees arrive directly from warfare and generalized violence with physical and psychological trauma, as well as loss of family members and total disruption of their lives, rendering urgent need for immediate medical and psychosocial attention. Multi-sectoral health interventions including HIV and AIDS components should be implemented as early as possible, and then followed by an expanded package of prevention, treatment, care and support that is tailored according to the health needs and epidemiological context.

## Refugees, Asylum Seekers and IDPs

### Key Actions:

**A. Ensure integration of HIV policies.** Promote mainstreaming of health and HIV policies into conflict-prevention activities, peacekeeping operations, disaster preparedness and contingency plans, humanitarian responses to crises and post-conflict and post-disaster reconstruction planning and implementation.

**B. Integrate HIV into assessments.** Assessments or other data collection efforts conducted among internally displaced persons, refugees and asylum seekers in such contexts as health, security, nutrition, or education should contain an HIV component.

**C. Educate young people about HIV.** Ensure that IDP and refugee children and young people have HIV information included as part of the education curriculum they receive.

**D. Make planning participatory.** Ensure that IDPs, refugees and asylum seekers be included in the processes of developing, implementing and evaluating policies and programmes that affect them.

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<sup>345</sup> General Assembly resolution S-26/2, Special Session on HIV/AIDS: Declaration of Commitment on HIV/AIDS, A/RES/S-26/2, (27 June 2001) para. 75. <http://www.un.org/ga/aids/docs/aress262.pdf> [accessed 25 September 2017].

**E. Address gender-based violence.** Integrate gender concerns into all health programmes and services for IDPs, including those addressing HIV and AIDS. In particular, gender-based violence, its prevention and specific psycho-social support for victims should be recognized and addressed.

## Refugees and Asylum Seekers

### Key Actions:

**A. Provide information, health assessment and urgent care on arrival.** Advocate for and support immediate health assessment and emergency care on arrival. Refugees and asylum-seekers should be given information immediately on how to access health care services, including HIV prevention and treatment services.

**B. Mobilize international support for health care in highly impacted places.** Facilitate international cooperation and support to provide means and capacity for health services commensurate with need in localities and countries facing large scale arrivals and/or large refugee populations.

**C. Include HIV within the wider set of services.** Promote inclusion of HIV information and services as part of a wider set of health care services for refugees and asylum seekers, including prevention of mother-to-child transmission, paediatric treatment and care, reproductive health, and psychological support for post-traumatic situations.

**D. Continue ongoing services for refugees.** Promote ongoing availability of and access to health care services for refugees and asylum seekers, whether they remain in a country of first asylum, find refuge in another country, resettle in a third country or return home voluntarily. Ensure that voluntary testing, counselling, and medical care specific to HIV and AIDS remain fundamental components of ongoing health care for refugees, as well as in the event of return or resettlement.

**E. Make HIV services accessible.** Advocate for locating recognizable facilities that provide HIV care and family planning services in areas that are accessible to refugees, and have the capacity to respond to individuals who have suffered trauma.

## Internally Displaced Persons (IDPs)

### Key Actions:

**A. Incorporate internally displaced persons into national plans and programmes.** Include IDPs in national health plans and national public health services. National HIV policies and strategic plans should include guarantees that IDPs have equal access to HIV services at the same level as other nationals.

**B. Link IDPs with relevant services.** Advocate, support and facilitate the establishment of adequately supported mechanisms to link IDPs to health care and specifically HIV services to ensure access to treatment and continuity of care. Services should include prevention, voluntary counselling and testing, treatment and care, and should be based where IDPs may be located or may be compelled to move to.

#### 4.10.1 Initiatives and Experiences on Actions Addressing Refugees, Asylum Seekers and Internally Displaced Persons

##### **Refugee Women in Agriculture for Rural Development (REWARD) project, Rwanda**

**Context:** Around 1.4 per cent of the total Gihembe refugee camp population in the Northern province of Rwanda is HIV-positive. As HIV-stigma often leads to social exclusion and violence, women refugees living with HIV experience double discrimination due to traditional gender role constraints.

**Purpose and Objectives:** The *ONE UN Rwanda* programme works with the national government and local associations to improve the quality of HIV prevention, treatment, care and support and reproductive health services among pregnant women, children, youth and other key populations. In the Gihembe camp, it supports the *REWARD* project, which aims to economically empower women refugees living with HIV/AIDS; and the Tubeho Association (“Lets live” in Kinyarwanda) to improve their economic security and prevent gender-based violence.

**Activities:** For the well-functioning of the project, each woman devotes one full day a week to REWARD. Women meet regularly to discuss women’s issues, including health and finance, as well as project coordination. The group pools their resources and shares their savings, using consensus decision-making. Through the project, supplementary food is provided for women who have special nutritional needs because of their HIV status.<sup>346</sup>

##### **Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa**

**Context:** Millions of people are now able to successfully take antiretroviral therapy (ART) in a variety of different contexts and environments, including in low-income countries and in humanitarian relief settings. Nonetheless, international legal guidelines on the management and use of ART had not inclusively addressed migrants and crisis-affected populations in sub-Saharan Africa prior to 2013.

**Purpose and Objectives:** The Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa is an update of the 2007 Clinical Guidelines for antiretroviral therapy management for displaced populations in Southern Africa, released by the United Nations High Commissioner for Refugees (UNHCR) and the Southern African HIV Clinicians Society. It also complements the WHO’s 2013 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing infection. It aims at expanding the provision of ART to migrants and crisis-affected populations, whether or not they are displaced and to operationalize the recommendations found in WHO’s 2013 guidelines, by focusing on supporting clinicians in adopting a more integrated treatment response, acknowledging patients’ histories and trajectories.<sup>347</sup>

<sup>346</sup> One UN Rwanda. 2014. *Congolese refugees living with HIV forge ahead, gaining independence*. Human Development; Success stories. <http://www.rw.one.un.org/press-center/success-story/congolese-refugees-living-hiv-forge-ahead-gaining-independence> [accessed 25 September 2017].

<sup>347</sup> 2014. *Guidelines for the Delivery of Antiretroviral Therapy to Migrants and Crisis-Affected Persons in Sub-Saharan Africa* (September 2014) [http://www.unicef.org/aids/files/ART2014-189014B-LOWRES\\_\(1\).pdf](http://www.unicef.org/aids/files/ART2014-189014B-LOWRES_(1).pdf) [accessed 25 September 2017].



UNODC and UNHCR established and helped to improve **HIV prevention, treatment and care for services targeting Afghan refugees** in both **Iran** and **Pakistan**, as well as returnees in **Afghanistan**. The following interventions were implemented: conducting a mapping and vulnerability study among returnees; capacity development in strengthening service provision for nongovernmental organizations and law enforcement staff; provision of healthcare services for people who inject drugs in a joint initiative with UNAIDS and WHO; supporting drop-in centres and outreach HIV services and establishing a methadone maintenance therapy programme in Kabul.<sup>348</sup>

Through partnership with the wider humanitarian community, UNAIDS implemented a global programme addressing **HIV and AIDS in humanitarian responses** between 2008 and 2012. Specific support has been provided at country-level to **Central African Republic, Chad, Myanmar, Mozambique, Colombia, Zimbabwe** and **Libya**, including the continuation of critical HIV-related health services to populations directly affected by crises. Interventions comprised the following: training in blood safety, syndrome management of STIs, capacity building to establish a protection, provision of food and nutrition, targeted interventions to provide social and health services to people using drugs, training and integration of HIV counselling and testing and sexual and reproductive health services to mobile population, and referral services for survivors of gender-based violence.<sup>349</sup>

UNHCR and WFP, in consultation with UNAIDS Secretariat coordinated with regional and country partners to gather vital information on the HIV epidemic among emergency-affected populations in the **Horn of Africa** region, and facilitated **effective strategies reducing the risk of exposure and providing adequate services to displaced people** living with HIV through full integration of HIV interventions within the broader humanitarian response. Interventions implemented in Dadaab refugee camps in Kenya, which host over 500,000 Somali displaced persons, include comprehensive emergency obstetric care in all hospitals of the camp; management of HIV notably access to ARV treatment through the national programme; HIV and reproduction health services for key populations at higher risks; prevention of mother to child transmission services and promotion and provision of condoms.<sup>350</sup>

The capacities of national counterparts have been built in order to ensure the **integration of HIV and AIDS into the preparation of plans in disaster-prone areas**. Training, in-depth guidance and awareness raising in all regions on the principle of HIV programming in emergency settings were conducted with UN Country Teams, UN Joint Teams on AIDS, UNAIDS Country Coordinators, representatives from National AIDS Commissions, government disasters management units, civil society organizations and the International Federation of Red Cross and Red Crescent Societies.

On addressing **gender-based violence and HIV**, UNDP provided financial support in fragile States to the programme entitled “A Gender-Responsive Approach for Reintegration and Peace Stabilization”. This programme was implemented in **Aceh, Indonesia**, and provided support to 450 vulnerable persons with a focus on women, including ex-combatants, women associated with armed forces and armed groups, and conflict victims in high-damaged villages. The project also mapped key HIV groups in Aceh and strengthened the capacity of relevant government stakeholders to addressing needs of these populations in government planning. Results suggested that most vulnerable persons were supported by the programme through the reintegration phase and were equipped to move forward with viable

<sup>348</sup> United Nations Office on Drugs and Crime (UNODC). 2012. *Country Programme for Afghanistan 2012-2014* (Vienna, UNODC, 2012).

<sup>349</sup> UNAIDS. 2012. *AIDS, Security and Humanitarian Response*, 30th Meeting of the UNAIDS Programme Coordination Board (Geneva, 5-7 June 2012).

<sup>350</sup> UNHCR, World Bank and IGAD. 2010. *HIV Behavioural Surveillance Survey in Dadaab Refugee Camps, Kenya*.



livelihood options. Moreover, mapping HIV target groups increased general awareness of HIV and served as the first step towards ensuring a continuum of care. Local governments are now equipped to include such groups in development planning.<sup>351</sup>

**Including HIV in the response to the humanitarian crisis following a natural disaster** can be achieved through mobilization, coordination and advocacy at the national level. In October 2011, **Central America** and **Mexico** were heavily affected by the Tropical Depression 12E. OCHA, jointly with the Risk, Emergency and Disaster Task Force Inter-Agency Workgroup for Latin America and The Caribbean, mobilized to respond to the emergency following the floods in El Salvador, Guatemala, Honduras and Nicaragua and to make sure that HIV was a priority in the response. In El Salvador, together with WFP, UNAIDS, NGOs and the Ministry of Health, they worked together to include HIV in Rapid Need Assessments and ensure that national hospitals immediately dispensed the ARV to any person living with HIV who had lost his or her treatment in the aftermath of the disaster. Additionally, Post-Exposure Prophylaxis and condoms were also included in hygienic kits distributed to the displaced persons.<sup>352</sup>

#### 4.11 Specific Targeted Approaches for Mobile Workers

Factors associated with HIV vulnerability may be accentuated for certain categories of mobile migrant workers due to the nature of work and mobility. For instance, transportation workers, such as long distance truck drivers or seafarers, who spend extended periods of time away from home, family and community may have both easier access to commercial sex and concurrent multiple partners as well as diminished access to prevention and treatment services.

The situations and conditions of mobile migrant workers and their family members require first of all recognition that they give rise to particular health service challenges and particular risks regarding HIV. While situations vary across different contexts, in most countries some or many mobile workers are engaged in transport, commerce, agriculture, construction, and informal cross-border trade sectors, among others. Specific public health approaches are needed, particularly to integrate them in national HIV and AIDS multi-sectoral strategic policies and plans and to encourage partnerships with existing institutions and stakeholders.

##### Key Actions:

**A. Generate more data on mobile workers.** Improve and enhance collection, analysis and dissemination of relevant, reliable disaggregated data on the different groups of mobile migrant workers, to best tailor health as well as HIV prevention and treatment programs toward their specific situations and needs.

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<sup>351</sup> UNDP. 2012. *How to Guide: Gender-Responsive Disarmament, Demobilization and Reintegration*, Inter-Agency Working Group on Disarmament, Demobilization and Reintegration (IAWG) (New York, 2012).

<sup>352</sup> UNAIDS. 2012. *AIDS, Security and Humanitarian Response*, 30th Meeting of the UNAIDS Programme Coordination Board (Geneva, 5-7 June 2012).

**B. Integrate mobile workers into HIV and AIDS planning and programmes.** Advocate for and contribute to integration of mobile workers in transport, agriculture, construction and informal cross-border trade into national HIV and AIDS multi-sectoral strategic plans.

**C. Collaborate with other stakeholders.** Build and participate in partnerships among existing institutions, organizations and coalitions among all relevant stakeholders, most notably mobile workers themselves, to advance legislation, policies and practices addressing health and HIV prevention and services for mobile workers and their families.

**D. Provide HIV information and care in an accessible manner.** Ensure that information on HIV and health care services is made available to mobile workers in the places where they are employed. This is particularly relevant in the transport sector. Advocate for and support an interconnected network of health service access points located where significant numbers of mobile workers congregate, which may be distinct places in different sectors.

**E. Improve working conditions for mobile workers.** Promote efforts to improve the working conditions of mobile workers, for example by developing recommendations and regulations calling for required rest breaks and maximum working time, as well as by establishing or improving facilities for rest at work-sites or on travel circuits.

#### 4.11.1 Initiatives and Experiences on Specific Targeted Approaches for Mobile Workers

##### The Transport Corridor Initiative in Southern Africa

**Context:** Development in Southern Africa significantly relies on road and rail routes connecting raw material resource extraction sites, industries, seaports, and population centers. The many 'mobile' migrant workers involved, notably transport workers, cross border commercial workers and others who are away from home and home countries frequently and for extended periods of time are at higher risk of exposure to HIV due to lack of knowledge on prevention and consequently risky sexual behaviour. Women in poor communities along transportation and commercial routes are especially at risk, since some have no alternative to resorting to commercial sex work as a source of income.

**Purpose and Objectives:** In 2007, ILO with funding from the Swedish International Development Agency (SIDA) set in motion a *transport corridor initiative* targeting cross-border mobile migrant workers and their families in South Africa, Zimbabwe, Malawi and Mozambique. In collaboration with cross-border institutions, companies and small or informal traders and communities regularly interacting with migrant workers in transportation and commerce, the ILO *transport corridor initiative* aims at improving key access to health services and HIV prevention mechanisms in transport corridors in Southern Africa.

**Activities:** The *transport corridor initiative* has trained peer educators, notably executives of 128 "cross-border institutions" (e.g. customs agencies and other regulatory bodies) and of 76 transport companies in the implementation of HIV and AIDS programmes and for the regular distribution of condoms. At the Ressano-Garcia border between South Africa and Mozambique, the project reached out to informal communities operating along the railways. An agreement was signed between ASSOTSI, an informal sector association, and customs authorities to ensure that informal workers are not excluded from access to HIV services at border areas. In Zimbabwe, the ILO facilitated the mobilization of leaders

among small businesses and informal sector associations, which led to the creation of a Savings and Credit Cooperative (SACCO) at a key border post. This cooperative offers short-term loans to its members with short-term loans, which provides them with a chance for greater local integration.

**Outcomes:** Over 42,000 transport workers, including long-distance truck drivers, are estimated to have benefited from the *transport corridor initiative*.<sup>353</sup>

Roadside centres are a considered solution to issues faced by **road transport workers**, particularly truck drivers. In **Bangladesh**, a joint programme by the International Transport Workers' Federation and Care-Bangladesh led to the setting up of an estimated network of 45 drop-in centres nationwide with a system of condom distribution through peer outreach to workers and more than 200 depot-holders (workers promoting good health practice and use of clinics in the communities), which helped avoid stigmatization and empower truck drivers' HIV protection abilities. Four thousand transport workers received services every month from the programme and were able to spend leisure time in these centres with their friends while receiving general medical services and HIV information and treatment.<sup>354</sup>

Other innovative approaches developed for **road transport workers** include development of a “smart cards” or “health passports” system strengthening long-term quality and efficiency of providing services along the road. In **South Africa**, the project “Trucking against AIDS” developed smart cards recording transport workers' medical history so that they can visit any clinic of the project and consequently have access to the services and treatment they may need. Distribution of condoms was also part of the services included while sex workers were reached and encouraged to go for voluntary counselling and testing.<sup>355</sup>

Counselling, care and treatment services offered to transport workers also benefit sex workers and other sex partners through HIV and STI awareness and education campaigns. Less common but as important is the intervention on transport workers' wives. In **India**, an initiative demonstrated some of the benefits, as well as difficulties, in facilitating communication on HIV between truckers and their wives. The Boruka AIDS Prevention project empowered mobile truckers' wives through training sessions and HIV awareness activities. At the end of each session, they were given a question to discuss with their husband and the most active women were selected as peer educators to enforce the sustainability of the project. Results concluded that wives have significantly increased their HIV knowledge and prevention ability, though dialogue with their husbands, who are on the road most of the time, remained difficult.<sup>356</sup>

<sup>353</sup> ILO: Leaving No One Behind: Reaching Key Populations through workplace action on HIV and AIDS (Geneva, ILO, 2014): 55-56.

<sup>354</sup> New Tactics in Human Rights. 2006 *Engaging Key Stakeholders: Ensuring the Rights to HIV/AIDS education and health care services*. <https://www.newtactics.org/tactic/engaging-key-stakeholders-ensure-right-hiv-aids-education-and-health-care-services> [accessed 25 September 2015].

<sup>355</sup> ILO: *Labour and Social Issues Arising from Problems of Cross-border Mobility of International Drivers in the Road Sector* (Geneva, ILO, 2006).

<sup>356</sup> International Organization for Migration (IOM): *HIV and Mobile Workers: A Review of Risks and Programmes among Truckers in West Africa* (Geneva, IOM, 2005).

## 4.12 Segments of Migrant Populations at Particular Risk

Particular measures are needed to ensure rights protection, access to health care and to HIV prevention and treatment for certain migrants and segments of migrant populations facing greater risks of exclusion, denial of services and violations of human and labour rights as well as of exposure to HIV. Among these groups are migrant sex workers, migrants identified or identifying as LGBTI (lesbian, gay, bisexual, transgender or inter-sex), and victims of trafficking or forced labour.

Sex workers, LGBTI persons, victims of trafficking and persons in forced labour are especially vulnerable to health pathologies including HIV and AIDS and to poor access to health care and treatment because they are marginalised, stigmatised, in some situations criminalized, and often excluded from legal protection and from existing health services, all the more so when they are migrants. Ensuring that information reaches them and that they have full access to health and HIV services and treatment is essential for upholding public health as well as for realization of all individuals health-related rights. Recognizing the existence and the rights of persons in these groups at risk is primordial to reducing the health and HIV risks they face and to ensuring their access to health care and services.

Services provided to persons among these population segments – whether sex workers, LGBTI persons, victims of trafficking or of forced labour – should promote the involvement of persons concerned in the delivery processes, in particular in their design and implementation as well as through peer education. Such an approach is pertinent for services aiming to ensure universal access of persons concerned to sexually transmitted infections (STIs) and HIV prevention, including information, education, condom delivery, voluntary counselling and testing, as well as antiretroviral therapy, care and support services. Particular action to address and eliminate discrimination against sex workers, LGBTI persons, trafficked persons and victims of forced labour who are migrants is also needed.

### Key Actions

#### Sex Workers

**A. Defend the human rights and dignity of persons engaged in sex work.** Policy, discourse and treatment by government authorities, health services providers, and communications media should acknowledge the humanity as well as the rights and dignity of sex workers. Provide know your rights information and training to sex workers and to authorities, institutions and other concerned actors.

**B. Address the structural and legal barriers that affect sex workers.** Governments and all stakeholders should prioritize and intensify efforts to protect the human rights of sex workers and to increase their access to HIV prevention and treatment services. This includes reviewing and repealing punitive laws having a negative health outcomes and that contradict public health evidence.<sup>357</sup>

<sup>357</sup> UNAIDS. 2017. Joint United Nations Statement on ending Discrimination in Health Care Settings. [http://www.unaids.org/sites/default/files/media\\_asset/ending-discrimination-healthcare-settings\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/ending-discrimination-healthcare-settings_en.pdf) [accessed 25 September 2017].

**C. Enact specific legal protection for sex workers.** Promote the enactment of anti-discrimination and other rights-protection legislation to protect sex workers from discrimination and violence. Advocate for and support specific training for law enforcement officials and health care providers to guard against stigma and discrimination in their interactions with sex workers.

**D. Support sex workers empowerment.** Actively reach out to sex workers and ensure they receive information on healthcare, particularly HIV prevention, voluntary testing, counselling and treatment. Support them to become agents of education and collective self-empowerment within their own communities, by engaging them in dialogue and involving them in information dissemination campaigns and other measures to bolster the effectiveness of health enhancing as well as HIV prevention measures.

**E. Elevate access to information and services.** Promote and enable free education on HIV prevention to sex workers as well as provision of information on how and where they can access medical and counselling services.

**F. Provide training to public authorities and institutions.** Training and awareness-raising on protection of sex worker rights, access to health care and services, and specific approaches on HIV prevention, care and treatment should be provided to public authorities and relevant institutions.

### **LGBTI migrants**

**A. Defend the human rights and dignity of LGBTI migrants.** Discourse and treatment by law enforcement, health services providers, and communications media should acknowledge the human rights of all LGBTI persons. Provide information on rights and defending rights for LGBTI migrants as well as to authorities, institutions and other concerned actors

**B. Decriminalize LGBTI identities and consenting adult relations and include protection regarding sexual orientation and sexual identity in anti-discrimination legislation.** Enact anti-discrimination legislation that protects persons from discrimination and violence regardless of gender identity or sexual orientation.

**C. Ensure access to information and services.** Promote and enable availability of health information and services, including especially HIV prevention, counselling and treatment, to all LGBTI migrants.

**D. Provide safe environments for healthcare and HIV services.** Ensure that access and treatment of all persons in medical and counselling services are free from discrimination, stigma or hostility for any reason, including on the basis of sexual orientation or gender identity.

**E. Provide training for public officials and health personnel.** Specific training on human rights protections, non-discrimination, accessing health services, and HIV and AIDS concerns should be provided to public authorities, concerned civil servants, law enforcement personnel and health care providers regarding public policy and in interactions with LGBTI persons as well as other persons and groups at particular risk.

### Trafficked persons and victims of forced labour

**A. Defend the human rights and dignity of trafficked persons and victims of forced labour.** Ensure that law enforcement, health services providers, and communications media acknowledge the human rights and dignity of victims of trafficking and forced labour and treat them accordingly.

**B. Ensure victims of trafficking are not criminalized.** Repeal laws that criminalize victims of trafficking and punish victims for any offenses or activities related to trafficking, such as forced prostitution or immigration violations.

**C. Incorporate HIV into anti-trafficking initiatives.** Ensure that HIV information is incorporated into programmes and strategic plans designed to combat trafficking in persons.

**D. Prevent deportation or return where there is risk.** Victims of trafficking should not be deported or returned where there is a risk that they or their family members would be harmed.

**E. Ensure that risks for returnees are recognized.** Voluntarily returned victims of trafficking or forced labour survivors should be recognized as key vulnerable populations and provided with health care and HIV services in their country of origin.

**F. Provide long-term support and security to survivors.** Advocate for and ensure provision of support services, psychological support and long-term security, as well as health care and counseling including voluntary testing for HIV and any necessary treatment for victims of trafficking or forced labour. Involve victims of trafficking or forced labour in training and peer support activities that challenge stigma. These activities should incorporate issues related to HIV and AIDS.

**G. Train health officials.** Provide training to health professionals so they can identify and assist victims of trafficking or forced labour, given that they may be the only professionals to encounter victims in captive situations.

#### 4.12.1 Initiatives and Experiences on Segments of Migrant Populations at Particular Risk

##### General Department of Human Rights – Dubai Police, United Arab Emirates

**Context:** In the United Arab Emirates (UAE), Abu Dhabi and Dubai are the cities with the highest prevalence of HIV cases. These are the large cities in the UAE, a country with a very large migrant population. These cities also have significant sex work activity as well as incidences of human trafficking. Sex workers are among the populations most at risk of infection and find it difficult to practice 'safe sex' and to access treatment and care services due to power relations, the illegality of their work and fear of social rejection.

**Purpose and Objectives:** In 2006, the Dubai police established a General Department of Human Rights with the purpose of strengthening protection of women who are victims of sex work trafficking

and providing them HIV prevention and testing services. This was initially conceived as a short-term intervention, yet instead has since become part of the ongoing institutional and organizational structure of the police force.

**Activities:** The Department disseminates *Information, Education and Communication* (IEC) materials to expatriates (translated into their languages) in various locations, including at HIV-testing centers. It seeks to link persons in need to HIV-testing and drug-treatment services. It also helps identify cases of sex work-related human trafficking.

**Outcomes:** Since its establishment, the Department has identified around 50 cases of sex work-related human trafficking per year. It has linked persons in need to key services providers, such as HIV-testing and drug-treatment services.<sup>358</sup>

### Sex Workers:

In **New Zealand**, sex work has been decriminalized and is subject to standard occupational health and safety regulations. Law enforcement treats the sale of sex as it does any other business, without any intrusion or interruption unless existing laws are being violated.

The 1991 Anti-Discrimination Law of Queensland, **Australia** makes it unlawful to discriminate against a person because of their lawful sexual activity, including a person's status as a lawfully employed sex worker, whether or not self-employed.

The “Movimiento de Trabajadores Sexuales del **Perú**” conducts trainings with police and security forces, local authorities and health-care workers in order to change discriminatory attitudes and practices towards sex workers and encourage them to defend the rights of sex workers, particularly in relation to gender-based violence.

Aids ACODEV is an NGO formed by sex workers in **Cameroon**. It uses "educational night patrols" to educate sex workers about HIV prevention at sex work “hot spots” in the capital city. Its peer educators help in sharing information, demonstrating condom use, and sharing negotiation skills for safe sexual practices.

SISONKE is an NGO founded by sex workers in **South Africa**. It consistently engages in community empowerment by training sex workers as paralegals to help curb violence and abuse, and by providing human rights and health training and education to strengthen sex workers' ability to protect themselves from HIV and know their rights.

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<sup>358</sup> ILO: *Leaving No One Behind: Reaching Key Populations through workplace action on HIV and AIDS* (Geneva, ILO, 2014): 59-60.



### LGBTI Migrants

Recognizing the particular risks LGBTI refugees and migrants may face, including hostility from other migrants or persons in host communities, migration departments of several cities such as **Geneva** and **Lausanne** in **Switzerland** set up ‘safe house’ accommodation facilities for arriving LGBTI refugees and migrants. Support services include attention to health and access to HIV care and support. Civil society organizations in cities such as Seattle, New York, and Vancouver have taken similar initiatives.

The Schwulenberatung Berlin, jointly supported by donations and the **State of Berlin**, provides an array of support services for LGBTI refugees, asylum-seekers and migrants, including a Drop-In Centre “CAFÉ Kuchus”, a specialised counselling centre, legal advice on asylum procedures and migration laws, psychological counselling, and an Official Shelter for LGBTI refugees. The center has specific support activity for refugees and migrants living with HIV. Staff or “LGBTI friendly” interpreters provide services in more than 20 languages. [http://www.schwulenberatungberlin.de/refugees-english#paragraph\\_3](http://www.schwulenberatungberlin.de/refugees-english#paragraph_3)

The **United States** Department of State Program on Refugees and Migration (PRM) works with international organizations including UNHCR, other US government agencies such as Department of Health and Human Services and non-governmental organizations (NGOs) to increase assistance to and protection of LGBTI refugees. Actions include providing safe emergency shelter, training staff to understand and address the needs of LGBTI refugees, and strengthening the network of agencies serving LGBTI persons, including those at the local level as well as supporting research on protection challenges faced by LGBTI refugees in urban settings.

See: <https://www.state.gov/j/prm/policyissues/issues/c62979.htm>

“Reaching Out-Winnipeg” (ROW) in **Canada**, a program helping people who face persecution and discrimination based on sexual orientation or gender identity, provides information and guidance to assist and support LGBTI refugees. Its objectives include to “create an increased number of permanent resettlement opportunities for LGBTI refugees in Winnipeg,” resettlement being a permanent form of refugee protection. It offers on-line information on LGBTI refugees (<https://reachingoutwinnipeg.com/lgbt-refugees/>) and an extensive listing of Canadian and international agencies assisting LGBTI refugees and asylum-seekers: <https://reachingoutwinnipeg.com/canadian-and-international-lgbt-refugee-serving-agencies/>

The LGBTI Freedom & Asylum Network (LGBT-FAN) in the USA is dedicated to helping people who are seeking safety in the United States because of persecution based on sexual orientation or gender identity in their home countries. LGBT-FAN members include asylum-seekers and people who have already gained asylum, LGBTI rights activists, faith leaders, LGBTI community center staff, policy experts, scholars, and refugee resettlement workers. It produced *Stronger Together, a Best Practice Guide Supporting LGBT Asylum Seekers in the United States*.

[http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/LGBT\\_Asylum\\_Seekers\\_FINAL.pdf](http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/LGBT_Asylum_Seekers_FINAL.pdf)

### Trafficked persons

The UNDP Regional HIV Programme in Asia and the Pacific advocated for the integration of an HIV prevention and care component in anti-trafficking activities, as well as for a minimum standard of care for trafficked women rescued from forced labour and sex work. Indeed, the first women's court on trafficking and HIV was set up with the Asian Women Human Rights Council and the **NGO, Yakeba**, in **Bali**, in 2009. This format consists in both a call for action against human trafficking and HIV, and an empowerment process of trafficked victims aiming at showing resilience of people living with HIV and confronting stigma.

Between 1997 and 2005, the NGO **Maiti Nepal** provided shelter and care to 448 repatriated sex trafficking survivors, most of them women and girls involved in forced sex trade and therefore with high prevalence of HIV. As a local NGO part of a larger network in South Asia, Maiti Nepal was able to provide trafficking prevention and intervention services for individuals detained in brothels. Repatriated survivors were protected from brothel owners and hosted in temporary shelters before moving to longer-term rehabilitation facilities located in their region of origin. Maiti Nepal provided legal assistance and required healthcare. This includes HIV testing, which is undertaken after the provision of verbal consent with an average time of seven months after brothel servitude for the victim to recover first. HIV test results are recorded by hospital-based laboratories and are retained within the medical record. Such approaches help returned trafficked victims to recover, acquire HIV prevention and care knowledge, and be protected from social stigma and patterns of ostracizing on the basis of a *HIV-positive status*.<sup>359</sup>

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<sup>359</sup> J. Silverman et al.: "HIV Prevalence and Predictors of Infection in Sex-Trafficked Nepalese Girls and Women" in *Journal of the American Medical Association* (2007, Vol. 298, No.5, August): 536-542

# Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action

This publication analyses the interplay between fair labour migration policies, effective responses to HIV and broader health goals to be addressed in countries of origin, transit and destination. An overview of contemporary migration, with a focus on labour migration, is also provided as a basis to frame the discussion.

There are about 150 million migrant workers economically active in the world - employed, self-employed or otherwise engaged in remunerative activity. These are one of the groups left behind in the pursuit of sustainable development. The United Nations' 2030 Agenda for Sustainable Development, Goal 3, aims at ensuring healthy lives and promoting well-being for all at all ages, including for migrant workers and their families.

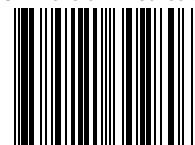
While highlighting the association between HIV-related risk factors and the complex conditions of migration, the publication advocates for improving migrants' access to health and HIV services through the adoption of a human rights-based approach in the governance of the entire migration process; as well as decent working conditions for all migrant workers.

An analysis of the normative framework around migrants' rights regarding HIV and health is provided to set the scene for a framework for action proposing HIV responses targeting migrant workers. To ensure the effectiveness of such responses, the publication recommends that these actions be integrated into broader policies and measures on access to adequate social protection; on inclusive occupational health and safety programmes; and on the protection of the fundamental rights of women and men migrant workers.



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